MENTAL HEALTH AND RELATIONAL NEEDS ASSESSMENT OF CAMBODIAN REFUGEE FAMILIES IN THE UNITED STATES: A TRANSGENERATIONAL ECOLOGICAL PERSPECTIVE

by

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(Under the Direction of Elizabeth Wieling)

ABSTRACT

An estimated 158,000 Cambodian refugees were admitted to the U.S. between 1975-1994 due to civil wars and genocide. Upon arrival, Cambodians were placed in states that had enough entry level jobs, social services, and cheap housing, mostly in high crime neighborhoods. Most Cambodian genocide survivors were preliterate farmers with limited employment skills. They also faced extreme language and transportation barriers, acculturation difficulties, disability, and untreated physical and mental health illnesses. For about 40-plus years of their resettlement, they have not been supported properly by local immigration infrastructures and their history of genocidal trauma was often forgotten. The purpose of this study was to conduct a formal mental health and relational needs assessment of Cambodian refugee families in key resettlement states across the U.S. This study is grounded in a Human Ecological Model (Bronfenbrenner, 1995) and incorporates a trauma informed lens (SAMHSA, 2014). This study employed principles of critical ethnography to guide the methodological conceptualization, design, analysis, and presentation of results. Participants were 18 key informants (i.e., clinicians, educators,

community leaders, legal and human rights activists) who provide services to the population in major cities where most Cambodian refugee families resettled. In-depth interviews were conducted virtually among key informants. All interviews were analyzed using the Developmental Research Sequence (DRS; Spradley, 1979). Results show the need for addressing mental health and family relationship issues among Cambodian refugee families. Untreated mental health illnesses such as PTSD, depression, anxiety disorder, psychotic disorder, and other severe mental health conditions are present, especially among the grandparents' generation. Substance abuse, particularly alcohol abuse, is under reported and used as an alternative for mental health treatment across generations. Tension in couple relationships, parent-child relationships, and intergenerational relationships (of at least three generations) is a pressing concern. There is the need to reconcile family relationships among the population. Systemic evidence-based treatments need to be culturally adapted to effectively address mental health and relational issues of this population. More clinicians and educators need to be trained in trauma treatment, trauma informed care, as well as in Cambodian history and cultural values when they work with the population.

INDEX WORDS: Mental health; family relationships; needs assessment;

Cambodian refugees; critical ethnography; transgenerational ecological framework; forced displacement; post resettlement stress; acculturation stress; intergenerational transmission of traumatic stress.

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DEDICATION

I dedicate this work to my interview participants who shared their time, energy, pain, and personal and professional experiences with me to produce this study. This work is also dedicated to all Cambodian refugees, the Cambodian genocide survivors, my family, friends, and known people whose stories resemble those represented in this work. Finally, I do this for all forcibly displaced families who struggle. It is for you that I strive to find ways to create a better world, so that you may find a safe and nurturing place for you and your families outside of your home countries.

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LIST OF ABBREVIATIONS

Khmer	Cambodian language/ Cambodian people
MFT	Marriage and Family Therapy/Marriage and Family Therapist
ORR	Office for Refugee Resettlement
PTSD	Post-traumatic Stress Disorder
RSARFD	Resources for Southeast Asian Refugees Facing Deportation
SAMSHA	Substance Abuse and Mental Health Services Administration
U.S.	United States of America
USCIS	U.S Citizenship and Immigration Service
UNBRO	United Nations Border Relief Operations
UNHCR	United Nations High Commissioner for Refugees
UNTAC	United Nations Transitional Authority in Cambodia

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CHAPTER 1
INTRODUCTION

"You say goodbye to your country, your people, your home, your friends, your family. Everything you knew. You cry the entire flight."

Arnesa Buljusmic-Kustura

Bosnian writer, researcher, and genocide educator

The ubiquitous impact of psychological trauma among forcibly displaced populations around the world is a pressing and growing public health concern (Magruder et al., 2017). Organized violence (i.e., civil wars, genocide), human rights violations, and the increasing rate of climate change related disasters continue to displace people from their home countries to seek resettlement elsewhere for safety (Ballard et al., 2020; United Nations High Commissioner for Refugees [UNHCR], 2022). It is estimated that by the middle of 2022, approximately 103 million people worldwide were forcibly displaced (UNHCR, 2022). Among these displaced people, about 36.5 percent are children (UNHCR, 2022).

Forcibly displaced and stateless people face many types of adversity such as food and economic insecurity, as well as limited access to health and protection services (McGuire et al., 2021). The full extent of the impact of the COVID-19 pandemic on displacement is not yet known, although UNHCR data shows a decrease of arrivals of new refugees and asylum-seekers in most regions, which can be understood as linked to the pandemic (UNHCR, 2022). However, it is reasonable to predict that the challenge to physically migrate during COVID might be

placing certain vulnerable populations at increased risk for their lives and exposure to ongoing persecution and violence.

Exposure to various types of traumatic events such as witnessing the death of family members, starvation, forced labor, loss of home and belongings, persecution, and family separation are often unavoidable aspects of forcible displacement (Slobodin & de Jong, 2015a). Despite tremendous intergenerational resilience and sheer survival in the face of extreme adversity, experiencing these types of traumatic events exposes refugee populations to psychological and relational consequences that can threaten their ability to maintain healthy relationships with their family and community unless critical support systems are in place (Hanson-Bradley & Wieling, 2020; UNHCR, 2022). Even when refugees are finally resettled, which generally involves a long process that can take years, the traumatic events color their reactions to "normal life" as a resettled person in a new community.

The United States (U.S.) has a long history of refugees' admission since 1891 (U.S Citizenship and Immigration Service [USCIS], 2021). The significant periods of refugees' admission were: the 1910-1920 Mexican Revolution, the Immigration Act of 1917 (literacy requirement), the 1921-1924 Quota Acts (easier for northern and western Europeans but more difficult for Jews and minorities before and during WWII and the Holocaust), 1939-1945 World War II (massive global refugee crisis), the establishment of United Nations (1945-Truman presidency), Displaced Persons Act of 1948 (the U.S. admitted 350,000 out of 7 million displaced persons in Europe), the establishment of the United Nations High Commissioner for Refugees (1950-1951), Refugee Relief Act of 1953 (200,000 escapees from communist countries), Hungarian Escapee Program (1956-1957), Fair Share Refugee Act of July 14 1960, Cuban Refugees of 1959-1962 (58,000 Cubans were admitted), Hong Kong Parole Program of

1962 (about 15,000 Chinese were admitted), Migration and Refugee Assistance Act of 1962 (about 20,000 Cold War victims), the 1965 Amendments to the Immigration and Nationality Act (10,200-17,400 refugees from noncommunist countries each year), Cuban Airlift of 1965 (over 250,000 Cubans), Cuban Adjustment Act of 1966, the establishment of United Nations High Commissioner for Refugees Refugee Protocol, Indochinese Immigration and Refugee Act of 1975 (130,000 - 300,000 Southeast Asian refugees in 1975-1980), Refugee Act of 1980 (from Vietnam and Cambodia), Mariel Boatlift of 1980 (125,000 Cubans), the Lautenberg Amendment of 1990 (from Laos, Cambodia, and Vietnam), First INS Asylum Offices opened (1991), Nicaraguan Adjustment and Central American Relief Act (1997), Haitian Refugee Immigrant Fairness Act (1998), and the establishment of Department of Homeland Security, USCIS, CBP, and ICE (2002-2003) (USCIS, 2021). Based on its history, the U.S. was a country that hosted significant numbers of refugees since the early 1900s, but has dramatically decreased hosting refugees worldwide since the early twenty first century (Krogstad, 2019). The decision making of refugee admission to the U.S. is dependent on the presidency and its political priorities. For example, during Donald Trump's administration, the U.S. hosted the least number of refugees of all time in its history, while other host countries increased their intake of refugees during a time of an enormous surge of refugees globally (Krogstad, 2019). At the end of Trump's presidency, the U.S. admitted only about 18,000 refugees as one of the most affluent countries in the world (Krogstad, 2019).

Between 1975 to 1994, the U.S. hosted refugees who were Indochina war victims from Southeast Asia (i.e., Vietnamese, Laotian, and Cambodian) (Krogstad, 2019; USCIS, 2021). These refugees experienced not only war, but a genocidal regime before and after the war. Very little research has been done on the effects of the genocide on the survivors who became

refugees. The U.S. took in 157,518 Cambodian refugees after the war. These people mainly settled in the northern states where the weather is extremely different from that in Cambodia. Many suffered from mental health disorders due to trauma, which has impacted further generations.

Some background about the situation is necessary to understand the current plight of first, second, and third generation Cambodian immigrants. In 1975, communism came into full power in the three countries causing civil wars, human rights violations, and genocide in Cambodia between April 17th 1975 to January 7th 1979 (Chandler, 1979, 1994; Kiernan, 2002). Nearly half of the Cambodian population perished during these 4 years. Approximately three million Cambodians out of the seven million total population died due to political execution, torture, famine, forced labor, exhaustion, and illness under the genocidal regime known as "Khmer Rouge" or "Pol Pot" regime (Chan, 2015; Chandler, 1979, 1994; Heuveline, 2010; Kiernan, 2012). Most importantly, Cambodians experienced extreme disruption of family functioning and relationships as the regime separated parents from children, husbands from wives, and siblings from siblings according to their age groups (Kiernan, 2002). According to historian Ben Kiernan (2002, 2012), it was recorded that no more than two people were allowed to be together and for a limited amount of time. At the end of the genocidal regime, many families could not find each other and were not sure if their family members were still alive. Because Cambodians did not feel safe to stay in Cambodia due to the fear of a second genocide, Cambodian survivors migrated by foot to the neighboring country of Thailand (Chan, 2015; Kiernan, 2002). Cambodian refugees continued to live in harsh conditions in Thai refugee camps for about another decade (Chan, 2015). Some were able to get admission to the U.S., while some were pushed back to Cambodia by Thai military troops (Chan, 2015). Many Cambodians continued to

die due to extreme fatigue, famine, poor physical health, and from landmines placed all over the countryside during the genocide.

Four waves of Cambodians migrated to the U.S. between 1975 and 1994 (Chan, 2015; Chi-Ying Chung, 2001; Wycoff et al., 2011). The first wave consisted of wealthy university students, while the second was comprised of scholars and professionals who had working liaisons with the U.S. government (Chan, 2015; Scully et al., 1995). The third wave consisted of thousands of educated people and professionals fleeing the country at the beginning of the Khmer Rouge regime through refugee camps in Thailand, the fourth was represented by a large number of preliterate farmers arriving the U.S. as refugees in the 1980s and 1990s (Chan, 2015, Wycoff et al., 2011). Approximately 158,000 Cambodian refugees were admitted to the U.S. between 1975-1994 (Chan, 2015).

These Cambodian resettled refugees were exposed to tremendous levels of psychological trauma before and after resettlement (Chan, 2015; Kiernan, 2002), and the intergenerational transmission of trauma was poorly understood and virtually undocumented. To date, very few studies have systematically documented their wellbeing across psychological, relational, community, and economic levels. These war-torn refugees have resettled in the U.S. for about 40+ years and yet their needs in terms of mental health and family relationships have not been formally documented, so it is hard to call for political action, structural reform, and effective psychological and family-level interventions in response to their unique needs. Therefore, the current study grounded in an ecological framework aims to conduct and formally document a mental health and relational needs assessments by interviewing key informants who provide services to Cambodian refugee families across the U.S.

Traumatic Stress and Displacement Among Cambodian Refugees

Pre-Migration. To fully understand psychological and relational impacts of the war and genocide on Cambodian refugees in the U.S., it is important to have a brief historical and political knowledge of Cambodia. Cambodia is a small country in Southeast Asia located between Thailand, Vietnam, and Laos (Chandler,1979, 1994). The majority of the population is ethnically Khmer and speak Khmer as their first language. Cambodian culture was influenced by Indian civilization and its main religion is Buddhism rooted in India. During the Angkor era (802-1431), Cambodia ruled most of Southeast Asia and was known as the Kingdom of Angkor (Chan, 2015; Chandler, 1979, 1994). Angkorian kings built many temples that still attract tourists from around the world. At the end of the Angkor era (1431), its neighbors Siam (Thailand) and Vietnam invaded and took turns ruling Cambodia for centuries depending on who was more powerful at that time (Chandler, 1979, 1994). In the mid-19th century, Siam and Vietnam divided Cambodia into two and ruled over it. Between 1863 to 1953, the French colonized Cambodia. Simultaneously, the French also colonized other countries in the region such as central and south Vietnam and Laos (Chan, 2015). These occupied territories were known as French Indochina. Between 1941-1942, Japan invaded and occupied most of the Southeast Asia region, despite European colonization at that time. In March 1945, as Japan was losing the war, Japan encouraged the local leaders of Southeast Asian countries to claim independence from the Europeans. The Cambodian King, Norodom Sihanouk, made the attempt and got independence from France in 1953. King Sihanouk was very politically active in 1955 and broke diplomatic relations with the U.S. in 1967 (Osborne, 1994). He maintained a relationship with China, as he predicted it would become the most powerful country in Asia (Osborne, 1994).

The Cambodian communist movement was active in the 1930s, dissolved during World War II, and recreated itself in 1951 sponsored by the Vietnamese government (Chan, 2015). This group started with 2000 members and was divided into 3 parts. One part was led by French-educated Saloth Sar, otherwise known as Pol Pot, a name assumed as leader of the Khmer Rouge (Chandler, 1992; Kiernan, 2002). In 1970, King Sihanouk was overthrown by his prime minister, General Lon Nol, and his deputy, Sirik Matak (the King's cousin) (Chan, 2015). Lon Nol's government quickly rebuilt a relationship with the U.S. government, which provided Lon Nol with $1.18 billion dollars in military aid and $503 million dollars for civilian aid for his 5-year ruling of the country (Chan & Kim, 2003; Chan, 2004). During that time, King Sihanouk joined the Khmer Rouge, his enemy, to fight against Lon Nol's government.

In 1970, a civil war between the Khmer Rouge and the Lon Nol government began in Cambodia, causing about half a million Cambodian deaths and internally displacing at least three million out of its total population of about seven million (Chan, 2015). The Khmer Rouge controlled about one sixth of the country with 15,000 troops. By 1975, its troops grew to about 200,000, and they took over Cambodia on April 17th,1975, when the bloody genocidal regime started (Chandler, 1979, 1994; Kiernan, 2002, 2012). There were five main conditions that contributed to the rapid growth of Khmer Rouge troops (Chan, 2004). First, King Sihanouk used his popularity to gather rural people to join the Khmer Rouge to fight against Lon Nol. Second, the Khmer Rouge took advantage and convinced rural people that they could help the king back to power. Third, the U.S. heavily bombed eastern Cambodia, which north Vietnamese troops used for their military path to south Vietnam during the Vietnam War. Forth, north Vietnam provided military aid to the Khmer Rouge for the beginning two years of the civil war. Fifth, Khmer Rouge troops became very skillful and effective in the battlefield.

Between 1975-1979, the Khmer Rouge regime took over Cambodia using brutality as a method to transform all aspects of Cambodian society (Chan, 2015; Kiernan, 2002). The primary mission of the regime was to get rid of capitalist Western influences by returning to a classless society where everyone worked as farmers and owned no personal possessions (Blair, 2000; Chan & Kim, 2003; Chan, 2015; Chandler, 1979, 1994; Kiernan, 2002). Two million citizens in Phnom Penh, the capital city of Cambodia, were forced to evacuate from the city to assigned rural areas and prepare to work on the rice fields (Kiernan, 2002, 2012). On the way, the Khmer Rouge interrogated people at gunpoint to identify former government officials, military commanders, educated people, and other professionals, who were immediately shot to death (Chan, 2015). The Khmer Rouge destroyed Buddhist temples (sacred places for about 90 percent of Cambodians), killed many Buddhist monks, closed down education institutions, destroyed private property, money, banks, hospitals and all types of Western- influenced institutions (Chan, 2015; Kiernan, 2002, 2012). Family members were forced to leave their property and move to unfamiliar places either together or separately (Kiernan, 2002). Specifically, adults were forced to work for up to 15 hours per day with very limited food provided, while children were taken away and put into separate living quarters. Children were brainwashed and taught to report the acts of their family members to regime commanders. As a result, some parents were killed, and some children were trained to be fighting troops (Kiernan, 2002). No physical signs of exhaustion or displays of emotions were allowed, as it meant certain death.

During the regime, despite compliance to the rules of the Khmer Rouge and due to the paranoid nature of the regime leaders, many people--including the Khmer Rouge's own officials and commanders--were arrested, interrogated, tortured, and killed brutally if they were suspected of disobeying regime rules (Chan, 2015). The Khmer Rouge turned a school in Phnom Penh into

a torture camp known as S-21, now the Tuol Sleng Genocide Museum (Kiernan, 2002, 2012). Their motto was that "It's better to kill ten people by mistake than to leave one guilty person alive." Additionally, the Khmer Rouge also persecuted and killed ethnic minorities such as Cham (Muslims from Malaysia), Vietnamese, Chinese, and indigenous minority groups (Kiernan, 2002, 2012). By the end of the regime, about one third of Cambodia's total population had died. Because of the mass killing of civilians by the leaders of Khmer Rouge, Cambodia was once known to the world as the "killing fields" (Mollica et al., 1987).

The Khmer Rouge regime came to an end on January 7th, 1979, due to the returning of the Khmer Rouge military commanders who opposed Pol Pot and escaped to Vietnam during the regime itself (Kiernan, 2002, 2012). They brought with them 120,000 Vietnamese troops. These former Khmer Rouge and about 40,000 troops fled into the jungles, taking with them thousands of civilians. The new government was sponsored and indirectly led by the Vietnamese military (Chan, 2015). A civil war between the Khmer Rouge in the jungles and the Cambodian government led by Vietnamese military continued for another 10 years, mostly in the countryside. Vietnamese troops withdrew from Cambodia in 1989 because of the intervention of the United Nations and other countries in the region. The United Nations Transitional Authority in Cambodia (UNTAC) was created in 1991 to deal with the influx of about 360,000 Cambodian refugees at the Cambodian-Thai border (Chan, 2015). The Khmer Rouge still continued disturbing people in the rural areas, especially in the northern part of the country until the late 1990s when most of its leaders surrendered to local governmental authorities (Kiernan, 2002, 2012).

During Migration. At the end of the Khmer Rouge regime, the survivors migrated within the country to search for family members whom they were separated from and who may

still be alive (Chan, 2015). After a few months of internal migration, more people became sick and starved to death due to a lack of food supplies and low rice production. At this point, many Cambodians attempted to leave the country and fled to refugee camps in Thailand. The elderly, women, and children were initially allowed to enter Thailand, but most were later pushed back to Cambodia by the Thai military (Scully et al., 1995). The Thai government was overwhelmed by half million refugees from three countries (i.e., Cambodia, Vietnam, and Laos) (Chan, 2015) and the Thai government considered this influx to be a threat to their security and national resources.

Because Thailand did not sign the 1951 and the 1967 United Nations Convention Related to the Status of Refugees that outlined how refugees should be treated, the Thai government had the legal right not to host Cambodian refugees (Chan, 2015). Even though Thailand allowed UNHCR to build camps to host refugees and feed them in their territory, Thailand had the power to administer the camps by themselves. In 1979, an international conference held in Geneva attended by 65 countries agreed that neighboring countries of first asylum (i.e., Thailand, Malaysia, Singapore, Indonesia, the Philippines, and Hong Kong) should continue to host refugees temporarily (Chan, 2015). Then, the countries of second asylum, such as the United States, Canada, Australia, and France, would continue to increase admitting more refugees. Sadly, this agreement applied only to boat refugees, not refugees on land, as in the case of Thailand. This led to the Thai government's decision to relabel "displaced persons" to "illegal immigrants or illegal entrants" (McNamara, 1990; Muntarbhorn, 1992). Then, Thailand closed its border and deported 40,000 refugees back to Cambodia, causing the death of the majority of them through stepping on landmines planted by the Khmer Rouge during their regime (Chan, 2015). There was a huge international outcry over this outcome, thus stopping Thailand from deporting the remaining Cambodian refugees.

There were two types of camps found along the border of Cambodia and Thailand: 1) refugee camps and 2) border camps. “Refugee camps” were created by UNHCR in Thai territory while “border camps” were inside Cambodia itself. Refugees who were placed in “refugee camps” had an opportunity to be interviewed for potential resettlement while refugees in “border camps” did not have the same opportunity because the Thai government forbid UNHCR from entering Cambodia. The United Nations then established the United Nations Border Relief Operations (UNBRO) to support over 300,000 Cambodian refugees in the “border camps.” Unfortunately, food supplies designated for people in “border camps” had to be handed to the Thai government first, then to Cambodian officials. By the time it reached the refugees, most of the food supplies had been sold for personal benefit among those authorities (Mason & Brown, 1983).

Those who were able to enter Thailand continued to migrate across camps for years (between 1-12 years) while they were waiting to obtain admission to the second asylum countries, such as the U.S., for resettlement (Coli & Magnuson, 1997). The first camp they were placed in was named Sakeo and was located in a rice field with very poor living conditions (i.e., shelters were hastily made from plastic tarps in a few hours; the ground was muddy when raining; there were open toilets with very poor hygiene; and people died because of widespread of disease, germs, and exposure to elements). This condition was broadcast and received international attention, especially after the visit of Mrs. Rosalyn Carter, President’s Jimmy Carter’s wife, to the Sakeo camp. As a result, in November of 1979, a bigger camp called Khao Dang I was established by UNHCR to host those Cambodian refugees who later got admitted to the U.S. and who were the fourth wave of Cambodian refugees entering the U.S (Chan, 2015; Shawcross, 1984). Even though the bloody Khmer Rouge regime ended, Cambodian refugees

continued to experience traumatic stress due to migration, uncertainty, constant adjustment to adverse conditions, severe poverty, lack of food, harsh labor conditions, lack of family and host country support, and complicated grief (Becker et al., 2000).

Post Migration. The 1980 Refugee Act allowed Cambodian refugees in Khao Dang I the opportunities to enter the U.S. The U.S Cambodian refugee recruitment program that started in 1975 and ended in 1994, admitted a total of 157,518 Cambodians (148,665 as refugees, 6,335 as immigrants, and 2,518 as humanitarian and parolees) to the U.S. (Chan, 2015). There were also many more Cambodians admitted to the U.S. after 1994 with the status of immigrants, not refugees. Cambodian American born children and youth are among the fastest growing population in the U.S. It was estimated that approximately 339,000 immigrants with Cambodian descendants lived in the U.S by the year of 2019 (Budiman, 2021). Although these children of the original refugees did not themselves experience the horror of the genocide and subsequent camps, their experience is impacted by their parents' and grandparents' experiences.

The Office for Refugee Resettlement (ORR) was established to facilitate the resettlement of this large group of Cambodian refugees along with Vietnamese and Laotian refugees (Chan, 2015). To prevent overloading resettlement problems to a particular state, resettlement officers sent these refugees to different states. There were four factors that defined resettlement placement decisions: 1) location of voluntary service agencies, 2) location of existing relatives in the U.S., 3) locations that had low-cost housing, and 4) locations that had entry-level jobs with no English-speaking requirements. Prior to the first wave of Cambodian refugees entering the U.S., there were no existing Cambodian communities in the U.S.

Many Cambodian refugees readily resettled in Long Beach, California, as it was known to Cambodians due to its history of having Cambodian students enrolling in engineering and

other technical courses during the 1950s and 1960s when the Cambodian government had diplomatic relations with the U.S. government (Chan, 2015). The Cambodian Students Association established during that time (1950s-1960s) quickly transformed into the Cambodian Association of America that supported the refugees during the four waves of their arrivals (Chan, 2015). Long Beach has the largest population of Cambodian descendants followed by Lowell, Massachusetts. Perter Pond (a protestant minister) used to work with Cambodian refugees in the Thai border camps and was a strong advocate who made Massachusetts a refugee-friendly state with the assistance from Kitty Dukakis, the wife of Governor Michael Dukakis at that time (Chan, 2015). These two population centers were attractive but could not support all of the refugees.

The Khmer Guided Placement Project or "Khmer Cluster Project" was established by ORR to prevent chaos and crisis among service delivery agencies such as social services, schools, and public assistance programs in one particular state (Mortland & Ledgerwood, 1987). Hence, ORR persuaded Cambodians refugees to be placed in cities that did not have large numbers of Cambodian and other Indochinese refugees, but which had cheap housing, enough social services, and enough entry level jobs to accommodate a new immigrant population. Some of these choices turned out to be disastrous for the refugees. Because of poor planning and lack of coordination among involved agencies, resettlement in New York City turned out to be a huge failure because rural Cambodian refugees could not keep up with the fast-moving city life. In addition, they were placed in locations with high levels of criminality that adversely impacted their safety and their children's outcomes (Chan, 2015).

Cambodian refugees who were pushed back to Cambodia from the Thai border always thought that those who were able to enter refugee camps in Thailand were fortunate, as they had

a chance to get admission and start a new life in a developed country such as the U.S. Was it true? Unfortunately, this ideal was not reality for the majority of resettled families. Those who were able to migrate to the U.S. continued to be exposed to traumatic stressors and acculturation stress due to a complex array of factors (Chan, 2015; Wycoff et al., 2011).

First, they had to start their life and rebuild their family from scratch, as there was limited funding from the host country to support the start-up of newly resettled refugees (Wycoff et al., 2011). Second, they faced unemployment due to limited educational backgrounds, particularly for the fourth wave of farmers from rural areas of Cambodia (Chan, 2015; Kiernan, 2012; Kulig, 1996). Even though many of them were able to get entry level jobs, many more were left unemployed and lived on disability funding (Chan, 2015). Third, language and transportation barriers prohibited especially the first generation of Cambodian refugees from seeking physical and mental health support (Berthold et al., 2014). Fourth, most first- and second-generation Cambodian refugees experienced acculturation stress and culture shock. Most importantly, these refugees were very new to an oppressive system with a long history of racism and discrimination (Chan, 2015). Fifth, intergenerational conflict is common, as the generations who were born in the U.S. were more likely to assimilate to the culture of the host country in order to fit in, while the older generations may not understand the new culture and instead demand compliance from their descendants (Sack et al., 1995, 1996). Sixth, traumatic stress, particularly PTSD and complicated grief due to their severe traumatic experiences, remains under-documented and untreated in the U.S., even today (Mollica et al., 1997; Mollica et al., 2014).

This complex situation affecting multiple generations after the initial refugees' arrival means that the ongoing consequences of poor mental health and disrupted family relationships persist and is transmitted from one generation to the next. The trauma in the forms of mental

health disorders (i.e., PTSD, depression, anxiety disorder, resettlement stress) (D'Avanzo et al., 1994; Kinzie et al, 1988; Mollica et al., 1997; Mollica et al., 2014; Sack et al., 1995, 1996), educational challenges (i.e., dropout, poor grade, inability to focus), interpersonal issues (i.e., social withdrawal, inability to maintain healthy relationships and intimacy, intimate partner violence, intergenerational conflict, child maltreatment) (D'Avanzo et al., 1994; Mollica et al., 1997, Chang et al., 2008), and antisocial behaviors (i.e., delinquency, gang violence, crime) frequently lead to incarceration and deportation (Chan, 2015; D'Avanzo et al., 1994). Ironically, after offering refuge to people fleeing genocide, the U.S. failed many of their children and grandchildren, who are facing deportation because of this history of trauma. The harsh consequence of this failure is family separation in the form of deporation. In order to understand this situation and to prevent it for future refugees, this research is needed to examine the impact of traumatic stress on mental health and relationships of refugees, as well as to interrupt the intergenerational transmission of traumatic stress.

Project Overview

Research Significance

Due to the severe trauma inflicted during the Khmer Rouge regime, years of waiting in refugee camps in Thailand, and limited support from the U.S., the country of resettlement, Cambodian refugees still suffer from mental health and relational issues without any public attention or interventions since their arrival about 40+ years ago (Chan, 2015; Mollica et al., 1997; Mollica et al., 2014; Wycoff et al., 2011). PTSD, disruptions in family functioning, and the intergenerational effects of trauma exposure and displacement resulting from the Khmer Rouge genocide have still not been properly addressed (Mollica et al., 2014; Sack et al., 1995, 1996). Barriers spanning from language and transportation challenges (Berthold et al., 2014) to lack of

trained service providers in culturally responsive interventions persist in Cambodian resettled communities (Mollica et al., 2002). The question is who is supporting this population with these major life issues. Other than physical health and psychiatric services, limited services have been tailored for Cambodian refugee families to address their mental health and relational issues (Mollica et al., 2002). Therefore, this current dissertation addresses the critical need for a mental health and relational needs assessments among Cambodian refugee families in the United States. The study investigated experiences and needs of Cambodian refugees through the perspectives of professionals (i.e., psychiatrists, social workers, clinicians, educators, community leaders, and religious leaders) from around the country who have offered services to resettled Cambodian refugees. This formal documentation of mental health and relational needs of Cambodian refugee families can open a path for future scientific rigorous and clinical research testing multilevel interventions such as individual evidence-based PTSD treatments (i.e., Narrative Exposure Therapy-NET), family-based interventions (i.e., parenting-Generation PMTO), and community-based interventions (i.e., multi-family groups and home visitation) in order to support the Cambodian refugee community in healing in the aftermath of traumatic stress across system levels.

Epistemological Orientation and Theoretical Frameworks

Research Paradigm and Epistemology. As a systemic researcher and clinician, I am strongly connected with "Affirmative Postmodernism" (Rosenau, 1992). In postmodernism, it is believed that there is no absolute truth. Realities are socially constructed and evolve over time (Chenail et al., 2020; Freedman & Combs, 1996; White & Epston, 1990). People co-construct realities through language systems. According to Foucault (1980), it is important to emphasize knowledge and power in human relationships. Specifically, it is crucial to examine who is in the

position of power and authority in a relationship (i.e., parent and child, superior and subordinate, spouses, researcher and participant, etc.). Most importantly, it requires special attention to the dominant cultural agenda, as it influences how people construct their realities (Chenail et al., 2020; Freedman & Combs, 1996; White & Epston, 1990).

Epistemologically, I use social constructionism as my way of acquiring knowledge about reality (Gergen, 1985). According to social constructionism, reality cannot be discovered through research, as it is not an independent entity. Instead, it is co-constructed and interrelated in a social system (Gergen, 1985; Kukla, 2000). In other words, knowledge and realities are the product of the interactions among elements of an ecosystem (i.e., individual, family, environment, culture, etc.). Agreeing with the affirmative postmodern paradigm, social constructionists believe that reality is fluid, dynamic, and evolves over time according to the context in which it takes place (Gergen, 1985; Rosenau, 1992).

Trauma-informed Lens. The Trauma Informed Care framework developed by Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) is used as a lens to contextualize this study. According to SAMHSA (2014), Trauma Informed Care is defined as "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for providers and survivors, that creates opportunities to rebuild a sense of control and empowerment" (p. 133). In other words, to be trauma informed is to understand trauma through a culturally sensitive lens. There are six core principles of trauma informed care: 1) safety, 2) trustworthiness and transparency, 3) peer support, 4) collaboration and mutuality, 5) empowerment, voice, and choice, 6) cultural humility.

As a researcher who uses a trauma-informed lens, the emphasis on *safety* helps me ensure a safe, respectful, and welcoming environment throughout the process of the research. The idea of *trustworthiness* helps me ensure boundaries and confidentiality for my participants. *Peer support* helps me identify the existing peer support system or groups and if it is necessary, to create one. The concept of *collaboration* helps remind me about my positionality and power and how I ensure that I let the participants co-create reality and decisions with me. Thinking about *empowerment* helps me ensure that I create an environment that promotes autonomy, voice, and choice among the participants. Lastly, the importance of *cultural humility* reminds me to strive to continue learning about Cambodian cultural values and beliefs, especially among Cambodian refugee families in the U.S., despite my identity as a Cambodian too.

Traumatic Stress and Research. There is much evidence in the literature revealing the intergenerational effects of traumatic stress and highlighting parent-child relationships as the main mechanisms of intergenerational transmission of traumatic stress. Specifically, there is the relationship between parental PTSD and child outcomes (e.g., aggressive behaviors, mood disorders, conduct disorders, substance abuse, and relational issues) (Braga et al., 2012; Field et al., 2013; Fossion et al., 2015; Karenian et al., 2011; Kellermann, 2001; Lehrner & Yehuda, 2018; Letzter-Pouw et al., 2014; Nelson Goff et al., 2020; Perlstein & Motta, 2012; Scharf, 2007; Song et al., 2014). Additionally, individual traumatic stress also affects parents' marital relationship with each other. Specifically, traumatic stress can lead to feelings of disconnection and isolation, and cause angry outbursts, substance abuse, and intimate partner violence (Catani et al., 2009). Impaired functioning in couple and parent-child relationships are the main most common consequences of individual traumatic stress (Nelson Goff et al., 2020).

On the other hand, the existing literature also reveals intergenerational transmission of resilience among trauma-affected populations (Braga et al., 2012; Scharf, 2007; Song et al., 2014). Specifically, resilience in the form of strong parent-child relationships, high parent education levels, high parent socioeconomic status, and parental involvement predict positive child outcomes among Holocaust survivors, genocide survivor families, former child soldiers, and Cambodian immigrant families along the Southern coast of the U.S. (Braga et al., 2012; Mak et al., 2021; Scharf, 2007; Song et al., 2014). From a systemic perspective, resilience refers to the ability of the individual, family, and community to use its internal and external resources to bounce back from adversity (Masten, 2021; Ungar, 2013). Understanding resilience among populations affected by traumatic stress also requires the use of a multisystemic perspective because resilience at the individual level is dependent on resilience at other levels such as family and community (Lehrner & Yehuda, 2018; Masten, 2021; Ventriglio & Bhugra, 2015). Thus, treating traumatic stress requires multisystemic interventions (i.e., individual, family, and community) in order to adequately address the different levels of impact it has.

Relevance to Current Context

In addition to the historical traumas associated with the Khmer Rouge regime, migration, and post resettlement, the pandemic makes it even harder for the population to reunite with their family, especially among those who still have family members living in Cambodia.

During the Trump administration, thousands of Cambodian Americans were deported back to Cambodia due to criminal records, incarceration, gang violence, and drug abuse. These deportees were mostly second and third generation Cambodian refugees who were born in Cambodia and refugee camps. This means that they have no idea about the actual culture and language of Cambodia and lack ways to navigate their lives in Cambodia after deportation. Many

returnees or deportees are suffering from family separation, lack of social support, rejection from the host country of Cambodia, lack of work skills, addiction, and other mental health related issues.

Therefore, conducting mental health and relational assessments among the Cambodian American population is even more urgent in the context of the current pandemic and deportation crisis that exacerbates the existing mental health and relational disruptions among the population. This research calls for immediate action and scholarly attention to respond to the needs of this almost forgotten refugee population.

Research Questions

The purpose of the study is to conduct and document a Mental Health and Relational Needs Assessment of Cambodian Refugee Families in the U.S. from the perspectives of key informants who provide services to Cambodian communities in all stages of migration. The main research questions are: 1) What are mental health needs (e.g., culturally responsive treatments of PTSD, other psychiatric disorders, substance abuse, etc.) of Cambodian refugee families? and 2) What are relational needs (e.g., parent-child relationships, couple relationships, sibling relationships, intergenerational relationships, communal relationships, etc.) of Cambodian refugee families?

Answering these questions will provide a basis to develop more appropriate support for this population. Given the intergenerational nature of the trauma faced by this group, the research can positively impact not only current Cambodian Americans, but future children as well. It is important to understand the needs of this community in order to stop the passing down of trauma as an inheritance and to instead pass down the incredible resilience that this community has.

CHAPTER 2

LITERATURE REVIEW

"To be called a refugee is the opposite of an insult; it is a badge of strength, courage, and victory."

Tennessee Office For Refugees

This chapter presents an overview of the scholarly literature with respect to trauma-affected populations, particularly in the context of war exposure and forced displacement. First, I summarize research specifically conducted among resettled Cambodian refugee communities on their mental health status after trauma exposure and its impact across system levels (individual, family, and community subsystems). Second, intergenerational transmission of traumatic stress and resilience are presented to highlight the need to disrupt the intergenerational transmission of traumatic stress and strengthen the intergenerational transmission of resilience among refugee communities. Third, the ecological framework (Bronfenbrenner, 1995) is outlined as the main theoretical grounding of the study to design, document and obtain a deeper understanding of the mental health and relational needs of Cambodian refugee communities.

Mental Health and Relational Consequences of Trauma Exposure Among Cambodian Refugees

Individual Subsystem. Refugees escaping war and violence are at higher risk for adverse mental health consequences. Particularly, these war-affected refugees are susceptible to

mental health disorders such as PTSD, anxiety disorders, depression, adjustment disorders, complicated grief, psychosis, and suicide (Birman & Tran, 2008; Carlson et al., 1991; Fazel et al., 2005; Kim, 2016; Mollica et al., 1998; Mollica et al., 1987; Murray et al., 2010; Shannon et al., 2012; Wieling et al., 2020). Forcefully displaced refugees are particularly prone to experiencing and witnessing life-threatening events that can leave them vulnerable to developing PTSD (Fazel et al., 2005; Mollica et al., 1998; Mollica et al., 1987; Murray et al., 2010; Wieling et al., 2020). The accumulation of traumatic stress over time during the process of migration can lead to mental health complications due to its comorbid nature (Berthold et al., 2014; Berthold et al., 2019; Hinton et al., 2000; Hinton et al., 2011; Mollica et al., 1998; Mollica et al., 1987). Trauma survivors may continue to be impaired emotionally, behaviorally, cognitively, biologically, and spiritually long after experiencing traumatic events (Hanson-Bradley & Wieling, 2020; Nelson Goff, 2020). In the case of Cambodian refugee families that resettled to the U.S., the experiences often encompass a complex array of exposures to severe traumatic events for years during civil war and the Khmer Rouge regime, years of migration through resettlement camps, limited support from the host country, lack of access to culturally responsive mental health treatment, and little to no community level (e.g., school, medical system) infrastructure to support them in the healing and recovery processes (Chan, 2015; Mollica et al., 1998; Mollica et al., 1987).

Individual Symptoms of PTSD among Cambodian Refugees. At the initial phases of resettlement in the U.S., Mollica and colleagues (1987) conducted a study on the psychological impact of war exposure among refugees from Indochina (i.e., Cambodian, Vietnamese, and Laotian) and reported that this group was among the most highly traumatized populations as evidenced by their trauma exposures (average of 10 events and 2 torture experiences). The study

also reported that many participants were diagnosed with major affective disorder, PTSD, the comorbidity of major affective disorder and PTSD, and the comorbidity of psychiatric disorders and medical and social disabilities in relation to their past traumas (Mollica et al., 1987). Cambodian women without spouses were reported manifesting more severe psychiatric and social impairments than other Indochinese patient groups. Another study conducted specifically among Cambodian refugees by Mollica and another team (1998) investigated the dose effect of trauma exposure on symptoms of depression and PTSD. The findings reported a mean of 14 Khmer Rouge related trauma exposures and an additional 1.3 trauma exposures during the past year (after resettlement). A strong correlation and dose of depression, PTSD, dissociative and cultural syndromes were revealed. The research team claimed that the cumulative effects of trauma continued to impact the preexisting psychiatric symptoms even after a decade of resettlement (Mollica et al., 1998).

A study conducted among Cambodian refugee women in Long Beach and Lowell reported PTSD symptoms (i.e., chest pain, pressure or heart palpitation, shortness of breath, sleeping a lot, being quiet, dizziness, a loss of concentration, feeling sick, loss of appetite, ruminating about war in Cambodia, loneliness) (D'Avanzo et al., 1994). Cambodian refugee women also shared about their grief related to leaving family behind, losing their culture, and lamenting their current physical health status. D'Avanzo and Barab (1998) conducted another study comparing Cambodian refugee women (N= 90 in the U.S. and N= 65 in France) by using the Hopkins Symptoms Checklist (HSCL) and conducting in-depth interviews. They reported high symptoms of depression, anxiety, and ruminating over past events (cultural bound syndrome of PTSD- "thinking a lot" or "Kitchreun" in Khmer) among participants in both sites (87% of women in the France and 65% of women in the U.S.). The researchers claimed that

there was high prevalence of undocumented PTSD among Cambodian refugees in both sites. The memories of the bloody genocide and migration process continued to linger and consequently led to poor overall health. Additionally, another recent study reported high prevalence of the cultural syndrome of "thinking a lot" among Cambodian refugees (the majority of them were diagnosed with PTSD) at an outpatient clinic in Lowell, Massachusetts (Hinton et al., 2016). The majority of participants were women who were household caregivers, unemployed and receiving disability benefits, and who did not speak English fluently.

Two consecutive studies conducted among Cambodian refugees settled in Greensboro, North Carolina, between 1983-1985 by Carlson and Rosser-Hogan (1991, 1993) reported that a large proportion of Cambodian refugees still manifested high levels of psychiatric symptoms such as PTSD, dissociation, clinical depression, and anxiety disorders even after a decade of resettlement in the U.S., and that there was a high correlation between the number of trauma exposures and the severity of these psychiatric symptoms. The researchers were alarmed by the severity of the symptoms found among this "non-clinical" population and called for clinical interventions to be developed and implemented for the population.

Marshall and colleagues (2005) conducted a cross sectional study of mental health after two decades of resettlement among 586 Cambodian refugees (Aged 35-75) residing in Long Beach, California. All participants reported the experience of severe traumatic events before immigration. Specifically, ninety nine percent of that sample were exposed to near-death starvation and ninety percent had family and close contacts murdered during the Khmer Rouge regime. The findings reported a high prevalence of PTSD and major depression and the comorbidity of the two. The severity of these disorders increased for those who were older in age, unemployed, disabled or retired, and who had poor English proficiency and lived in poverty.

Two decades after resettlement, the population continued to have high rates of psychiatric disorders stemming from their past trauma exposure. In 2006, these researchers conducted a related study among the same participants on their rate of seeking mental health services (Marshall et al., 2006). Among 339 participants who met criteria for PTSD, major depression, and alcohol abuse, most of them sought medical care (N=70%) and were referred by medical doctors for psychiatric care (N=46%).

Substance uses among Cambodian refugees. Substance use is stigmatized in the Cambodian culture, so people tend to hide information related to personal use, but do share about others in the family who use drugs or alcohol. Due to cumulative stressors pre and post resettlement, Cambodian refugees are at risk of substance abuse in response to their mental health issues (D'Avanzo, 1997). A study conducted among Cambodian immigrant families along the Southern coast of the U.S. reported high levels of substance use (i.e., alcohol and tobacco) of their family members and frequent angry outbursts, particularly among those who lived through the Khmer Rouge regime (Mak et al., 2021). Another study by Berthold and colleagues (2007) conducted among 339 Cambodian refugees in the largest Cambodian community in the U.S reported alcohol disorder among the participants, even though participants denied personal use of alcohol. Two studies conducted by Marshall and colleagues (2005, 2006) reported a low rate of alcohol disorder among Cambodian refugees. Based on these studies, it is difficult to know the prevalence of substance abuse disorders in Cambodian refugee communities.

Comorbidity of mental and physical health among Cambodian refugees. The comorbidity of major affective disorders, PTSD, medical and social disabilities have been documented in Cambodian refugee communities (Mollica et al., 1998). Berthold and colleagues (2014) also found the comorbidity of depression and PTSD and physical health problems (i.e., diabetes,

hypertension, stroke, and heart disease) in all age groups among 136 Cambodian refugees residing in Connecticut and Massachusetts. The researchers reported that Cambodian refugees seemed to develop this comorbid condition at a young age. It was also reported that Cambodians experienced health disparities and premature death due to the complexities associated with these comorbidities, especially as they related to their untreated past traumas. In 2019, Berthold and another team conducted a study on the association between social isolation and poor physical and mental health among 100 Cambodian refugees in Connecticut. Social isolation, a symptom of depression, in the form of disengagement in community and religion led to negative overall health outcomes. This showed that the comorbidity still exists among the population despite over three decades of resettlement.

A study by Hinton and colleagues (2000) using a clinical sample from two psychiatric clinics in Massachusetts also revealed the connection between psychiatric problems and physical health among Khmer refugees. Specifically, they found that sixty percent of participants who had a sore neck, orthostatic dizziness, gastro-intestinal distress, and dizziness while seated also had panic disorder, which the researchers suspected was linked to untreated PTSD. In 2011, Hinton and another team investigated and found the association between "worry attacks" induced by panic attacks and PTSD among a clinical sample at the same site of their previous study (Hinton et al., 2011). These studies underscore the need for mental and physical care providers to assess for a range of comorbid disorders in this population.

Family Subsystem. Family separation and death of family members during the migration process severely disrupt and often destroy the family structure of refugee communities (Hanson-Bradley & Wieling, 2020; Nickerson et al., 2011; Slobodin & de Jong, 2015b; Wieling et al., 2020). These losses leave refugees at risk of experiencing complicated grief due to both the

concrete and the ambiguous nature of their losses (Carlton et al., 2008; Hanson-Bradley & Wieling, 2020; Nickerson et al., 2014; Utrzan & Northwood, 2017). In the case of Cambodian refugee families, the violence and brutality of the Khmer Rouge regime left them with concrete memories of the death of family members, as well as others close to them, and the threat of losing their own lives (Kiernan, 2002, 2012). After resettlement, they had to focus on personal survival and the wellbeing of their families and had no time to grieve. In addition to their concrete losses, they also experienced another type of loss referred to as ambiguous loss (Boss, 2006). According to Boss (2006), there are two types of ambiguous loss. The first type refers to the physical absence but psychological presence of loved ones – Cambodian refugees lived without evidence that certain family members were dead or alive but continued to long for them without knowledge of their status or whereabouts. The second type refers to having the physical presence of loved ones but psychological and emotional absence – Cambodian refugees who survived and resettled often suffered from severe PTSD and comorbid conditions that disrupted their relational functioning. These losses can be complicated to address without professional support from mental health workers.

Stress among Cambodian refugee families. D'Avanzo and team (1994) reported in their study among 60 Cambodian refugee women in Long Beach and Lowell the presence of aggressive and violent behaviors toward others and patterns of isolating oneself from family and friends. This study also reported concerns about infidelity and financial issues. A study by Hinton and colleagues (2011) reported "worry attacks" among a clinical sample of Cambodian refugees brought about by current stressors such as a lack of financial resources, children not attending school, and concerns about relatives in Cambodia. The researchers suspected that "worry attacks" were exacerbated by preexisting PTSD among the population.

Impact of family trauma exposure on mental health of Cambodian adolescent refugees. Mollica and team (1997) documented the effects of war trauma on functional and mental health outcomes of Cambodian adolescent refugees in a refugee camp in the Thai-Cambodian border. The results showed the cumulative effects of trauma through lack of food, water, and shelter. The adolescents reported psychiatric symptoms such as somatic complaints, social withdrawal, attention problems, anxiety, and depression. The dose effect of cumulative trauma and psychiatric symptoms was also strong among their parents. Rousseau and colleagues (2004) conducted a longitudinal study on the impact of the family environment on emotional and behavioral symptoms among adolescent Cambodian refugees residing in Montreal, Canada, and reported that family conflict increased over time and was associated with adolescents externalizing behaviors. On the other hand, gender, acculturation level, and family structure were related to adolescent internalizing behaviors.

Anger outbursts among Cambodian refugees. PTSD individual level symptoms, such as anger outbursts and an inability to regulate emotions, are common experiences among trauma-affected populations that can lead to intimate partner violence and all forms of child abuse in parenting (i.e., emotional, physical, and sexual abuse, and neglect) (Catani et al., 2008; DeMaria et al., 2017; Sriskandarajah et al, 2015; Saile et al., 2013). These also lead to unstoppable mental health issues among the subsequent generations as in the case of intergenerational transmission of traumatic stress among refugee families (Yehuda et al., 2001). Not being able to control intense and conflicting emotions of love and fear, as well as having no alternative parenting skills besides the familiar harsh punishment, leaves parents vulnerable to resorting to violent and harsh discipline practices toward their children (Herman, 1997). A common form of aggressive behavior parents use is corporal punishment, which falls along an unclear line between discipline

or physical abuse (DeMaria et al. 2017; Gershoff, 2002; Slep & O'Leary, 2007). Meta analyses of this literature show the link between parents' use of corporal punishment and negative child behavioral and emotional outcomes (Aucoin et al, 2006; Gershoff, 2002; Slep & O'Leary, 2007). Specifically, research shows that the use of corporal punishment makes children conform immediately with the parent's order, but leads to aggression, antisocial behavior, delinquency, low self-concept, low emotional adjustment, and high impulsivity (Aucion et al, 2006). Because children learn from their parents, violent and aggressive behaviors are more likely to pass to subsequent generations in response to stressful parenting and child behavioral management (Siegel, 2013).

Outbursts of anger associated with trauma exposure are also very common among Cambodian refugees. A study conducted by Nickerson and Hinton (2011) reported anger outbursts among Cambodian refugee participants in Lowell, Massachusetts. Their anger was reported to affect their marital relationship and led to verbal and physical violence, and sometimes suicidality.

Community Subsystem. The resources and support offered by the resettled countries define how fast refugee individuals and their families recover from adversity and cumulative traumatic stress (Slobodin & de Jong, 2015b; Wieling et al., 2020). Local authorities, particularly in the U.S., systematically fail to provide mental health support to newly resettled refugees (Shannon et al., 2012; Shannon et al., 2014, 2015). There is a lack of funding from the local government to support the startup of newly resettled refugee families in the U.S. Additionally, refugees experience adjustment issues and acculturation stress, as they need to learn a new way of living in a new unfamiliar host country (Birman et al., 2005; Lindert et al., 2008; Nwadiora & McAdoo, 1996; Persky & Birman, 2005). For example, seeing unfamiliar people speaking an

unfamiliar language, having no proper housing for oneself and the family, eating unfamiliar food, walking in unfamiliar neighborhoods, being in unfamiliar weather, and a lack of basic resources and social support are challenging without enough support systems (Chan, 2015; Murray et al., 2010; Shannon et al., 2012; Shannon et al., 2014, 2015). These experiences are not unique to Cambodian refugee families that resettled to the U.S. This population, saved from the Khmer Rouge regime and enduring years of migration in refugee camps, were not provided enough resources to meet even basic needs such as food, housing, language help (D'Avanzo et al., 1994), transportation (Berthold et al., 2014; D'Avanzo et al., 1994), mental health services, relationship supports, and parenting skills in the context of displacement. At the beginning of the 1980s, when the refugees needed that support, there was a lack of funding (Wycoff et al., 2011). Most importantly, this population sustained exposure to severe war trauma for approximately four years in the killing fields of the Khmer Rouge regime (1975-1979). Their precarious mental health and devastating losses they faced were compounded by their lack of skills for a modern job: most of these refugees were preliterate farmers who could only qualify for jobs involving physical labor (Chan, 2015; Kiernan, 2002). Not knowing English and not being able to commute between locations without assistance added stress to their preexisting mental health complications (Berthold et al., 2014; D'Avanzo et al., 1994).

School is usually the main social organization that works directly with refugee children, and school authorities often take the daily stressors of refugee children for granted (Paat, 2013). At home, witnessing parents' harsh labor conditions, having to grow up faster to offer paid labor support to the family (Meyer et al., 2020), experiencing parents' emotional dysregulation (in the case of parental PTSD), witnessing anger outbursts, domestic violence, and a host of other comorbid psychological and relational conditions, all translate to highly disruptive

developmental outcomes for refugee children (Siegel, 2013). At school, being bullied due to the differences in name, skin color, country of origin, language discrimination, and so forth is often compounded by children being forced to join gangs. For these children, with potentially compromised neurobiological processes, a lack of parental role models, the need to adapt to be successful within a predominantly white U.S. majority culture, the lack of educational support at school, parentification at home, and ongoing cultural and societal stigma and discrimination, place refugee children at risk for developmental disruptions, mental health disorders, school dropout, delinquency, substance abuse, and early arrests (Paat, 2013). In the case of Cambodian refugee families, gang violence, delinquency, crime, dropout, substance abuse, emotional dysregulation, and other psychiatric disorders leading to incarceration and deportation became common among the subsequent generations born during migration and after resettlement in the U.S. (Chan, 2015; Mollica et al., 1997; Rousseau et al., 2004). These issues among Cambodian later generation refugees still continue to happen without much attention from scholars, funders, or local government. More trauma informed care trainings (Substance Abuse and Mental Health Service Administration [SAMHSA], 2014) need to be provided to local school authorities, teachers, administrators, and social workers who work directly with these Cambodian refugee youth to support their developmental needs. Most importantly, multilevel needs assessments are needed to document their experiences and be used to inform the development of culturally attuned effective preventive and intervention models.

Intergenerational Transmission of Traumatic Stress

Parent-child relationships are the key mechanisms of intergenerational transmission of traumatic stress (Rowlan-Klein & Dunlop, 1998). Healthy family functioning is very challenging in family systems compromised by trauma exposure and little to no support during resettlement.

Factors that define family functioning are attachment, relationship satisfaction, family support and nurturance, family stability and adaptability, intimacy, communication, and family roles and rules (Becvar & Becvar, 2013). In the case of refugee parents, it is hard for them to ensure a healthy family functioning while they are suffering from poverty and poor mental health resulting from a stressful migration journey and resettlement in a new country in which mental health and community supports are missing (Hanson-Bradley & Wieling, 2020; Shannon et al., 2012; Shannon et al., 2014, 2015; Wieling et al., 2020). Because of the limited support from the U.S. government in terms of mental health and parenting skills at the start of resettlement, it is most likely that Cambodian refugee families in the U.S. have been experiencing an uninterrupted cycle of intergenerational transmission of traumatic stress (Sack et al., 1995, 1996; Wycoff et al, 2011). Sack and team (1995) conducted a study tracking PTSD and major depressive disorder across two generations of Cambodian refugees residing in the western part of the U.S. By interviewing 209 Cambodian adolescents and a parent of each adolescent, PTSD was found to be associated across parent-child generations. In 1996, the same team published another paper using the same dataset. Among 170 Cambodian youth and 80 mothers, a consistent correlation between pre-migration trauma, resettlement stress, and symptoms of PTSD was reported (Sack et al., 1996). A strong association between depressive symptoms and recent stressful events was also found. Despite being a decade after resettlement, these parent-child dyads reported these experiences in a highly consistent way.

Existing literature among war-affected and displaced populations such as Holocaust survivors, former child soldiers, genocide survivors, and refugees also shows the relationship between parental PTSD and the children's poor mental health outcomes. When parents suffer from PTSD, children are more likely to suffer from anxiety, depression, PTSD, conduct

problems, and adjustment problems (Daud et al., 2005; Field et al., 2013). Specifically, a study investigated secondary trauma among Holocaust survivors and revealed that the transmission of traumatic stress to the third generation occurred mainly as a result of living in the community with war history (Perlstein & Motta, 2013). Intergenerational transmission of traumatic stress through the parent-child relationships was also found among Ukrainian genocide survivors, Holocaust survivors, and Burundian former child soldiers (Bezo & Maggi, 2015; Braga et al., 2012; Song et al, 2014). These survivors demonstrated a wide range of fear-related emotions (i.e., sadness, anxiety, anger) and fear-related coping strategies (i.e., overthinking about stockpiling and food consumption, and avoidance and submission in communication) passed to subsequent generations over eight decades (Bezo & Maggi, 2015). Adverse parenting practices (i.e., the use of corporal punishment and showing aggression) also caused aggressive behaviors among their offspring (Song et al., 2014). Traumatic stress is sustained in affected populations for prolonged periods of time due to its psychological and relational consequences and the common lack of resources in the community (Landau et al., 2008; Weine et al., 2004). There is an ongoing need to understand trauma transmission processes and related social determinants of risk and protective factors to disrupt its transgenerational effects (Rowland-Klein & Dunlop, 1998; Sack et al., 1995, 1996; Wieling et al., 2020; Yehuda et al., 2001; Yehuda & Lehrner, 2018).

High parental involvement is associated with low aggressive behavior and high academic achievement in children and youth (Elsaesser et al., 2017). In contrast, low parental involvement puts children and youth at risk for conduct problems and mental health disorders (Elsaesser et al., 2017). Parental PTSD was also found to be correlated with low parenting satisfaction and involvement, poor parent-child relationships, and high stress in parental responsibilities (Gewirtz

et al., 2008; Gewirtz et al, 2010; Nelson Goff et al., 2020). Moreover, children's misbehavior triggered parental PTSD symptoms, leading to emotional intensity, anger, and the use of corporal punishment (Catani et al., 2009; Song et al., 2014). These symptoms also lead to complicated relationships and resentment in parent-child relationships (Gershoff, 2002; Slep & O'Leary, 2007). There is ample evidence in the literature documenting the need to address parental PTSD in order to moderate child mental health and developmental outcomes (Wieling et al., 2020).

This intergenerational mental health effect is stronger in a stressful than less stressful context (Nelson Goff et al., 2020). Daily stressors such as poverty, limited social support, discrimination, language barriers, intensive labor work, and limited leisure time for families exacerbate the preexisting mental health conditions and negatively affect the mental health and development of the children among refugee families (Betancourt et al., 2015). Cambodian refugee families experience similar stressors living in the U.S. Several scholars have noted that their initial resettlement process compromised their adjustment and exacerbated mental health issues related to living through the Cambodian genocide (Carlson & Rosser-Hogan, 1991, 1993; Mollica et al., 1998; Mollica et al., 1987). However, to date, very few to no scholars have attempted to develop or adapt evidence-based individual and family level interventions in response to the unique needs of this population.

Resilience Factors and Family Adjustment

From a multisystemic perspective, resilience is the ability of an individual, family, or community to use its internal resources (i.e., strong sense of self, strong family bond, resourceful and nurturing environment) to enhance its physical, relational, and community health to cope, adapt to, and bounce back from adversity (Masten, 2021; Ungar, 2013). To achieve resilience at the individual level requires the presence of resilience in the family and community level as well

(Lehrner & Yehuda, 2018; Masten, 2021; Ventriglio & Bhugra, 2015). In other words, resilience in one system level affects resilience at all other levels. There are three factors (i.e., protective, risk, and promotive factors) to consider when examining resilience across system levels (Masten 2021; Ungar, 2013). In the context of Cambodian refugee families, examining resilience across system levels is very important to understand their overall resettlement experience and needs (Ungar, 2013). A strong support system in the family and community may protect individual refugees from developing PTSD after experiencing years of war and migration. In contrast, the lack of support systems, such as protective policies for refugees in the resettled community, may contribute to the lack of resilience at the community level and can affect resilience development at the individual and family levels among Cambodian refugee families.

In addition to adverse consequences of trauma exposure in refugee communities, several studies also noted examples of post traumatic growth and resilience in the generation that directly experienced traumatic events, as well as in subsequent generations (Braga et al., 2012; Scharf, 2007; Song et al., 2014). These findings demonstrate the ability to bounce back and the presence of protective factors (i.e., parental high socio-economic status and high education, taking responsibility for the children, consequential thinking, and strong parent-child bonding) that guard against transgenerational transmission of trauma (Scharf, 2007). Specifically, Mak and colleagues' (2021) study revealed reports of strong parent-child relationships as a resilience factor against intergenerational traumatic stress transmission among Cambodian refugees living along the coastline in the southern part of the U.S. Moreover, positive parental involvement, support, and monitoring have demonstrated to be predictive of high academic achievement, low aggression, low delinquency, and low depressive symptoms in children and youth despite parental past exposure to war (Elsaesser et al., 2017; Peltonen et al., 2014).

The overarching framework for this study allows interventionists and mental health professionals to trace a mental health and relational needs assessment among Cambodian refugee families by incorporating an emic understanding of their culture, history, and lived experiences (Bernal et al, 1995; Bernal & Adames, 2017; Domenech-Rodriguez & Wieling, 2005). The integration of multiple perspectives such as trauma theory, ecological system theory, resilience, cultural responsiveness, and a social justice lens are critical to viewing traumatic experiences and resilience among Cambodian refugee families across multiple generations (Goodman, 2013). The combination of these perspectives is essential because of the complexity of the experiences of the refugees and their families.

Human Ecological Model

This study uses a human ecological framework (Bronfenbrenner, 1995) to explain the holistic nature of traumatic stress that Cambodian refugees experienced pre, during, and post resettlement. The human ecological framework emphasizes interactions across four system levels (i.e., microsystem, mesosystem, exosystem, and macrosystem) within time. Bronfenbrenner (1995) also highlighted that the individual has to deal with their developmental tasks in their environments. The framework consists of two propositions: 1) the reciprocal nature of development followed by the complexity of the interaction of the individual with their environment, and 2) the influence of the individual's biopsychosocial characteristics on the interaction with their environment. This places the individual at the center of their environment.

There are three personal characteristics (i.e., demand characteristics, resource characteristics, and force characteristics) identified by Bronfenbrenner (1995) that influence ecological processes. First, demand characteristics include age, gender, and appearance. These characteristics are easily noticeable and are responsible for setting the interactions into motion.

Second, resource characteristics include access to basic needs (i.e., housing, food, employment), which at first glance, can be thought to be easily noticeable. However, resource characteristics can also be unnoticeable and can refer to past experiences and intelligence, which remain hidden from others. Third, force characteristics include temperament, motivation, and persistence. Even though they cannot be seen easily, their outcomes can be observed. In the context of war-affected refugees and experiences of forced displacement, their development is mainly a function of individual characteristics.

The foundation of the revised ecological model is on the interaction among process, person, context, and time (PPCT) in addition to its original emphasis on the chronosystem and individual characteristics (Bronfenbrenner & Morris, 2006). It is very important not to misinterpret the message of the new revised version of the framework. A meta-analysis of uses and misuses of Bronfenbrenner's bioecological theory of human development showed a number of studies that misuse the model (Tudge et al., 2009). For example, three studies only focused on the influence of context and neglected the individual characteristics; five studies explained the individual characteristics in relation to context by using a unidirectional process; and seven studies demonstrated the influence of context on the individual characteristics, not examining their interaction. Therefore, it is crucial to apply the framework by discussing the interactions among ecological systems (i.e., individual characteristic and context) as suggested by Bronfenbrenner (1995).

Neurobiological. Exposure to traumatic events during the Khmer Rouge regime, migration histories, and resettlement are associated with extreme stress responses in the brains of war-affected Cambodian refugees. The amygdala dominates brain functioning and leads to fragmentation of the memory system as the brain remembers only the sensory, physiological,

cognitive, and emotional aspects of traumatic events without connecting them to the hippocampal memory that stores context, time, space and chronology of the events (Arnsten, 2009; Elber et al., 2011; Schauer & Elbert, 2010; Van der Kolk, 2015). These one-sided memories place individual refugees at high risk for the development of PTSD or Complex PTSD (Cohen et al, 2002). Without the context of space and time, refugees will experience the memory as an immediate emotional, sensory, or physiological event, not as an integrated memory. Any sensory cues at the present moment such as colors, smells, sounds, and feelings associated with their past trauma can trigger the re-experiencing of traumatic events from the past and lead to fearful trauma responses (Cohen et al., 2002; Kozlowska et al., 2015). Without a proper mental health assessment and PTSD treatment support from mental health professionals, war-affected refugees suffer by themselves and affect their immediate family members, especially through relationships with their spouse and children (Roth et al., 2014; Siegel, 2013; Wieling et al., 2020). Even for Cambodian-American children born after their parent's resettlement, there is an intergenerational effect of traumatic stress through parent-child relationships (Field et al., 2014).

Microsystems. The microsystem is the closest to the person. It describes people and institutions that directly impact a person. The general microsystems include family, friends, neighbors, and religious groups. For parents, the microsystems also involve work settings and coworkers. For children, the microsystems also cover peer groups, day care settings, and school (Hoffman & Kruczek, 2011; Paat, 2013). Among all the microsystems, parent-child interactions are particularly associated with trauma responses among refugee families (Siegel, 1998; Srinivasa, 2007). Trauma symptom transmission may also occur within peer groups among children, teens, and adults (Tyano et al., 1996). For Cambodian refugee parents, they are more likely to pursue jobs that involve harsh physical labor due to language barriers (Wycoff et al.,

2011). Moreover, their colleagues are usually their peer refugees who experienced similar cumulative traumatic stress (Hoffman & Kruczek, 2011). Seeing each other may also trigger trauma responses in the case of those who meet the criteria for PTSD (Cohen et al., 2002). For refugee children, people they encounter at daycare and school may not be informed or have knowledge about traumatic stress and its intergenerational effect on the children (Hoffman & Kruczek, 2011). Refugee children and youth may appear aggressive or misbehave as the result of many stressors their parents experience at home and in a new country (Catani et al., 2009; Song et al., 2014). Moreover, they may not have a language to explain their experiences to people they encounter outside their home and at school unless school professionals have knowledge about traumatic stress when they work with refugee children (Paat, 2013). This misunderstanding results in a lack of support for the children and they have no models from which they can learn new coping mechanisms or behaviors.

Mesosystems. Mesosystems refer to the relationships or interactions among elements of microsystems of their immediate context (Bronfenbrenner, 1995). For example, the relationships or connection between refugee parents and school, refugee parents and their co-workers, refugee parents and their neighbors, and refugee parents and peers of their children (Hoffman & Kruczek, 2011; Paat, 2013). Because of the limited resources and support from the resettled country's government, refugee families usually live in low resource communities with high crime and delinquency, and send their children to low resource schools without enough academic guidance and language support (Paat, 2013). Refugee parents often cannot communicate with school professionals due to a language barrier, so they need their children's help in conveying their message to the school and from school to them (Hoffman & Kruczek, 2011; Paat, 2013). This is a stressful process for the refugee children and youth. Refugee children are often bullied

and discriminated against by their local peers and sometimes by local teachers for their looks and slowness in learning (Paat, 2013). This shows the lack of understanding of school professionals in terms of the struggles of refugee children in their adaptation and acculturation to a new educational system of the host country. In addition, the stress of trying to reconcile differences between their parents' culture and the host country culture can be very difficult for the refugee children to deal with by themselves without the help from their school (Paat, 2013).

Exosystems. The exosystem describes the relationship between the environment in which the individual does not have an active role and their immediate context. Neighborhood, community systems, health care systems, school systems, and mass media are systems that influence refugee families indirectly (Hoffman & Kruczek, 2011; Paat, 2013). These systems are external to the individual refugees, but they have a significant impact on them individually and within their families (Hoffman & Kruczek, 2011). The inability for these exosystems to recognize the physical and mental health needs of Cambodian refugee families that they are working with shows the lack of preparedness of the receiving community to support the adaptation and acculturation process of refugee families. Exosystem issues like community racism, refugee blaming, communication barriers (language), lack of community social support, inability to use technology, and limited access to health care and mental health care services are very common among refugee parents (Hoffman & Kruczek, 2011; Paat, 2013). In addition, issues like racism from peers and school professionals, bullying, inability to catch up or focus on studies, lack of educational support, gang violence, incarceration, and child labor are very common among refugee children and youth (Paat, 2013). To ensure the physical, psychological, relational, and social health of Cambodian refugee families, there is an urgent call for neighborhood, community, school, health care, and mass media support to have greater

awareness about traumatic stress and its intergenerational impact within refugee families. Most importantly, there is a need for cultural adaptation of systemic family-based interventions to support the growth and adaptation of this population.

Macrosystems. Larger cultural contexts such as society norms, government systems, sociopolitical factors, economic factors, and cultural subsystem norms are elements of macrosystems (Hoffman & Kruczek, 2011; Paat, 2013). Macrosystems evolve over time as each generation influences change (Santrock, 2007). Existing literature demonstrates the association between social class, race, ethnicity, gender and trauma response (McCann & Pearlmen, 1990). Moreover, societal, and cultural subsystem norms can either positively or negatively affect the adaptive coping and response to trauma exposure (de Silva, 1999). The history of genocide prior to years of migration and resettlement in the U.S. puts Cambodian refugee families at a disadvantage within these macrosystems. Limited resources and support for positive family adaptation and adjustment from the U.S. government -- employment, housing, childcare, parenting skills, health care, mental health care, community resources -- place these refugee families at risk of exacerbating their physical, mental, and relational health issues since their initial resettlement back in 1980s.

Chronosystem and Developmental Processes. The chronosystem covers life transitions and life course perspective (Bronfenbrenner & Ceci, 1994). Life transitions involve both normative and nonnormative events (e.g., migration and resettlement). These events not only affect Cambodian refugees individually, but they also affect their family processes. In order to understand the experience of Cambodian refugee families, it is important to understand the chronosystem influences on all system levels of Cambodian refugees (neurobiological, microsystems, exosystem, mesosystems, and macrosystems). Bronfenbrenner and Ceci (1994)

also introduced a new concept “proximal processes” which refers to the interaction between the individual and the environment that forms the basis for human development. Examples of proximal processes are parent-child relationships, peer relationships, leisure activities, and school or work. Adaptation to traumatic stress is manifested through these processes. Considering the case of Cambodian refugee families, armed conflict and mass violence in their migration, the stress of migration, and the stress of resettlement in a new country are extreme nonnormative events and life transitions. While they can appear to be functioning in the larger system of school or work, there is a lot of unseen need that impacts how they can process new experiences and how they understand what happened to them. This study examines the types of supports needed and proposes ways of providing those supports so that parents and children can address mental health and relational issues.

In sum, a literature review of the impact of trauma exposure on the individual across system levels was presented in this chapter. Studies conducted among Cambodian refugees since the early stage of their resettlement in the U.S. and among refugees in general were organized according to individual, family, and community levels. Moreover, studies on intergenerational transmission of traumatic stress and resilience among refugees were also demonstrated in the chapter. Cambodian refugees have experienced a complex and multi-faceted trauma history that requires in-depth analysis and understanding of their needs in order to support their positive development in their new country. The chapter ends with a brief description of the human ecological framework as the systemic theoretical grounding of this research. Chapter three follows with a detailed description of the methods for the study.

CHAPTER 3

METHODS

"Refugees are neither seen nor heard, but they are everywhere. They are witnesses to the most awful things that people can do to each other, and they become storytellers simply by existing. Refugees embody misery and suffering, and they force us to confront terrible chaos and evil."

ARTHUR C. HELTON

Lawyer, refugee advocate, teacher and author

Research Design

The purpose of this study was to conduct a mental health and relational needs assessment of Cambodian refugee families resettled in the U.S. This qualitative research study employed principles of critical ethnography to guide the methodological conceptualization, design, analysis and presentation of results (Madison, 2005). Critical ethnography allowed me to highlight the voices of Cambodian refugees that have long been underrepresented in the mental health and family literature. This population has been invisible to scholars despite significant mental health and relational needs stemming from the civil war, genocide, and resettlement processes. Critical ethnography allows researchers to advocate for marginalized populations (Carspecken & Apple, 1992; Madison, 2005). I was also assisted by Spradley's (1979) guidelines emphasizing descriptive and exploratory interview questions intended to capture cultural phenomena and nuances. All interviews were conducted in Khmer and English according to participants'

preference and comfort level in sharing their experiences. The interviews were transcribed and coded in the original languages and domain analysis of Khmer interviews were translated into English after initial coding had taken place and for final phases of the domain analysis across participants.

In-depth ethnographic interviews were conducted with **key informants** (i.e., mental health providers, educators, human right advocates, religious leaders, community leaders) who were former Cambodian refugees themselves and who provide services to their community across various resettlement states in the U.S. Main research questions focused on functional family patterns – both challenges and resilience -- that exist and stem from various war- and migration-related stressors. Key informants were asked to describe what they have observed to be mental health and relational needs of the Cambodian community they work with and how these needs could be addressed effectively. In-depth interviews started with the grand tour question, "Could you please reflect and share what you see as the overall adjustment and wellbeing of Cambodian families who resettled in this area?" Mini tour questions addressed specific professional environments, family dynamics and relationships, parenting and parent-child relationships, children and adolescents, couple and marital relationships, mental health, substance use, war-related experiences, and broader economic and socio-political community needs (See Appendix C for the Interview Questions).

Participants

Eighteen key informants who provide mental health, physical health, and social services to Cambodian families in five major states (i.e., California, Massachusetts, Pennsylvania, Minnesota, and Washington) gave their consent and were interviewed between May and September 2022. The length of the interviews ranged from 50 minutes to 2.5 hours. Fifteen of

the eighteen participants were former Cambodian refugees while three are expatriates who have experienced working with the Cambodian population. The participants were categorized into three groups: grandparent generation (first generation refugees), parent generation (second generation refugees), and expatriates. Among the eighteen, ***four*** participants represent the grandparent generation, ***eleven*** represent the parent generation, and ***three*** are expatriates. The standard profiles of the participants are demonstrated in Table 1. A brief description of each participant was also presented. However, occupations, education and pronouns of the participants were changed in the description to protect their confidentiality.

Table 1

Participant Demographic Information

Participant	Age Group	Education	Profession	Work Setting
P1G2	35-55+	PhD	Clinical Psychologist	Various settings
P2G1	**60-70+**	Master's	Director	Non-Profit Organization
P3G2	35-55+	Bachelor's	Director	Non-Profit Organization
P4G2	35-55+	Master's	Social Worker	Prison
P5G2	35-55+	PhD	Clinical Psychologist	University
P6G2	35-55+	PhD	Clinical Psychologist	Prison
P7E	35-55+	PhD	Professor	University
P8G2	35-55+	PhD	Community Health Professional	Non-Profit Organization
P9G1	**60-70+**	Bachelor's	Senior Case Manager	Non-Profit Organization
P10G2	35-55+	Master's	Social Worker	Non-Profit Organization
P11G2	35-55+	PhD	President of Buddhist Temples	Non-Profit Organization
P12G1	**60-70+**	Bachelor's	Senior Case Manager	Non-Profit Organization
P13G2	35-55+	Master's	Marriage and Family Therapist	Non-Profit Organization, Hospital
P14E	35-55+	PhD	Medical Anthropologist	Non-Profit Organization
P15G2	35-55+	Master's	Youth Program Manager	Non-Profit Organization
P16E	35-55+	Post-master's	Pastoral Psychologist	Non-Profit Organization
P17G1	**60-70+**	Vocational Training	Senior Case Manager	Non-Profit Organization
P18G2	35-55+	Bachelor's	Youth Program Manager	Hospital

Note. **P** = Participant; **G1** = First generation/Grandparent generation; **G2** = Second generation/ Parent generation; **E** = Expatriate

Grandparent generation. Four participants represent the Cambodian grandparent generation who lived through all migration stages (pre, during, post migration) and resettled in the U.S. between 1975-1990s. These participants were in their twenties during initial resettlement and are currently in the 60-70+ age range. Most importantly, three of these participants worked with Cambodian refugees since they were in refugee camps in Thailand, while one of them arrived the U.S. in 1975 and has worked with Cambodian refugees since the first wave of Cambodian refugees to the U.S.

P2G1 is the director of a nongovernmental organization. P2G1 arrived the U.S. in 1990. P2G1 reported that he was the last person in his family who arrived the U.S.; his parents and siblings arrived the U.S. in 1980s. P2G1 valued education, studied in refugee camps, got a scholarship to obtain a bachelor's degree abroad before being resettled in the U.S. When he arrived in the U.S., P2G1 pursued further studies and obtained another master's degree. P2G1 determined that he would devote his life to supporting Cambodian families both in the U.S. and in Cambodia. P2G1 also writes books about the refugee journey and how to be successful in a new country as a refugee.

P9G1 is a senior domestic violence case manager. P9G1 arrived in the U.S. in the 1980s with her husband and two kids. P9G1 reported in tears that her family was educated and rich before the Khmer Rouge regime, but the regime took the lives of her father and two siblings. P9G1 reported that the world turned upside down for her family when Khmer Rouge came into power. Moreover, P9G1 also reported that she has two siblings who are living with severe PTSD and Parkinsons disease as a result of the torture and living through the Khmer Rouge regime. P9G1 worked as a French translator in refugee camps in Thailand. P9G1 values education and reported that she started learning English and went to college as soon as she arrived the U.S.,

which was almost impossible for her to manage along with being a mother of two. P9G1 graduated with a Bachelor of Human Service and became a domestic violence case manager.

P12G1 is a senior case manager. P12G1 arrived the U.S. in the 1980s with her husband and two kids. P12G1 reported that her husband and she volunteered and worked with newly resettled refugees soon after she arrived. P12G1 was from a well-educated and affluent family in Phnom Penh before the Khmer Rouge regime. P12G1 shared that Khmer Rouge took her father's life at the beginning of the regime. P12G1 worked as a midwife in refugee camps in Thailand. P12G1 values education and pursued a Bachelor of Human Services as soon as she picked up the English language, while her husband pursued a Bachelor's of Engineering. P12G1 reported that she has been running parenting groups and domestic violence groups for Cambodian families since she became a case manager in 1990s.

P17G1 is a retired case manager. P17G1 arrived the U.S. in 1975 along with the first wave of Cambodian refugees to the U.S. P17G1 was the wife of a captain in the Cambodian air force prior to the Khmer Rouge regime. Upon her husband's request, P17G1 decided to leave Cambodia with her two small children. P17G1 stayed in a refugee camp in Thailand for about six weeks before flying to the U.S. along with other military families. P17G1 started living in the U.S. as a single mother of two young children, and never heard from her husband again. P17G1 attended job trainings, as she had to earn and pay the bills on her own. P17G1 also valued education but could not pursue her studies because she had children to take care of and was supporting herself. P17G1 shared that she experienced working with the four waves of Cambodian refugees in the U.S. P17G1 worked as a case manager for Cambodian communities and school settings until she retired.

Parent generation. Eleven participants represent the Cambodian parent generation who lived through all stages (pre, during, and post) of migration. These participants arrived the U.S. as babies, children, and youth. Thus, their age range is between 35 to 55+. These participants obtained higher education (i.e., bachelor's, master's, and PhD) as they were younger, picked up English quicker, and experienced less traumatic events than the grandparent group. All of them work in mental health, health, and community settings (i.e., social work, therapist, community health workers, etc.).

P1G2 is a clinical psychologist who has worked in various settings in the U.S., including hospitals, prisons, universities, and non-profit organizations. P1G1 was born during the Khmer Rouge regime and reported not having traumatic memories related to the Khmer Rouge regime or while living in refugee camps, as he was too young. However, when he was in high school, he started volunteering at a nongovernmental organization to support Cambodian elders who requested disability-related funding. P1G2 shared that the volunteer experience brought him to the field of mental health as his college major because he observed so much genocide-related trauma among Cambodian refugee elders. P1G2 reported feeling burned out from working in the U.S., as there is a lack of prevention and intervention structural supports for the Cambodian community. Currently, P1G2 provides relationship building and parenting trainings in Cambodia, where he moved during the initial outbreak of the Covid-19 pandemic.

P3G2 is a director of a nongovernmental organization. P3G2 was born in a refugee camp in Thailand and arrived the U.S. when he was eight months old. P3G2 reported that he barely speaks Khmer and feels that English is his first language. P3G2 is very passionate about supporting Cambodian youth, with whom he has worked since high school. P3G2 graduated with a Bachelor's of Human Services degree due to his passion for serving the Cambodian

community. P3G2 reported witnessing mental illness comorbid with physical illnesses among his parents, siblings, and many Cambodian families. Currently, P3G2 provides intergenerational and youth-related programs to a Cambodian community. P3G2 acknowledged the importance of mental health and relational needs assessment among Cambodian refugee families.

P4G2 is a social worker in charge of custody in prison settings. P4G2 is currently a PhD student in intercultural studies in the U.S. P4G2 was born a few years before the Khmer Rouge regime and lived through all migration stages. P4G2 reported that she arrived in the U.S. in her early teens with her two older siblings and without her parents. Her parents were educated prior to the Khmer Rouge regime and her dad was executed as soon as the Khmer Rouge took over the country. P4G2 was sponsored by a catholic church to come to the U.S. and decided to shift her religion to become a Christian. P4G2 experienced discrimination from her own community due to shifting her religion. P4G2 is determined to continue working to support her community as a social worker even though many community members do not like her as a Cambodian Christian.

P5G2 is a clinical psychologist working in a university setting. P5G2 is not a Cambodian refugee but came to the U.S. in 2010 to pursue his master's and Ph.D. in clinical psychology. P5G2's research interest is in intergenerational transmission of trauma among Cambodian families. P5G2 experienced working with Cambodian elders at the beginning of his Ph.D. program and observed tremendous mental health issues, especially PTSD, among Cambodian elders. After graduation, P5G2 began offering counseling services in the university setting. P5G2 reported seeing a lot of anxiety and depression in Cambodian college students who seek his services.

P6G2 is a forensic psychologist and works in a prison. P6G2 offers mental health assessment and individual therapy to prisoners. P6G2 also currently sees some Cambodian

clients in the prison. P6G2 was born in a refugee camp in Thailand. P6G2 reported that she has no early memories about the Khmer Rouge or the life in refugee camps, but experienced confusion as a Cambodian living in the U.S. P6G2 uses English as her primary language but tries to speak Khmer even though it is not always understandable. P6G2 expressed that it hurts not being able to speak Khmer as a Cambodian. P6G2 married an American and has a teenag child. P6G2 expressed a concern that her child may lose connection with their Cambodian identity.

P8G2 is a community health professional and researcher working in a non-profit organization. P8G2 came to the U.S. with his wife and two children in 1990s to pursue his Ph.D. and decided to continue living and working in the U.S. after graduation. P8G2 has worked as a community health professional and researcher for more than 20 years, and has collaborated with many non-profit agencies working with Cambodian communities across the U.S. P8G2 reported observing mental health issues among elders and family relationship issues among Cambodian refugee families. P8G2 also reported barriers (i.e., language, transportation, insurance policies, lack of education, mental health issues, lack of community health workers, lack of Cambodian professionals, lack of cultural knowledge among professionals, etc.) to accessing wholistic health care among the population.

P10G2 is a licensed social worker working in a non-profit organization to support Cambodian families. P10G2 was born before the Khmer Rouge regime and remembered his life during Khmer Rouge regime, refugee camps, and initial resettlement in the U.S. P19G2 arrived when he was 16, went to high school, and graduated from high school at 21. P10G2 reported that his interest in trauma and mental health stemmed from his experience taking care of his own parents during initial resettlement. P10G2 is the first-born child among ten siblings, but only six remained alive after the Khmer Rouge regime. As a first-born child, he was responsible for

taking care of his parents and younger siblings. P10G2 shared that he used his experiences with his parents to offer services to other Cambodian elders in the community. P10G2 expressed a concern about mental health conditions of elders and stated that mental health and family relationship issues are still pressing issues among this population.

P11G2 has high ranking positions in an organization that preserves Cambodian culture and religion as well as in another agency that advocates for mental health support for communities of color. . P11G2 was born during the Khmer Rouge regime, lived through refugee camps, and arrived the U.S. when she was 11. P11G2 graduated with a Ph.D. in the mental health field. P11G2 accomplished her education in the U.S. and became a respected person among Cambodian communities. P11G2 started by stressing the importance of this mental health and relational needs assessment that is done by a Cambodian scholarP11G2 got married to an American and has a teenage child. P11G2 expressed concerns about intergenerational relationship gaps and untreated mental illnesses, particularly PTSD, among the Cambodian communities. Intercultural parenting support is also needed according to P11G2.

P13G2 is a licensed counselor and marriage and family therapist. P13G2 was born before the Khmer Rouge regime and lived through all migration stages. P13G2 reported that her father was a teacher and was executed during the Khmer Rouge regime. P13G2 arrived the U.S. with her mother and siblings when she was 11 years old. P13G2 reported that she struggled speaking Khmer when she started working with Cambodian elders as a therapist, thus she attended a Khmer language class to speak enough Khmer to help Cambodian elders. P13G2 got married to an American and has a teenage child. P13G2 expressed concerns about intergenerational relationships, especially intergenerational communication gaps. For example, P13G2 reported that she noticed during her family therapy sessions that the communication between grandparents

and grandchildren is very broken, and they barely understand each other. P13G2 also shared sadly that the grandparent generation who suffer from mental illness, especially PTSD, are dying off with their mental health needs left untreated.

P15G2 is a youth program manager in a nongovernmental organization. P15G2 was born during the Khmer Rouge regime and lived through all migration stages. P15G2 arrived in the U.S. in her early teenage years and was very confused about why the killing fields happened to Cambodia. P15G2 also shared that she witnessed alcohol consumption and anger outbursts of her father as well as domestic violence in the home. P15G2 reported that she tried to focus in school, as she valued education from an early age. P15G2 graduated with a master's degree in human services and mental health. P15G2 has served as a mental health professional to Cambodian elders and youth for more than 25 years. P15G2 reported that she has been an advocate for Cambodian youth to go to college so that they may have higher job skills to break their family's cycle of poverty, as well as to advocate for their community. P15G2 shared sadly that the grandparent generations are still suffering from untreated mental illness. Specifically, she stated that while there is limited access to psychiatric services, there is a lack of culturally tailored therapy for traumatized elders and their families.

P18G2 is a youth program manager in a hospital setting. P18G2 was born in refugee camps and does not have any memories about what happened during the Khmer Rouge regime and the refugee camps. P18G2 shared that his family never talked about the Khmer Rouge to him so he tried to learn about Cambodian history and migration history by doing research on his own in a library. P18G2 admitted that there is PTSD going on in his family and he believes that PTSD also presents in many Cambodian refugee families. P18G2 offers support groups to Cambodian elders and youth at his agency. P18G2 also reported that his agency offers home

visitations and supports to accessing physical and mental health resources to community members. P18G2 emphasized that supporting Cambodian youth is the priority of his work because they are still young and have a lot of opportunity to grow and advocate for their community.

Expatriates. ***Three*** participants are expatriates who have worked with Cambodian refugee families for many years.

P7E is a faculty member and a director of an international program at a university campus. P7E has been working with Cambodian deportees and their families for years. P7E admitted that she is the outsider of the community and what she experiences with the population may not be as deep as what the insiders experience. P7E reported having led support groups and meetings with deportee families regularly. P7E also works to support deportee families with legal and vocational services, both inside the U.S. and in Cambodia.

P14E is an American and recent doctoral graduate of Medical Anthropology. P14E went to Cambodia after graduating with a bachelor's degree in Anthropology in 2012. P14E worked in a public health setting in Cambodia for a year and met Cambodian deportees through her job. P14E came back to the U.S. and continued her education. P14E's research and scholarly interests are around deportee issues. P14E has been working on observing, advocating, and studying Cambodian deportees and their support systems. Currently, P14E works as a legal and immigration expert, collaborating with public defenders who offer services to Cambodian deportees.

P16E is an American and a director of a non-profit organization working to support families in post conflict countries. P16E graduated with a master's in pastoral counseling and studied further post-master courses in global mental health. P16E married a second-generation

Cambodian refugee has two teenage children. P16E experienced working with Cambodian populations both in the U.S. and in Cambodia. P16E went to Cambodia for four years and worked as a visiting professor in mental health in a Cambodian public university. P16E claimed that he has informally been observing mental health, particularly PTSD, and family relationships among Cambodian families since he met his wife more than fifteen years ago.

Site

The interviews were conducted virtually due to the pandemic and funding constraints. Key informant participants were recruited from Cambodian major states (i.e., California, Massachusetts, Pennsylvania, Minnesota, Washington, and Connecticut) across the U.S via emails and telephone calls (See Appendix B for The Email and Telephone Script).

Measures

The study used semi-structured ethnographic interview questions along with brief demographic interview questions at the beginning of in-depth interviews with key informants (see Appendix C for the Interview Questions).

Procedure and Sampling Methods

Key informants who were qualified for participation were introduced to the study and an email request was made for their participation. Participants also referred professionals they knew to engage in the study, which is known as snowball sampling. Interviews were audio recorded to promote efficient and accurate data collection and analysis; however, data were kept confidential and personal identifiers were not included in any official reports of the study.

Recruitment was guided by respondent driven sampling or snowball sampling. The sampling goal was to interview approximately 15-20 key informants. Fortunatly, ***eighteen key informants*** agreed to participate in the study during four months of data collection (May-August

2022). A modest incentive of $35 was provided in the form of a e-gift certificate. After generating an initial list of key informants who work within agencies that provide services to Cambodian families, these individuals were contacted via email and phone to introduce them to the study and explain why they were recruited. This information was followed by a request to meet and conduct a one-hour, in-depth interview regarding their assessment of family wellbeing and functioning in the Cambodian community. At the end of the interview, individuals were asked whether they know other professionals who are a useful source in providing more information about the topic (see Appendix A for the Recruitment Script).

Types of Data Collected

To contextualize in-depth interviews, a full ethnographic record was used. Observation notes, interview audio recordings, transcripts, and research memos were kept in the record along with any other items that provided a deeper understanding into the Cambodian culture. Even though these materials were not directly analyzed as part of the domain analysis, they provide context to the interview content.

Data Analysis

Data were collected and analyzed iteratively. Ethnographic data was gathered through observations and informal conversations with key informants via phone, text messages, and emails since the initial contact with key informants during recruitment process. The use of multiple reporters, key informants, and multiple data sources further expanded our understanding of mental health and relational needs of Cambodian refugee families. The researcher's reflexivity during recruitment and data collection process were also recorded in memos to inform the analysis and for data verification.

All interviews were analyzed using Developmental Research Sequence (DRS; Spradley, 1979). The DRS was designed with a twelve-step method of conducting ethnographic interviews and qualitative research data analysis. It was also used to articulate cultural knowledge shared by a community of participants. The Twelve Steps of the Developmental Research Sequence is demonstrated in Table 2.

Table 2

Twelve Steps of the Developmental Research Sequence (DRS; Spradley, 1979)

Step	Developmental Research Sequence
1	Locating an informant
2	Interviewing an informant
3	Making ethnographic record
4	Asking descriptive questions
5	Analyzing ethnographic interviews
6	Making a domain analysis
7	Asking structural questions
8	Making a taxonomic analysis
9	Asking contrast questions
10	Making a componential analysis
11	Discovering cultural themes
12	Writing an ethnography

Below are the twelves steps I used during the data gathering process and analysis:

1. **Locating an informant.** According to Spradley, 'informants' refers to people who participated in the interview. Thus, I use key informants and participants interchangeability throughout this dissertation. The key informants of this study have first-hand experience of the culture and are mostly former Cambodian refugees

themselves who experienced living before and during the genocide regime, refugee camps, and initial resettlement in the U.S. About a quarter of the key informants preferred to do the interview in Khmer while the rest preferred English or a mix of Khmer and English, as it was more convenient to them in describing their experience and observations.

2. **Interviewing an informant.** By following Spradley's recommendation, the key elements of an ethnographic interview should include an explicit purpose of the interview (e.g., purpose of the project, interview process, and recording procedure) presented by the interviewer to the interviewee during the initial contact of participant recruitment. In this study, I started drafting the purpose of this dissertation in an email format and telephone conversation script. Then, I sent emails to different organizations that work with Cambodian refugee families across the U.S. to request for their participation in the study. Simultaneously, to show respect (a value of Cambodian culture), I also called the participants who agreed to participate in the interview to introduce myself and the purpose of the study again to them. On the scheduled interview day, I started by asking consent and permission from the participants to sign on the paper consent form and to record the interviews. I also let the participants know that their personal information was not identified, and the audio recordings were kept confidential within the University's secure online platform. All participants gave their consent and were very familiar with audio recording of their interviews. I also let participants know that they can use either Khmer or English or a mix of both languages in the interview according to what was comfortable for them. I used three main types of questions (i.e., descriptive, structural, and contrasting) as recommended by Spradley.

3. **Making an ethnographic record.** According to Spradley, an ethnographic record includes field notes, audio recordings, photos, artifacts, and anything that captures the cultural sense of the study. In this study, I gathered only field/observation notes and audio recordings of the interviews. My field notes included my observations, thoughts, feelings, and reflections of each interview, as well as the interview summaries. There were a few interviews that left me with heavy feelings, as participants described multiple painful memories. I was impressed that these participants found describing their painful memories to be a relief of sortsand continued to participate until the end of the interview. On the other hand, audio recordings provided me with a verbatim record of the interviews. Then, I transcribed the interviews in their original language (i.e., Khmer or English or mixed). As I transcribed the interviews, I still continued to write down my field notes (which later envolved to memos) as I realized that there some important points that I missed taking notes. The participants' body languages and ways of talking about certain topics during the interviews were also noted to inform the analysis.
4. **Asking descriptive questions.** According to Spradley, the process of building rapport consists of apprehension, exploration, cooperation, and participation. In this study, rapport was made very quickly since all key informants who agreed to participate in the interviews were willing to share their experiences and observations with me, as I am also Cambodian. Many said that they appreciated that someone from the younger generation like me is interested in addressing issues related to mental health and wellbeing of Cambodian refugee families. Some participants ended the interview by wishing me luck with my dissertation and offered a promise of future collaboration to support Cambodian refugee families. According to Spradley's protocol, interview questions started with a

grand tour, then a mini tour, and ending with follow up questions. My grand tour questions were asked about participant's observations of overall adjustment and wellbeing among Cambodian refugee families in their area. My mini tour questions focused on specific aspects of their adjustment and wellbeing, like individual mental health, family dynamics and relationships, war related experiences, substance use, and community needs. Some follow up questions were asked to gain clarity and deeper understanding. For example, when an informant talked about parenting practices in general, I followed up by asking the informant to share more about parenting practice in different generations (i.e., grandparent, parents, and children) and the differences between parenting practices back in Cambodia and that in the U.S.

5. **Analyzing ethnographic interviews.** Spradley suggested the inclusion of culture and an ethnographic perspective throughout the process of data analysis. In this study, the process of data analysis (including collecting cultural data and formulating ethnographic hypotheses) started with the initial contact with the informants via emails, phone calls and texting, and during the interviews over a period of four months (May-August 2022). Analyzing cultural data occurred during the recruitment process, while writing ethnography fieldnotes happened at the end of each interview as well as during the transcribing. According to Spradley, *a domain* is a top-level category comprised of other categories. *Cover terms* refers to a category of cultural knowledge that falls under the domain. *Included terms* are under cover terms and have a sematic relationship such as being types of, or a reason for, the cover term. In this study, I used domains to refer to clusters of content organized thematically. I used categories for cover terms representing various levels of abstraction within domains. I used themes to refer to included terms

representing larger concepts of a group of codes. I also used sub-themes to refer to various examples of specific themes.

6. **Making a domain analysis.** By following the DRS guidelines, I employed seven steps in making the domain analysis of the interviews I conducted: (1) after transcribing the first three interviews; I started the open coding of those transcripts in ATLAS ti software; (2) I reviewed the open coding and began to document potential connections and meanings; (3) I determined the domains for the analysis (see more details in step 8 of DRS below); (4) I compared coding contents and processes with my major advisor; (5) I went back to finish up the transcribing of the remaining interviews and the repeat the steps above; (6) I used Excel spreadsheets to compile all participant's first round coding within designated domains (i.e., Domain I: Pre-Migration, Domain II: During Migration, Domain III: Post Resettlement in the United States); (7) finally, I looked for possible *cover terms/categories* and *included terms/themes* that appropriately fit the semantic relationship.
7. **Asking structural questions.** Structural questions were asked as the next step of the DRS. According to Spradley, many ethnographers formulate structural questions after an initial round of interviews add them in the subsequent rounds of interviews. In this study, I created several initial structural questions for thein-depth interview protocol and I kept revising them depending on the description the key informants offered during the grand tour questions in the first three interviews. For example, when I asked about the general adjustment and well-being of Cambodian refugee families from key informants' observations, my structural questions included: "Was the adjustment different between refugees who were preliterate and those who completed some education prior to the

war?", "How about refugees from different generations like grandparents, parents, and youth/children?", "How about refugees who came alone, with very few, compared to larger family groups?", "What were the agencies that offered support during early resettlement?", and "What types of jobs were available to Cambodian refugees during early resettlement?".

8. **Making a taxonomic analysis.** Transcripts were reviewed thoroughly for relationships between and among terms. According to Spradley (1979), there are nine universal relationships: strict inclusion, spatial, cause and effect, rationale, location for action, and function. Specifically, I reviewed the data, color-coded by domain and within domain, and identified themes and sub-themes that had a semantic relationship to one another. I constructed a taxonomy as I moved on with my analysis, which is briefly described here and used to present results in Chapter 4 (see Appendix D for the domain analysis summary and Appendix E for the complete domain analysis). According to Spradley, a domain is comprised of members that shared at least one feature of meaning. In this study, the feature of meaning was referred to the period of time during which they occurred. Thus, three domains (i.e., Domain I: Pre-Migration, Domain II: During Migration, Domain III: Post Resettlement in the United States) were identified chronologically according to the informants' narratives around the migration history of Cambodian refugees. The chronology arrangement helped me analyze the narratives of the experiences and observations consistently. Moreover, in each domain, I used an ecological framework to arrange different levels of abstraction and categories. Four main categories were identified: Category I: Self; Category II: Couple relationships, Category II: Parent-child relationships, and Category IV: Context. Then, main codes were grouped

according to each category within each domain. In each category, informants reported their observations and insights, which were grouped into themes and sub-themes according to the frequency that informants mentioned a specific theme. After transcribing and coding, I summed up the frequency of each theme mentioned by informants to indicate how often each theme was represented across informants, not as an indicator of greater truth in their lived experiences. In a few cases, I also included themes that were only mentioned by one or few informants. However, I did not include themes in this analysis of topics that participants raised that fell outside of the scope of the study.

9. **Asking contrast questions.** The next step of the DRS was to ask contrast questions. In this study, I included contrast questions as a part of my interview protocol. Examples of the contrast questions that I used are: "What is the difference between the metal health condition of elders at the time of initial resettlement and now?", "What is the difference between the living conditions of Cambodians at the time of initial resettlement and now?", and "What is the difference between parenting practices at the time of initial resettlement and now?" In short, my purpose for asking contrast questions was to gain insights from informants on how certain aspects, such as living conditions, individual mental health, family dynamics, adjustment to the U.S. context, and coping strategies have changed over time.
10. **Making a componential analysis.** This type of analysis identifies the essential components within the domain, as well as finds contrasts and similar attributes between the included terms/themes. This componential analysis involved detailed steps that the researcher took in developing and revising contrast questions as a result of what was identified by this process that emphasized the terminology and language. Because of the

terminology I used to create contrast questions and the emphasis of changes over time in the interview protocol during the first round of interviews, I made minimal changes to the wording so that Cambodian natives and expatriate informants could make more sense of those questions during subsequence interviews. According to Spradley, researchers need to adhere to the psychological reality of the informant's cultural knowledge in order to refine the attributes and semantic relationships between themes in a domain. In this study, I started the componential analysis by clustering themes/cover terms and sub-themes together, and searching for contrasts/binary values (e.g., *adaptive coping strategies* and *maladaptive coping strategies*) as well as those that had multiple values (e.g., *volunteering at the temples*, joining *meditation group,* and *joining an exercise program*). Then, I collapsed them into a larger theme *Coping with Stress*. Finally, I completed the rest of the analysis by using the same procedure.

11. **Discovering cultural themes.** These themes generally emerge from extensive analysis of interviews, going back and forth between literature and results, and through member checks. In this study, I re-examined the themes and sub-themes across domains to find cultural themes. Spradley called this process the transcending process with any one area of the conversation with the informants that consist of a larger truth or relevance to the culture. As a Cambodian, it did not take a long time for me to transcend this process as I immediately understood those cultural components even though I did not have a chance to conduct prolonged cultural observations within Cambodian communities across the U.S. during the data collection period. However, I spent prolonged periods of time in a Cambodian community in the southern part of the U.S. three years prior to the start of

this study. Therefore, I quickly picked up cultural messages about family dynamics, individual mental health, and wartime experiences from the narratives of the informants.

12. **Writing an ethnography.** According to Spradley, this type of writing requires a thorough digestion, translation, and effective communication to outsiders or lay audiences. In other words, this writing draws audiences from different backgrounds into the culture and conveys the researcher's understanding of the cultural meaning of what is shared. Moreover, the researcher can reflect the different levels of knowledge by writing at different levels, from macro to micro lenses. In this study, I tried to follow Spradley's suggestions by targeting different levels in my writing and by including multiple sources in the literature as well as my reflexivity.

Research Team

Chansophal Mak. I was born in Cambodia. My parents were children and survived the genocide because their parents were preliterate farmers, who were not the target of execution. However, they experienced harsh labor, starvation, family separations, severe fear of daily bombing and gun shots, and sickness. At the end of the regime, many survivors fled to refugee camps in Thailand. My parents' families also wished to migrate there, but it was too far and they decided to stay in Cambodia.

My parents met and married in 1986. Both valued education and went to vocational schools, which was an anomaly, as very few people prioritized education at that time. When my mother became pregnant with me, many people pressured her to have an abortion as she was still a student. However, she decided to keep me and continued her education. Since my parents went to school and worked during the daytime, I was mostly with my aunt and grandmother. When I was four, I experienced my father's harsh discipline through corporal punishment, and he put me

in school earlier than kids my age. My father's discipline was done through angry outbursts and left me with severe anxiety. My mother was silent in the background, as she was scared and avoided confronting my father.

These early experiences with my parents instilled a passion in me for the importance of education and mental health. It was almost impossible for me to attain knowledge in these fields due to limited educational resources in Cambodia. I started with a Bachelor's of Education and became a teacher for a year before I got funding to pursue a Master's of Counseling in the Philippines. After graduation, I returned to Cambodia and worked as a lecturer and counselor for four years. In these roles, I observed and witnessed how systemic and intergenerational family issues resulted from untreated trauma. I kept searching for more learning in mental health and was admitted for a doctoral degree in Marriage and Family Therapy (MFT) at the University of Georgia.

My personal and scholarly interest in traumatic stress among forcibly displaced populations propelled me to keep learning about the mental health and relational consequences of trauma exposure on individuals and families. Importantly, I learned about the multiple impacts of intergenerational transmission of trauma if it is not interrupted. This helped me to understand how genocidal trauma affected my parents' mental health and relationships. I understood why my father, who loved us, also hit us badly because he could not control his outbursts of anger resulting from prolonged exposure to trauma during his childhood. He did not know alternative parenting strategies that could help his children grow without harming their mental health.

I have been heavily exposed to the literature on Cambodian refugees and traumatic stress since the start of my doctoral degree in 2018. I learned that what my family experienced is very common among war-affected populations. Many Cambodian refugees are still suffering from

untreated mental illnesses related to the genocide, migration, and post-resettlement stress without enough support from local resettlement authorities. These gaps in resources placed Cambodian parents at a disadvantage for supporting their offspring to successfully adjust in the U.S. Parents mainly focused on survival, while children struggled at school; their struggles were exacerbated by a lack of awareness of school professionals in supporting refugee offspring. When children had school problems, they could not rely on their parents, as they also could not help themselves. The need for belonging led many youths to drop out and join gangs during the 1990s. Even though some youth finished high school, very few pursued college due to a lack of guidance and lack of knowledge about financial aid. Many of these youth ended up pursuing harsh labor jobs or committing crimes. If a noncitizen commits a crime, the severity of the consequences increases from doing jail time to facing the additional punishment of being deported. The lack of support for families when they arrived plays out in deporting their children when they do not succeed in a system stacked against them from the point of arrival.

The mental health and relational needs assessment among Cambodian families that I conducted for my dissertation brings focus to my interest and deepens my understanding of the supports needed in the U.S. for this population, as well as contributes to my understanding about Cambodians living in Cambodia, who have a similar background but without the migration aspect. I also wish to continue my research by culturally adapting evidence-based family interventions (parenting) to address intergenerational transmission of psychopathology among the population for my post-doctoral research. I wish to secure a faculty position in a DEI institution where I have a platform to continue my scholarship and can offer educational opportunities for underserved refugee youth.

Elizabeth Wieling. Dr. Wieling is a professor and director of the Marriage and Family Therapy program, Department of Human Development and Family Science, University of Georgia. Dr. Wieling has been my academic advisor since my second year of the program. I found Dr. Wieling because of our shared passion in studying traumatic stress and her expertise in traumatic stress and its treatments at individual and relational levels in the context of displacement. Her presence during my second year was transformative to me since I was searching for guidance and in need of a life-long mentor in the field of traumatic stress. She also has an extensive research agenda to develop systemic preventive interventions for communities affected by traumatic stress, including post-conflict settings and migrants both inside and outside the United States.

Trustworthiness

Trustworthiness criteria (Morrow, 2005) guided not only the research design, but also the data collection, and analysis. Ensuring trustworthiness is very important in qualitative research so that the data analysis and interpretation reflect the real experiences of the participants. I followed naturalistic paradigms that emphasize multiple standards and that acknowledge that reality is subjective rather than objective (Lincoln & Guba, 1985). According to Lincoln and Guba (1985), to ensure trustworthiness and ethical standards in qualitative research, there are four key evaluative criteria to consider: 1) credibility; 2) transferability; 3) dependability; and 4) confirmability. Additionally, I also used critical ethnography principles to guide me by reflecting on my positionality, dialogue with the participants and monologue with myself, and critical theory (trauma informed lens) in every step of the study to eliminate my own bias and assumptions as much as possible (Madison, 2005).

Credibility refers to how accurate a conclusion of the finding is. There are several techniques we can use to ensure credibility of study findings through: 1) prolonged engagement; 2) persistent observation; 3) triangulation; 4) peer debriefing; and 5) member checking (Lincoln & Guba, 1985). In this study, I tried my best to adhere to the techniques to ensure credibility suggested by Lincoln and Guba, but I have to admit the limitations of the virtual nature of the data gathering during the pandemic. There were several steps I took. First, prolonged engagement was done through relationship building with participants through phone, text message, and emails at initial contact during recruitment process. Building trust and safety with the participants is very important because it affects the openness in sharing of the participants. Because of the virtual nature of this research method, prolonged engagement was only done through emailing, telephone call, and texting. Second, persistent observation refers to the depth of information received through ongoing observation. In this study, I relied mainly on interviews and not on observation of participants in their surroundings. Due to the pandemic and to the great distances involved, I was not able to observe the participants outside of the interview context. Third, triangulation refers to the process of integrating different data sources while studying a phenomenon to minimize data misinterpretation (Lincoln & Goba, 1985). This was done through literature review, data collection, and discussion of relevant topics with key informants. If one informant made a theme (gender roles), I would check that point with following informants to build my understanding of the gender roles in multiple aspects such as in parent-child relationships, in couple relationships (e.g., older couples and younger couples), and at initial resettlement and now, etc. Incorporating findings from previous interviews as I moved forward allowed me to check to see the strength of this finding in relation to other informants' experiences and insights. Fourth, peer debriefing refers to the ongoing consultation with peers or

academic advisory members to discuss methodology, the researcher's subjectivity and bias, and data interpretation. In this study, I did the peer debriefing by constant consulting with my academic advisor (Dr. Wieling) on a weekly basis. This process brought me awareness and a reduction of my bias in my judgement and data interpretation. Fifth, member checking refers to the process of verifying the findings with the participants after data analysing (Lincoln & Guba, 1985). Ensuring anonymity of the data is very important in the process of member checking. Member checking was also done through asking clarifying questions during the interviews and through reviewing audio recordings and transcripts repeatedly. In this study, I sent the summary of the findings without revealing any identified information of other informants to some informants who agreed to offer more support after the data gathering. I revised some findings and terminology after receiving feedback from them.

Transferability refers to the findings in one context being relevant to other contexts. Transferability is used in qualitative research while generalizability is used in quantitative research (Lincoln & Guba, 1985). Transferability is achieved through awareness of the co-constructed nature of researcher and participant relationship (Lincoln & Guba, 1985). In other words, contextualizing the findings is the key to transferability in qualitative research. In this study, transferability was achieved though paying attention to factors such as the diverse locations of the participants (i.e., California, Massachusetts, Pennsylvania, Minnesota, Washington, and Connecticut), migration history, social support systems, and family functioning that may impact the mental health and relational needs of the participants.

Dependability refers to the extent to which a conclusion is accurate according to the findings. Dependability can be achieved through data auditing (Lincoln & Guba, 1985). In this study, I stored all interview transcripts, observation notes, memos, first cycle coding, second cycle

coding, and complete domain analysis, and uploaded them in a secure online platform owned by the University of Georgia. All of these documents were shared with Dr. Wieling, who audited the findings and independently reviewed all transcripts and summaries for consistency. In addition, I consulted with Dr. Wieling throughout the project on a weekly basis to clarify and verify findings.

Confirmability refers to the degree to which the findings are generated from the participants or from the researcher's bias and interest. Lincoln and Guba (1985) proposed two techniques to ensure confirmability: 1) audit trail, and 2) reflexivity. First, an audit trail refers to the detailed steps taken during the study. Those steps were collecting raw data, data reduction and analysis, data reconstruction and synthesis, process notes, and materials. Raw data consists of interview audios, transcripts and observation notes. Data reduction and analysis was done to summarize the data for future reference. Data reconstruction and synthesis was done by comparing findings to previous studies. Process notes include anything related to the methodology while materials refer to the research proposal and personal notes. Second, reflexivity encourages the researcher to be aware of their subjectivity in all stages of the research project (Halpern, 1983). In this study, reflexivity was done by keeping detailed records of my reflexive journals throughout the study. Thoughts, feelings, and questions during the interviews were recorded and discussed with Dr. Wieling to minimize and track my biases.

Potential Ethical Issues

Fifteen out of eighteen participants were both professionals and former Cambodian refugees themselves. Due to the nature of the questions included in the survey, the participants were reminded of times that they felt helpless and distressed. As the interviewer, I reminded participants that they were not asked to share personal experiences but to reflect on what they

know broadly about Cambodian resettlement experiences and community needs. Moreover, I continuously informed them that they could end their participation in the research study at any time, and if at any time they were uncomfortable during the interview, they could notify me immediately. A few participants showed psychological distress during the interviews as they talked about the death of significant family members in their family. These participants paused and cried during their sharing, but they still gave consent to continue their participation until they finished with the interview even though I informed them that they could stop the interviews at any time. At the end of the interview, these participants also shared that they felt relieved and happy to share their experiences even though it was difficult to do so. They expressed their wish that their experience could be helpful to inform the mainstream culture about the needs of this underserved community in the U.S.

The records of this study were kept confidential. In any sort of report, I will not include any information that will make it possible to identify a participant. Research records were stored securely on HIPAA, a compliant and university approved server and only key researchers have access to the records. Actual names of the informants were changed even on these records. All recordings of interviews are only accessed by the researchers, are kept safe and secured, and will be destroyed within two years of data collection.

Risks were minimized by consulting with community leaders and professionals familiar with the community in order to inform recruitment, in-depth interview protocols, while maintaining cultural and community-sensitivity. Risks were minimized by maintaining participant confidentiality through safe data security practices.

Conclusion

Principles of critical ethnography (Madison, 2005) were used to guide the study. The methodological protocols presented in this chapter include sections on participants, sites, procedures, types of data, the data analysis plan, the researcher team, methods to ensure trustworthiness, and ethical considerations. In chapter four, findings of this study are presented.

CHAPTER 4

RESULTS

"Refugees didn't just escape a place. They had to escape a thousand memories until they'd put enough time and distance between them and their misery to wake to a better day."

NADIA HASHIMI

Pediatrician, novelist, politician

In this chapter, I will present the summary of my domain analysis procedures that followed the guidelines of the Developmental Research Sequence (Spradley, 1979). Next, I will present my detailed domain analysis consisting of ***three domains***–Pre-Migration, During Migration, and Post Resettlement–in the United States. For each domain, I plan to elaborate on four *cover terms/categories*: Impact on Self, Couple Relationships, Parent-Child Relationships, and Context. In each category, I will present key themes along with relevant quotations from key informants who participated in the study. To conclude each domain, I will provide my critical analysis and reflections of the findings using my interpretive and subjective relationship in conjunction with the narratives provided by study participants. Since the findings of Domain III represent the focus of this dissertation, they required greater detail than the first two domains. This chapter will conclude with an introduction to the final discussion chapter.

Domain Analysis

Following DRS guidelines, the domain analysis of the interviews includes seven steps: after transcribing the first three interviews, I (1) began the open coding of those transcripts in ATLAS ti software; (2) reviewed the open coding and began to document potential connections and meanings; (3) determined the domains for the analysis; (4) compared coding contents and processes with major professors; (5) completed transcriptions of the remaining interviews and repeated the same steps listed above; (6) utilized Excel spreadsheets to compile participants' first round of coding, within the designated *domains*; and (7) looked for possible *cover terms/categories* and *included terms/themes* that appropriately fit the semantic relationships. Table 3 lists analytic steps of the Domain Analysis Procedures that were implemented in this study.

Table 3

Domain Analysis Procedures

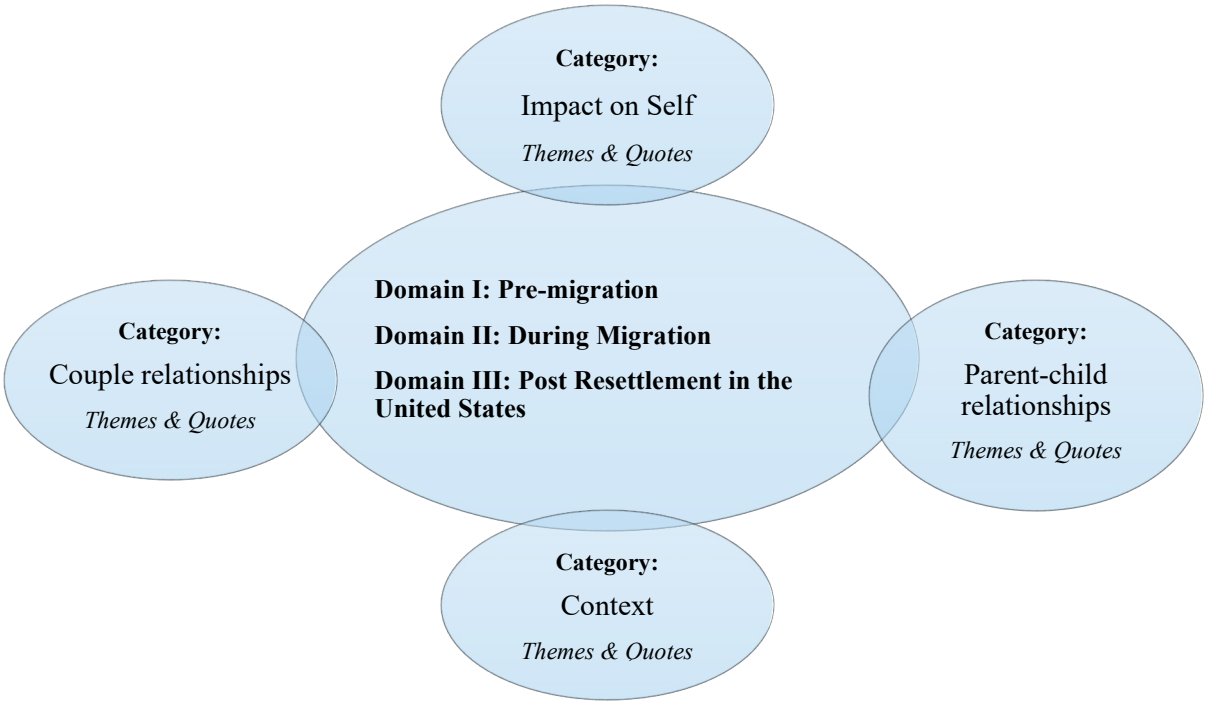
Step	Domain Analysis
1	Open coding of the first three transcripts in At.Lasti
2	Document potential connections and meanings among codes
3	Determine the domains for the analysis
4	Compare coding contents and processes with major advisor
5	Complete transcription of remaining interviews
6	Use Excel spreadsheets to compile coding within designated domains
7	Look for possible cover terms/categories and included terms/themes

As a result, I identified three domains: Pre-Migration, During Migration, and After Resettlement in the United States. Each domain consists of four *cover terms/categories* (i.e., Impact on Self, Couple Relationships, Parent-Child Relationships, and Context) based on the

human ecological model (Bronfenbrenner, 1995). In each category, I introduced significant *included terms/themes* and then provided quotations from my participants' responses. I used the terms few (20%); some (50%); most (75%); and all (100%) in regard to the participants to capture the frequency of the repetition of a theme (see Appendix D for the Domain Analysis Summary, and Appendix E for the Complete Domain Analysis). The Summary of Domains, Categories, and Themes is presented in Figure 1.

Figure 1

Summary of Domains, Categories, & Themes



Note. Few (20%), some (50%), most (75%), & all (100%) are used to show frequency of themes.

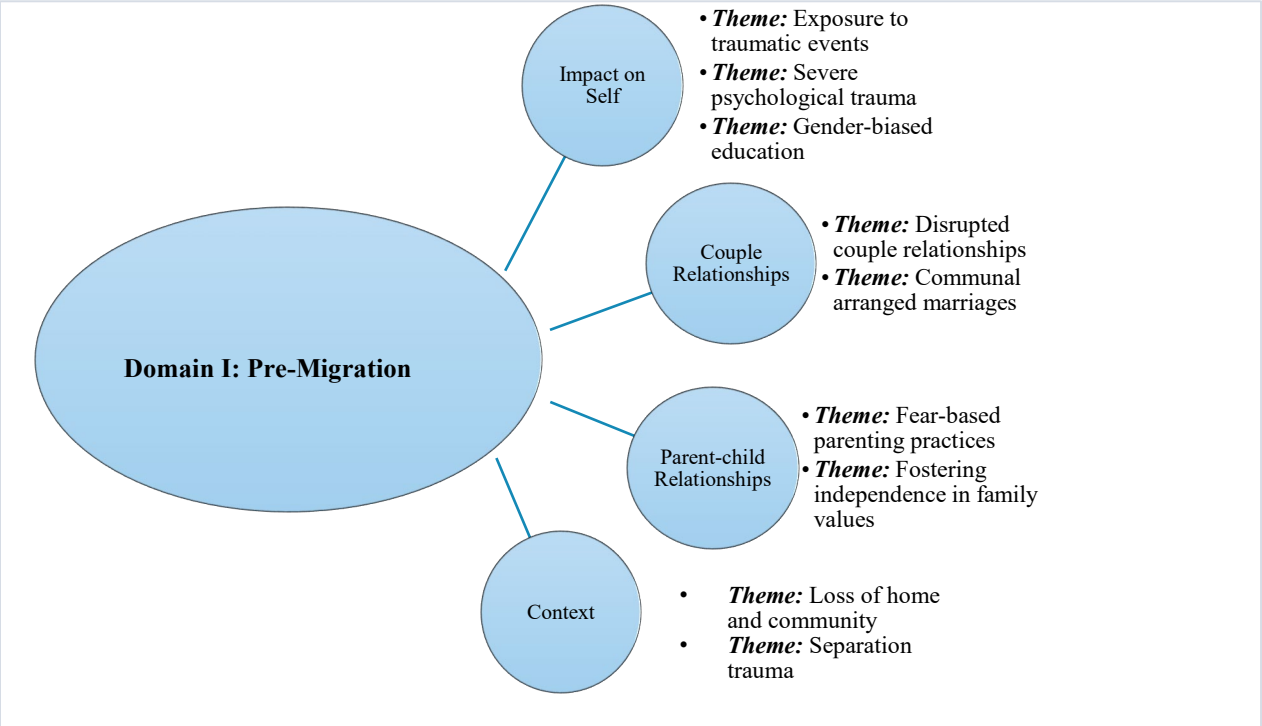
Domain I: Pre-Migration

Pre-migration refers to the period prior to the Pol Pot or Khmer Rouge regime (1970-1975) and also during the Pol Pot regime (1975-1979). Civil wars and genocide marked the Pol Pot regime in Cambodia. Cambodians who lived in the countryside have experienced the effects

of these civil wars since 1970. For those Cambodians who lived in Phnom Penh, they continued to weather the impact of these wars until the Khmer Rouge seized full power in April 1975. In Domain I, I identified and present four categories (Impact on Self, Couple Relationships, Parent-Child Relationships, and Context). In each category, I present significant themes followed by quoted material shared by key participants. The summary of Domain I: Pre-Migration is presented in Figure 2.

Figure 2

Domain I: Pre-Migration



Category: Impact on Self. Individual Cambodians endured multiple traumatic events caused by the wars since 1970; these individuals lived with psychological trauma along with stressful emotions on a daily basis. Most importantly, they did not have a chance to attend school without disruption from wars. As a direct consequence of living through the pre-migration period

in Cambodia, respondents reported three main themes: *Exposure to traumatic events, psychological trauma, and gender-biased education.*

The theme ***Exposure to traumatic events*** emerged in the responses of all participants in this domain. Between 1970 and 1979, Cambodians experienced an array of traumatic events inflicted by the civil wars and the genocide. The level of trauma varied from individual to individual, according to their social status. Specifically, educated people and those who lived in the city were often the target of execution and punishment, while those who lived in the countryside could typically adjust better to the labor-intensive work thrust upon them by those in power. Participant P4G2 shared:

> My father was a police officer in Kampong Cham province. Pol Pot people came to our house and told us that they needed my father to join a meeting. From then, my father never came back home and everyone knew what happened, but no one talked about my father's absence anymore. My grandfather on my mother['s] side was a village leader and the same thing happened to him. Since the beginning of the regime, two important family members just faded away.

Participant P9G1 shared:

> My family was educated and wealthy. We never experienced any hardship prior to the Pol Pot regime. My father was a professor, and my mother worked in a ministry in Phnom Penh. My siblings and I just went to school, and we didn't have to do any housework as we had [a] housemaid who did everything for us. Suddenly, our life turned upside down when Pol Pot came into power. My father committed suicide in 1975 because he did not believe his friends when they told him to move out of Cambodia. He kept blaming himself for not saving his family. Two of my siblings were beaten to death at [a] very young age and two are living with severe PTSD [Post-Traumatic Stress Disorder] and Parkinson[']s] disease now.

The theme ***Severe psychological trauma*** surfaced in the responses of all participants who lived in the countryside since 1970 during the time of the Vietnam War, accompanied by stressful emotions, such as fear, anxiety, and excessive worries inflicted by chronic civil war and genocide. On the other hand, participants who lived in the city experienced similar levels of psychological distress when the genocide regime began in 1975. Participant P2G1 shared:

> During [the] Vietnam War in 1970, the U.S. also bombed the countryside of Cambodia almost every day. People in the countryside were on guard and lived with life-threatening fear and anxiety every day. They worried about themselves and their family. Many people dig [dug] a camp under the ground and stayed there to save them and their families from the bombs. During the daytime, they had to risk their life to find food for their families. Many of them died because of the bombs when they were searching for food.

Participant P17G1 shared:

> In the ’70s, many farmers migrated to Phnom Penh. I lived in the city and I just knew that there were wars and bombing in the countryside, but I didn’t experience the difficulty in living in the countryside and migrating to the city for safety. They had no home, job nor food. They were farmers, and all they knew was to grow rice, you know. They were everywhere–on the streets and on the public garden. They looked sad, worried, and hungry. It was just hard to see them.

The theme ***Gender-biased education*** emerged in the reports of all respondents who lived in the city and countryside. Two participants who represented the Grandparent Generation Group stated that they were in early adulthood before the genocide regime and grew up in affluent families in Phnom Penh. These two females reported that they attended high school and learned French prior to the wars. They added that they could not go to school when the wars started because it was unsafe to travel to school–even prior to the genocide–and because they married spouses and had newborns.

In the countryside, only men could attend school and most of the education took place at Buddhist temples, according to the responses of participants who lived in the countryside before the wars. The government discouraged women from going to school for safety reasons, coupled with the belief that women should only work as homemakers. Participant P10G2 shared:

> In [the] 1970s, only men got to go study, and most of education took place in pagodas. Moreover, Buddhist monks were teachers during that time. This means that women were not allowed to go study because it was believed that women should just learn how to be good homemakers. Additionally, it was not safe for women to go outside the house by themselves to study when war was going on in the countryside.

Participant P17G1 shared:

> In [the] 1970s, I studied accounting before I got married, then I decided to postpone my studies because I had a newborn. Not long after that, there were civil wars in the countryside, so many people in the countryside migrated to Phnom Penh and they were everywhere on the streets. It was not safe at all for me to go back to school on my own while my husband worked in the province in the Air Force.

Category: Couple Relationships. The family arranged marriages prior to the genocide, but during the genocidal regime, the commanders handled this process. The respondents identified two main themes in regard to this category: *Disrupted couple relationships* and *communal arranged marriages*.

The theme ***Disrupted couple relationships*** surfaced in the reports of three participants who represented the Grandparent Generation. One participant (P17G1) reported that her husband worked for the Air Force in the province while she was living in Phnom Penh and raising a newborn on her own in the 1970s. After a few months, she had to leave the city to follow her husband. During the Khmer Rouge regime, couples had no time together because of their assignments to different work camps and the fact that they typically labored for more than 15 hours a day, seven days a week. Participant P12G1 shared:

> During [the] Pol Pot regime, they didn't allow us to stay together. We were divided to different work camps and spent most [of] our time working intensively there. We worked more than 15 hours every day, and we came back home with exhaustion and hunger. We just lived with life-threatening fear as we could be killed anytime, not to mention about our couple relationships.

The theme ***Communal arranged marriages*** emerged in the responses of two participants representing the Grandparent Generation. These individuals reported that, during the Khmer Rouge regime, approximately 10 to 12 couples had their marriages planned in a wedding event that would take place in a single service. Those marital partners did not know their spouses and some ended up in abusive relationships. Participant P9G1 shared:

> During [the] Khmer Rouge regime, they matched young people and arranged marriages all at once. There were about 10 to 12 couples in a communal wedding. Those couples didn't even know each other. Some of them ended up in very abusive relationships. To protect me from marrying an unknown person and [an] abusive marriage, my parents secretly arranged me to be with a know[n] person and told the Khmer Rouge people that I was married. I am still living with my husband now.

Participant P3G2 shared:

> My own parents were arranged during the Khmer Rouge time because they were young adults during that time. Like other young adults, they had to accept whatever the regime arranged for them. As you know, any opposition could lead to immediate execution. You see, they got married because of fear and they continued to live together until my dad passed away here in America. In my experience, my parents were very disconnected and never showed any affection to each other as a couple.

Category: Parent-Child Relationships. Two main themes emerged in this section–*fear-based parenting practices* and *fostering independence in family values*–in the reports of most participants in the Pre-Migration Group.

The theme ***Fear-based parenting practices*** surfaced in responses to questions related to the time during the wars and the genocide. This component primarily occurred among parents living in the countryside who had limited education. Some participants reported that parents who were farmers and living in the countryside created the rule "Be home before sunset" to protect their children from danger when it got dark outside. Participant P10G2 shared:

> Parents created the rule "Be home before sunset" because they didn't want their children to be outside when it got dark since it was not safe for them. There were gunshots, bombings, and robbery going on, especially during the nighttime. That's why this rule was created, and it worked pretty well during those times.

Participant P12G1 shared:

> I think the concerns of their children's safety among older parents were valid during the wartime. They just wanted to make sure their children were not in danger, then they created a lot of fear-based rules to protect their children. The rules worked very well during those times; however, these rules were passed along without revising. When younger parents applied the rules here, it prevented their children from growth.

The theme ***Fostering independence in family values*** focuses on the value of education and being independent, regardless of gender, a perspective identified by participants whose parents completed their education in the city. Participant P9G1 shared:

> I once asked my father why I have to study when I'm just a woman; I could just get married and depend on my husband. That's what other women during my time did; however, my father told me that I have to learn and be independent even though I'm a woman. My father also added that my mother and him worked and were independent and they had a strong partnership.

Participant P12G1 shared:

> My parents were very progressive among parents of their time. I was [a] youth in the 1970s, and my family lived in Phnom Penh. I got access to [a] good education, regardless of my gender; you know, I'm a female. My parents paid for my education and gave me freedom to hang out and join activities with male friends. During those times, anyone who went to DECARD school were from high-income families. I went to that school. I know some French; that's why I picked up English quickly when I arrived here.

Category: Context. Chronic wars and family separation determined the Context of Pre-Migration. With no peace in the country since 1970, people performed their family and societal roles with fear. Most participants' comments in this category cited two main themes: *loss of home and community* and *separation trauma*.

The theme ***Loss of home and community*** emerged with a focus on internal migration in the comments shared by most participants who experienced living in Cambodia before and during the Khmer Rouge regime. A contingent of residents in the countryside migrated to the capital of Phnom Penh to seek safety prior to the Khmer Rouge regime between 1970-1975 in the midst of daily bombings outside of the capital city, especially in the provinces near Vietnam and Laos on the Cambodian border. As a result, people from the countryside became homeless and lived on the streets in Phnom Penh without jobs or food. Participant P17G1 shared:

> In [the] 1970s, civil wars took place in the countryside of Cambodia. Many people from the countryside migrated to Phnom Penh. They lived on the street, and they were everywhere. They were farmers and uneducated, you know. They didn't have job[s], so

> they didn't have enough food for their families. They stayed like that for a long time, as I remember. The country was already very chaotic prior to [the] Khmer Rouge regime.

The theme ***Separation trauma*** caused by the genocide was severe, especially among Cambodians who lived in the city as reported by some participants who lived before and during the Khmer Rouge regime. When the Khmer Rouge took over Phnom Penh in April 1975, they separated people into different destinations. Some families–separated at the beginning of the regime–never saw each other again. Even the ones who reunited with their families received placement in different work camps, according to their genders and ages. Participant P9G1 shared:

> They separated my family into different work camps. My parents were separated and my siblings were separated into different camps, according to our age groups. Sometimes, they allowed us to come home and visit our parents. I was 16 during the Khmer Rouge regime, so they put me in a young adult work camp. One of my younger brothers was put in the children's camp. One day, he sneaked out to visit my mom in the evening. They caught him and beat him severely [shared amidst sobs]. He was very small, and he missed my mom, so he sneaked out. He died after a few weeks because his lungs were severely injured due to that severe beating. He vomited with blood and pieces of his lung came out. He died in my mom's arms [weeping].

Participant P13G2 shared:

> I was very small during Khmer Rouge time. They put me in a children's camp. I think I was about 6 or 7 at that time. I had a very unclear memory about the difficult life, but I remembered I sneaked out to visit my mom at night in a different camp. During those times, many children were attacked and eaten by wolves while they ran in the woods to visit their parents at night. I remember my mom telling me not to visit her because she was afraid that I may be eaten by the wolves or get caught and hit to death.

Researcher's Reflections and Critical Analysis of Domain I

The civil wars and the genocide regime between 1970-1979 marked a period of extreme inhumanity, one that Cambodian survivors will not forget, especially those of adult age at that time. The ongoing hardships and the innumerable deaths of family members that occurred nationwide leave an indelible mark on the psyche of all who experienced it. My family did not

escape these horrors. To this day, they express that the trauma and losses experienced during that time remain with them, etched in their memories forever. Since my childhood, I remember hearing the narratives about the Pol Pot regime. Even though I was born in the late 1980s, I have a deep personal connection to the pain and consequences associated with the Killing Fields in regards to the mental health and family relationships of Cambodian survivors. I am part of the younger generation who lives in the midst of the intergenerational effects of the Killing Fields.

On an individual level, the stories that participants recounted for my research did not shock me. Accounts of Cambodians exposed to life-threatening events, such as daily bombings, gunshots, the murders of family members and acquaintances, extreme labor conditions with minimal food, prolonged family separation, and losses in all aspects of life are the stories I grew up on. What I heard from the participants in this study aligned with the narratives that I heard from my family and acquaintances throughout my life. The number of exposures to these horrors varied according to the respondents' ages, gender, education, and social status. For example, educated adult males from the city faced a sentence of immediate execution, while adult male farmers from the countryside faced relegation to an extremely harsh labor situation. This also reminded me of my father's narrative about his beloved older brother–murdered because he liked to read and hid books in his house. Adult females also experienced extreme adversity, such as forced marriages, sexual violence, and horrific labor situations with minimal food. The government shipped children off to camps with limited contact with their parents and forced them to work if they were old enough.

My father went through adolescence during the regime and shared stories about his early life with me and my family. My mother was a young child during that time and only remembered her placement in a children's camp–away from her parents. These types of trauma left severe

psychological and physiological impacts on those who survived, such as anxiety, inexpressible anger, unresolved grief, helplessness, excessive worries, and extreme fear. These residual effects also led them to experience extreme hypervigilance in response to their prolonged trauma exposure. As the offspring of Cambodian survivors and as part of my scholarship in traumatic stress, I have observed the full range of psychological and physiological stress symptoms among my family members, friends and acquaintances. My younger self once viewed those as normal responses and ways of living. After gaining knowledge about traumatic stress and its consequences, I realized that those responses represent common post-traumatic stress reactions that most likely require professional intervention. Unfortunately, many individuals unconsciously and unknowingly live with the traumatic stress reactions without treatment, causing them to experience difficulties in maintaining their own mental health, and relationships to others.

During the Killing Fields era, Cambodian families became extremely dysfunctional because basic survival and coping with adverse conditions took precedence over normal family life. Family members struggled to perform their desired roles amidst forced separations in different work camps and by their all-consuming labor assignments for the communal society. Due to a lack of family time, the meaning of family became conflated with separation, death, and emotional pain. Connecting with my family narratives, my grandparents on my mother's side suffered more than other members due to the fact that my grandparents were young adults at that time. Separated from each other, my grandparents only found each other after the regime ended.

On another note, parents arranged marriages before the Khmer Rouge period, while Khmer Rouge commanders arranged marriages during that period. Regardless, marriages occurred due to arrangement rather than by choice. The absence of love and selection in these

marriages often affected parenting practices. During the war and the genocide period, parents relied on practices primarily based on fear coupled with the objective of survival. For example, my grandparents married and had five children prior to the Khmer Rouge regime. Their children–including my mother–left home for different children's camps, but sneaked out to see my grandmother whenever they could. My mother told me that one of my aunts died due to a lack of parental care to treat her illnesses. My grandfather worked in a faraway labor camp and escaped to Vietnam through the border. With my mother's family scattered throughout the country, they rarely experienced family time during the regime.

In sum, prolonged trauma exposures severely affected individual Cambodians as well as their families. Specifically, their Couple Relationships and Parent-Child Relationships typically hinged on fear-based techniques that contributed to additional dysfunction in the context of family separation during a decade of civil war and the Killing Fields. As a family scholar conducting this study, I found the recounting of the narratives of war-torn families particularly painful due to the direct ties to my own painful memories and complicated grief.

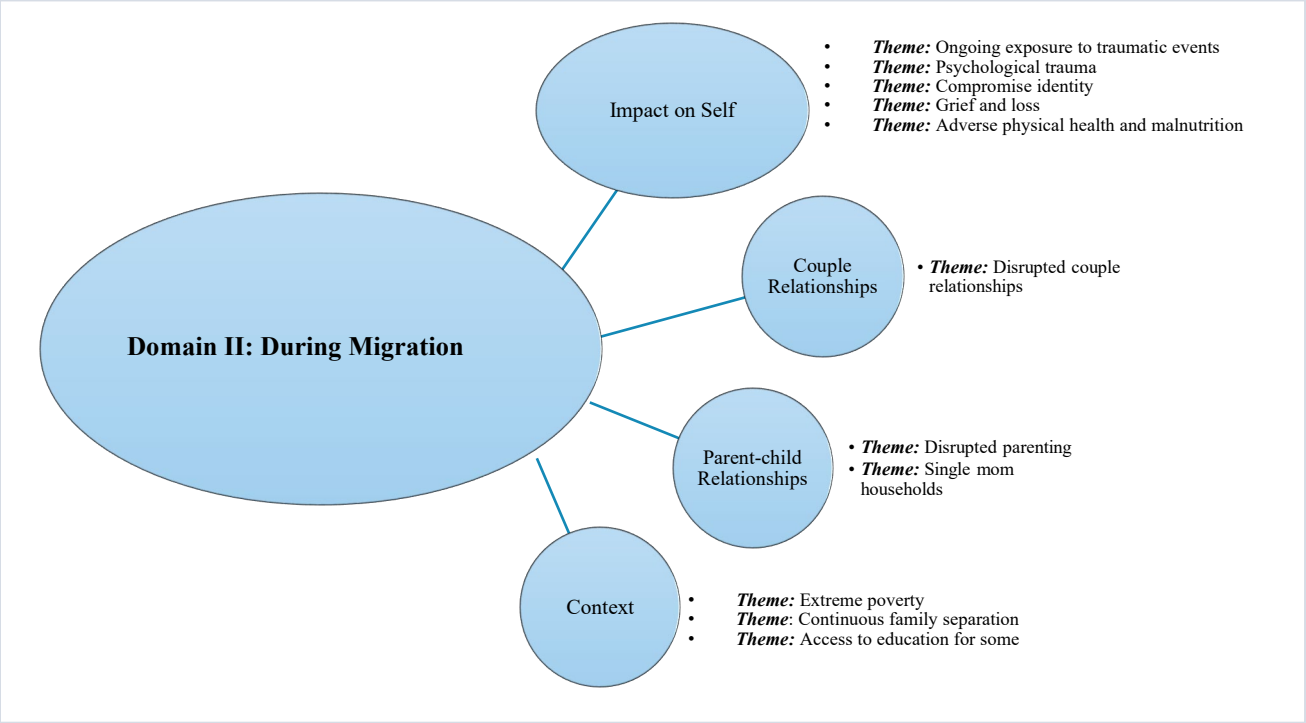
Domain II: During Migration

Cambodian survivors experienced living in refugee camps in Thailand from 1979 to 1994. Even though the genocide regime ended January 7, 1979, many Cambodians who lived in the countryside near the border of Thailand migrated to refugee camps in Thailand. Most participants reported that the journey by foot to refugee camps in Thailand posed the same life-threatening challenges as attempting to survive during the genocidal regime, specifically robberies, gunshots, and even landmines when crossing the border to refugee camps in Thailand. These Cambodian survivors continued to live in harsh conditions with limited food supplies in refugee camps for more than a decade. In Domain II, four categories (i.e., Impact on Self, Couple

Relationships, Parent-Child Relationships, and Context) emerged in the details shared in conjunction with significant themes derived from quotations from key informants in each category. The summary of Domain II: During Migration is presented in Figure 3.

Figure 3

Domain II: During Migration



Category: Impact on Self. Cambodian survivors continued to experience multiple psychological traumas while dealing with issues related to their identity, mental health, and physical health as a residual effect of living through years of civil wars, the genocidal regime of the Killing Fields, and in refugee camps. On the other hand, surviving civil war and the genocidal regime served as a badge of honor labeled as individual resilience among these survivors. Respondents cited five emergent themes–*ongoing exposure to traumatic events*, *severe psychological trauma, compromised identity, grief and loss, poor physical health and malnutrition, and individual resilience*–in their reports of living in refugee camps in Thailand.

The theme ***Ongoing exposure to traumatic events*** surfaced in the responses of all participants who resided in refugee camps. These respondents agreed that exposure to trauma did not end after the wars and noted the harsh living conditions and the scarcity of resources and food supplies that exacerbated the horrific conditions in refugee camps, in addition to the residual psychological and physical health effects of losses and family separation during the wars. Participant P2G1 shared:

> By the time the survivors arrived in refugee camps, they were already very weak–mentally and physically. The survivors had only bone and skin. Many of them could not stand more harsh lives, especially the elders and those who were very sick–and passed away. I think you know this. The food in refugee camps was not enough, so we had to risk our lives to travel to another camp in [the] search for food. Some people sold food they found to earn some money to support their remaining family members.

Participant P12G1 shared:

> I worked as [a] translator and, most of the time, translated for medical teams in refugee camps. At that time, I did not know about mental health effects and their signs or symptoms, but I learned about it after some years of working in America. In refugee camps, I only noticed the physical health conditions. I remembered one time they studied [the] physical health of survivors who were women, and they found that women who were in their 40s had the physical health age of people in their 60s. It was terrible. Their physical health was depleting during the wars and refugee camps. Sometimes, I was really impressed of the fact that we survived the Killing Fields.

The theme ***Severe psychological trauma*** surfaced, along with stressful emotions such as fear, anxiety, anger, emotional pain, grief, and ambiguous hope in the reports of most participants. Participant P10G2 shared:

> Yeah, we survived the Killing Fields, but the walk to refugee camps in Thailand was very dangerous, too. Pol Pot people were still around, especially near the border of Thailand. There were a lot of robbers, too, and Thai border armies. These people still opened gunshots and killed each other. We crossed the borders with a lot of fears and anxiety. Many people who were already weak physically and ill died along the way, too. Once we arrived [at] the camps, there were so many people and we lived like animals. We had no time to process our pain and losses. Food supplies were very limited, and sometimes we had to earn a living by selling stuff on the street. We stayed there years before we got the sponsor to come to America.

The theme ***Compromised identity*** surfaced in the reporting from some participants who stated that Cambodian survivors had very low self-esteem and a fear of foreigners. Most importantly, they learned to hide their personal information for safety purposes and to enhance their chances of being admitted to a third country of resettlement. Many refugees changed their names and birthdays as if they were new people. Participant P1G2 shared:

> We have problems with trust. During the Killing Fields, people were executed because of their professional and social identities, so they learned to hide their identities. Many survivors changed their names and ages before they got sponsored and moved to the third country. There's definitely a psychological impact on top of the trauma when a person living [decides to hide] their real identity for the rest of their lives.

Participant P2G1 shared:

> We were once colonized by the French, so we learned to be afraid of foreigners. Cambodians wouldn't cause any problems with foreigners unless they had no choice. Because of the refugee camp time, many Cambodians considered foreigners from the third countries as helpers, so Cambodians respect foreigners and they won't create problems with foreigners unless they have no choice.

The theme ***Grief and loss*** over losing loved ones proved widespread in the participants' responses. The term "mental illness" was not a term that Cambodians knew during their time refugee camps. They did understand that all Cambodians expressed deep sadness over the loss of some or all their family members, friends and acquaintances due to execution, murder, and illnesses. They experienced painful emotions and often cried when talking about the death or loss of their family members. Participant P9G1 shared:

> All we know about mental health is that people became very sad and cried when they talked about their family, the loss, and the separation during the war. We tried not to remind [them] about it because it's too painful for some people. I only learned more and more about mental illnesses and their symptoms when I started working with Cambodian refugees in America. It took me years to grab the concepts.

The theme ***Adverse physical health and malnutrition*** emerged in the responses of all participants who lived in refugee camps. They mentioned the issue of very poor physical health

as a result of living through the Khmer Rouge regime and stated that many people passed away during that time since their bodies could not withstand the prolonged exposure to such harsh conditions. Participant P10G2 shared:

> The physical health of the survivors in refugee camps was very bad. You know, they lived with minimal food and [were] overworked for years. The daily food we had for almost four years of the Killing Regime was a few grains of rice cooked in plenty of water– nothing else. All of us were malnourished with multiple health conditions. Many people died because of malnutrition and illnesses during that time, too. Then, in refugee camps, we experienced the shortage of food supplies, too.

The theme ***Individual resilience*** made its way into the accounts of most participants as an outcome of all the adversities they experienced. Respondents agreed that enduring the horrors of the Killing Fields proved almost impossible for them, yet they promised themselves that they would rebuild their lives and their families in a safer place if they survived. Participant P9G1 shared:

> I promised myself that if I survived [the] Pol Pot regime, I would devote myself to serve others who need help. That's why I went to college to get a degree in Human Services after resettling in the U.S. I also told my clients and families I saw that their lives are precious. They survived the death, and they can be anything they want to be in America if they don't give up.

Participant P1G2 shared:

> They survived [the] Pol Pot regime and refugee camps. These people are very resilient. They are still alive even though they suffer from untreated mental illness and [the] comorbid[ities] of mental illness and physical illness. They described their life after [the] Pol Pot Regime as being born again. I don't think that these survivors are weak people.

Category: Couple Relationships. *Disrupted couple relationships* served as the primary identifier and the main theme of this category by some participants.

The theme ***Disrupted couple relationships*** surfaced in the respondents' reports due to the genocide and other issues related to migration. Men, the primary target during the genocide, died

from murder at the hands of the government, leaving many single mothers and their young children to fend for themselves in the refugee camps in Thailand. Participant P12G1 shared:

> There were many single mothers whose spouses were executed during [the] Pol Pot Regime. They had a few small kids with them. Some of them got remarried in the refugee camps and gave birth to new babies, while many remained as single mothers and raised their kids by themselves after their resettlement to America.

Participant P13G2 shared:

> My dad was a professor before the Khmer Rouge Regime. He was executed immediately when the regime took over, leaving three of us–my mom, my two siblings, and I–living through the regime. I was very small at that time, but I was about 10, I think, when the regime ended, and my mom decided to go back to Thailand to find her relatives. However, the Thai government refused to let her stay in Thailand even though she was originally from Thailand. Then, we decided to go through refugee camps in Thailand as other survivors. It was a rough journey for a mother of three small kids until we found a sponsor to come here.

Category: Parent-Child Relationships. In addition to the individual consequences of trauma exposures during the civil wars and genocide, Cambodian survivors could not properly perform their roles as parents in refugee camps due to a dysfunctional family system that resulted from the death of important family members during the wars and migration. *Disrupted parenting* and *single-mom households* emerged as the dominant themes in this category.

The theme ***Disrupted parenting*** surfaced in the narratives of most participants. These respondents agreed that Cambodian survivors who lived in refugee camps lacked parenting skills and just focused on making sure their children stayed alive and had food to eat. Participant P10G2 added:

> There was no family life since [the] Pol Pot regime, not to mention about parenting. The family structure was severely damaged. How could survivor parents perform their roles with prolong[ed] life-threatening fear and being in a survival mode that didn't seem to end? Cambodian parenting practices had no chance to progress due to years of civil wars and migration for safety.

The theme ***Single-mom households*** emerged in the responses of participants who experienced life in the refugee camps due to the government targeting men and murdering them during the Khmer Rouge Regime. The death of many men left women in these refugee camps as the sole providers of care for their children. Participant P12G1 shared:

> Many men died during the war, leaving many women surviving as single mothers. There was a lack of [a] father figure in many families. Many kids were raised with the lack of [a] father figure in refugee camps.

Participant P11G2 shared:

> There were so many single moms, and many of them remained single until they arrived in America. These single moms experienced so many adversities in their lives and some were very young to be a parent by themselves. They ignored themselves and made sure their children survived the refugee camps and the new country. They sacrificed their lives for their children.

Category: Context. Cambodian survivors who lived in refugee camps in Thailand dealt with living in extreme poverty and with very limited food supplies while waiting to resettle in the third country. Many of them–including their children–had to risk their lives by selling goods from camp to camp to earn a living. Moreover, family separation continued to occur as the survivors often failed to secure a sponsorship with the same individual or organization. As a result, the majority of survivors had to force themselves to relocate to a third country and separate from their family. Despite this hardship, many of these survivors searched for informal education in the camps–a virtual impossibility. Most participants' comments in this category cited three main themes: *extreme poverty, continuous family separation, and access to education for some*.

The theme ***Extreme poverty*** emerged in the reports of most participants. They remained in agreement that Cambodian survivors continued to live in harsh conditions in refugee camps in Thailand for another decade. Participant P10G2 reported:

> Cambodian survivors had nothing left, but lives. I'm not sure if poverty was the right term to describe that. Our shelter was made of plastic on the rice field. We didn't have enough food every day. Some people–including children–became street vendors as food supplies in the camps were limited.

The theme ***Continuous family separation*** remained present after the wars, and respondents from the Grandparent Generation expressed this sentiment. These participants reported that family separation continued to happen due to the uncertainty regarding their sponsors and the country from which they hailed. Participant P9G1 shared:

> My younger sister and brother were sponsored by different people from two different countries. My sister got a sponsor to America, while my brother got a sponsor to Germany. Then, my mom decided to let them go for their safety and future. After a few years, my mom also got a sponsor to America. I could not go with them yet at that time because I also had my husband and two children, so my small family arrived [in] America later than my sister and mom.

The theme ***Access to education for some*** surfaced in the responses of a few participants categorized as youth who, as a result, studied in refugee camps in Thailand. Participant P1G1 shared:

> I'm from [a] farmer's background. My parents were not educated, but I always wished to go to school. I went to study in refugee camps. They taught us some Khmer reading and writing. They also taught us English. I was the first refugee who got a scholarship to study in Japan. That's why I was the last one in my family who came to America.

Participant P10G2 shared:

> I went to study when we were in refugee camps in Thailand. I studied Khmer until Grade 6. That's why I know how to read and write in Khmer. Then, we got a sponsor to come to America. I first resettled in Minnesota when I was 14.

Researcher's Reflections and Critical Analysis of Domain II

The announcement of the "end of the Killing Fields" falsely suggested the termination of deaths and family separation in Cambodia. Cambodian survivors who lived near the border of Thailand risked their lives to cross the border to enter refugee camps in Thailand because they

did not feel secure in Cambodia. Survivors who resided far from the border, in the case of my parents' families, migrated internally to search for their separated family members. As a result, massive internal migration occurred in Cambodia, especially into the capital city, Phnom Penh. There were many vacant houses without owners due to the emptying of the capital 4 years prior. Survivors resettled in Phnom Penh after the war, occupying empty houses and trying to rebuild some semblance of family. In the provinces closer to the border of Thailand, massive migration to refugee camps took place in 1979 and the 1980s proved as life-threatening as living through the Killing Fields. I remember hearing the narratives articulated by survivors who could not relocate to the refugee camps and, instead, remained in Cambodia. These survivors expressed that people in refugee camps were "lucky" due to their chance to restart their lives in a safer and wealthier country. They did not experience life in the refugee camps. I must admit my own ignorance of the realities of life for Cambodian refugees until I came to the United States and began working with a Cambodian community in 2018.

On an individual level, the survivors endured continued exposure to traumatic events, such as robberies, stepping on landmines planted by the Pol Pot troops during their regime, gunfire, and bombings as they traveled to refugee camps. However, not all Cambodians gained entry to Thailand, as many encountered soldiers at the border who pushed these Cambodians back or shot them because they deemed them illegal migrants. I grew up believing the "fact" that the Thai government and population did not like Cambodians because we are poor and uneducated. The typical Cambodians attempting to enter Thailand were hungry, stole food, and provided cheap labor for jobs at the border and within Thailand. I now understand the vast complexity of the narratives Cambodians experienced and that disparities in power and geopolitical factors exacerbated discrimination and misunderstandings between the Thai and

Cambodian populations. I have come to grasp more deeply why those who entered refugee camps continued to live in harsh conditions with limited resources and food supplies for years before they attained sponsors to resettle in a third country between 1980s and 1990s. This continuous exposure to extremely harsh events increased the psychological trauma and added to the multiple physical health conditions already challenging Cambodian survivors. As a result, many of these individuals died in refugee camps as their bodies could no longer fight against harsh conditions. It saddens me to know that a number of those who had already survived the Killing Fields lost their lives due to a scarcity of basic essentials in refugee camps.

At the family level, all Cambodian survivors lost at least one significant family member as a result of the Killing Fields and migration, requiring a host of adjustments within the family structure. With men and the educated as the targets of the Killing Fields, many families lost their husbands and fathers. In traditional Cambodian culture, women take on the role of homemakers and fail to receive encouragement to pursue an education. These females learn to depend solely on their husbands. With this cultural backdrop, the sudden loss of her husband requires that a woman switch roles and become the sole authority figure for her children. Most importantly, these women carry the weight of the extreme traumatic events they experienced during the war. Their children, raised without a father figure, also lacked the presence of other significant family members in the refugee camps, such as grandparents. These events laid the groundwork for a psychological shock that also ushered in a family role crisis across the country and in resettlement settings. In addition to this context, the refugee camps came with a scarcity of food supplies and other basic resources, negatively contributing to the existing psychological and physical health issues of these survivors. In sum, the refugee camps only added to the array of individual mental health issues and family development problems facing Cambodian survivors.

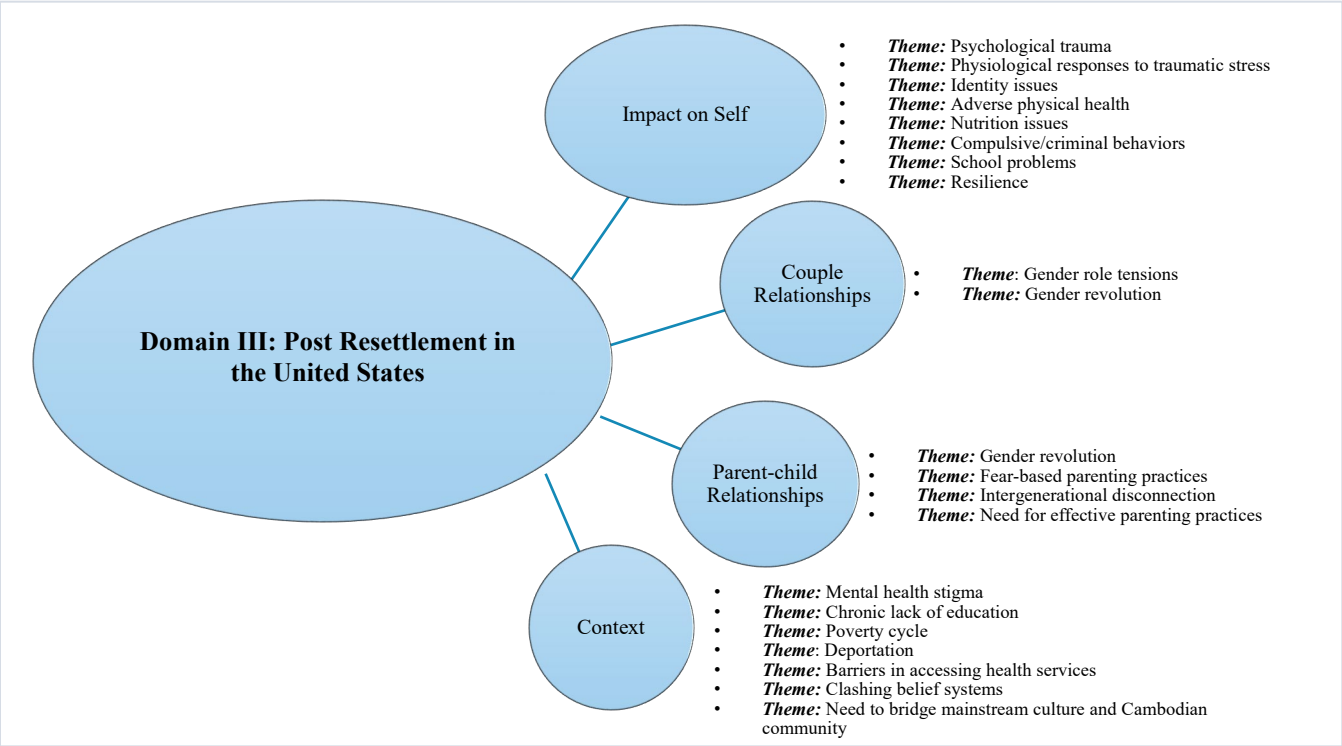
Hearing the narratives that chronicle what took place in the refugee camps pushes me even harder to develop a system of sustainable multi-level interventions to address the profound traumatic stressors that plague Cambodian refugee families.

Domain III: Post Resettlement in the United States

Four waves of Cambodian refugees gained admission to the U.S. between 1975-1994, with the majority receiving access during the 1980s and 1990s. The 1980s and 1990s groups consisted of the third and fourth waves, primarily preliterate farmers and individuals exposed to the horrors of multiple civil wars and genocide-related trauma as well as the difficulties inherent in residing in refugee camps. Screened at initial resettlement, these individuals reported having severe mental health conditions, such as PTSD and anxiety-related disorders, in addition to very poor physical health. Types of assistance for initial resettlement varied according to the states of resettlement. Consistent with Domains I and Domain II, Domain III also features four main categories: Impact on Self, Couple Relationships, Parent-Child Relationships, and Context, along with significant emergent themes for each category. Since Domain III serves as the focus of this dissertation, this section will integrate more detailed descriptions of themes followed by quotations from the respondents. The summary of Domain III: Post Resettlement in the United States is presented in Figure 4.

Figure 4

Domain III: Post Resettlement in The United States



Category: Impact on Self. By the time Cambodian refugees arrived in the United States, they had faced multiple war- and trauma-related stressors, leaving them severely compromised in terms of their mental health and their relational skills. As a result, respondents echoed the presence of a significant number of themes in this category: *psychological trauma, physiological responses, adverse physical health, nutritional issues, compulsive/criminal behaviors, school problems, combined maladaptive and adaptive coping strategies, and resilience*.

The theme ***Psychological trauma*** surfaced in the forms of mental illnesses/conditions among the Grandparent Generation, the Parent Generation, and the Grandchildren Generation. The Grandparent Generation continues to suffer from mental health conditions (i.e., PTSD, untreated trauma, depression, anxiety disorder, anxiety attacks, hallucinations, suicide

ideation/attempts, complicated grief, schizophrenia, acculturation stress, etc.) as a result of living through the war, genocide, refugee camps, and limited support at post-resettlement. Participant P13G2 shared:

> Elder generation[s] still live with unresolved mental illnesses, especially PTSD. They don't always get the support they need because of [a] lack of awareness about mental health and stigma, you know. Most of the time, they seek for physical health treatment and are referred by physicians for psychiatric treatment. Many of them are passing away, too, because they are the group of 70-plus years of age.

Participant P2G1:

> In my organization, we created some events to connect elders in the community. These elders are very hopeless as they could not do anything here by themselves due to language, transportation and cultural barriers. They depend on the young. Some young people, they become individualistic and they focus more on themselves–not the elders in their family.

Participant P15G2:

> I've seen clients in the community who are elders. They were referred for psychiatric service with us, and I also provide home visitation to them as a case manager. Many of them can get triggered easily and worry excessively. They told me they couldn't sleep at night and they couldn't get out of the house by themselves during the day. Most of them live with PTSD and anxiety-related disorders.

On the other hand, the Parent Generation who experienced their childhoods during the war, witnessed the genocide, and resided in the refugee camps presented a combination of behavioral issues, including Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactive Disorder (ADHD), coupled with mental health issues such as anxiety disorders, depression, and adjustment disorders during the early stage of resettlement as reported by some licensed clinicians who were former refugees. Participant P10G2 shared:

> In the 1990s and early 2000s, many youths disappeared from school, sneaked out at night, and had problems with their study. These youth were referred to us, and we diagnosed them with ODD, ADHD, adjustment disorder, anxiety disorder, and depression. After years of experience and observation, I noticed that these youth were from very dysfunctional families where their parents lived with mental illness and disability incomes. There's no doubt that they acted out and had school problems.

Psychological trauma emerged as a recurring problem stated by the Grandparent Generation, along with stressful emotions such as anxiety, anger, hopelessness, helplessness, sadness, shame, excessive worries, and boredom that they mentioned in conjunction with other mental illnesses. Because of intergenerational living and intergenerational effects of mental health, the Parent and Grandchildren Generations also noted that they had experienced similar stressful emotions as those cited by the Grandparent Generation. Participant P1G2 shared:

> I feel so sorry for our elders. They could not do much for themselves due to their mental health and physical health. Most of them are at home and experience extreme boredom, hopelessness, and sadness. You know, in America, when you cannot drive nor speak the language and you are old, there's not much you can do. They just stay home, watch TV, and so on. This makes their overall health even worse. Sometimes, their children and grandchildren don't respect them because the elders depend too much on the young and could not support the young. This leads to anger, resentment, shame and kinds of stressful emotions.

Participant P5G2 shared:

> I think Cambodians are angry people. The most predominant emotions of our population are anger and irritation. When I was younger, I didn't understand why we got angry so easily. After years of study, and I graduated with a Ph.D. of clinical psychology, I understood why our population can get triggered so easily when they encounter stressful situations that they don't have control over. Their anger can lead to violence at home and everyone in their family is affected by that.

Participant P12G1 shared:

> Based on my observations, anger stood out among our people, like teens in the 1990s formed gangs because of anger toward the bullying they experienced at the early resettlement. The gangs were formed to protect their peers from being bullied and anger also happened at home. Parents got angry easily and hit their children and claimed that it's a way to discipline children. Anger also happened in couple relationships and led to violence and divorce.

The theme ***Physiological responses to traumatic stress*** surfaced in the forms of somatic complaints among the Grandparent Generation. Due to stigma surrounding mental illness and the lack of vocabulary in Khmer to describe mental illnesses, these grandparents usually shared their

somatic symptoms (i.e., sleep problems, headache, dizziness, blurry vision, overthinking, chest pain, worrying, etc.) as a method of describing their mental well-being. Participant P10G2 shared:

> Our elders still live with a lot of PTSD, anxiety, and depression, but when they come to see [a] psychiatrist or see me at our place, they only talk about their somatic symptoms. They told me that they think a lot and cannot sleep most nights. They told the psychiatrist that they have chest pain, headache, blurry vision, dizziness, and they ask for medication to get rid of these symptoms. If the psychiatrists or mental health professionals are not trauma-informed and culturally responsive, they just give medications and they are not effective in helping these elders.

Participant P12G1 shared:

> Cambodians always complain about the pain from somewhere they can't spot on. They are not aware much of their mental health issues. For example, they may say, "My heart keeps bumping and it almost jumps out of my chest" or "I don't see things clearly" or "I have a stomachache" or "I cannot breathe well" or "I cannot sleep at night" or "I have a headache" or "I think a lot." These somatic complaints have so much to do with untreated PTSD, anxiety, and depression that they are not aware of or don't want to accept.

Participant P13G2 shared that:

> When working with Cambodians, you will hear a lot of somatic complaints, such as feeling dizzy or headache, having blurry eyes, having a stomachache, racing heart, having nightmares, thinking about families back in Cambodia, and so on. Providers need to know how to use those symptoms in their diagnosis.

The theme ***Identity issues*** surfaced across three generations in the participants' responses related to the beginning stage of these refugees' resettlement and reflected a relationship with the mental health conditions of this population. Those in the Grandparent Generation discussed more experiences with identity issues than individuals in the Parents Generation and the Grandchildren Generation. Specifically, people in the Grandparent Generation were adults during the war and genocide, thus making them the targets of the regime. Those in the Grandparent Generation recounted more exposure to severe trauma than those in the younger generations. Most

participants who reported concerns of identity crisis and untreated mental illnesses affiliated themselves with the Grandparent Generation. Participant P2G1 shared:

> Cambodian culture is very hierarchical. Elders were on top of the society and were respected by the young. Elders were on top of the pyramid when they were in Cambodia; however, their pyramid turned upside down when they arrived in America. Here, children are on top of the hierarchy. [The] elder generation is the lost generation here. With mental illnesses as the consequences of the wars and genocide, they are dependent on the young and they are very hopeless and helpless as well as [finding] themselves useless in America.

Participant P4G2 shared:

> I'm more concern[ed] about the elders. Many of them still live with mental health issues. They expressed that they are too sick to work or function properly in their family. They told me that they feel that they are less than a person in this country and that they are not counted. It's so sad. On the other hand, [the] Parent Generation experienced identity issues differently than [the] Grandparent Generation. Participants who are also from [the] Parent Generation shared [in] their experiences and observations that they experienced confusion with the identity that they could not recall during their childhood. Particularly, these [in the] Parent Generation know that their families escaped from the wars to resettle in the U.S., but they had no ideas why the wars and the Killing Fields happened, as their parents rarely talked about it at home.

Participant P18G2 shared:

> Most parents don't talk about their experience during the genocide and the war in their family. My parents also never talked about that, too. I was born during the genocide, but I was too young to remember anything. I was so confused why that happened. I believed most of my generation had to learn our history from the library by ourselves.

Participant P15G2 shared:

> I always wondered why civil wars and the genocide happened in Cambodia. None of my parents talked about it at home. They just want to forget it. When I was in college, I did my own research in the library because I was confused and could not believe what happened to our people during the genocide. This may be one of the reasons why I graduated [with] a Master of Counseling [in] Psychology.

The theme ***Adverse physical health conditions*** emerged in reference to high blood pressure, diabetes, heart diseases, heart attack, hypertension, stroke, and multiple physical health diagnoses as a common issue among those in the Grandparent Generation. In addition, some

listed kidney failure, which correlated with substance abuse. Some participants even named these physical health conditions as “Cambodian diseases.” These diseases prompted studies by medical and mental health researchers that revealed an association with numerous untreated mental health conditions experienced by this population. No different from the intergenerational effects of mental health, the intergenerational effects of these physical ailments also surfaced in the reporting shared by the Parent Generation. This theme did not play a role in the responses from those in the Grandchildren Generation, possibly due to the fact that at their age, they have experienced few if any physical maladies. Participant P2G1 shared:

> Diabetes type II, high blood pressure, hypertension, [and] stroke are all Cambodian diseases [Laughs]. These definitely link to their untreated mental health and knowledge about nutrition. You can read some research conducted among them at the initial resettlement. They arrived here with very poor physical health and mental health conditions, then they just continued to live like that on their own.

Participant P3G2 shared:

> Our population, especially our elders, are not quite healthy. Many of them still lived with the residual effects of severe physical depletion during the wartime. Like, in my family, my dad recently passed away due to a heart attack, and he lived all his life with high blood pressure and diabetes. My mom is not quite well, too, but she just tries to survive for the children and grandchildren.

The theme ***Nutritional issues*** emerged on a regular basis in the responses of those in the Grandparent Generation, potentially a testament to the fact that they do not know what it means to eat healthily. Among the respondents in the Grandparent Generation, eating the food of their culture equates to eating healthy, yet that is not the case according to nutritional standards. Participant P3G2 shared:

> When I conducted a training related to nutrition with our elders, I did an initial check to see how much they know about healthy eating. They shared with me confidently that they eat healthily. When I asked what they eat, they said they eat rice and dried fish [Laughs]. That’s their definition of healthy eating. I think we need more force to bring more awareness about nutrition and healthy eating among our elders and their families.

Participant P8G2 shared:

> Education on nutrition is a part of our health promotion program. Our community health workers always try to educate our population about nutritional food that their bodies at their ages need during the home visitation. Sometimes, they also host a group meeting in the community to talk about nutrition and health. We still need a lot of education on nutrition, especially for our elders and parents. There's still limitation[s] to our work due to [a] shortage of funding and workforce.

Participant P17G1 shared:

> Some parents don't have time to cook fresh food for their children because they work most of the time. They learned from Americans. They bought and stored, you know, a lot of frozen foods, chips, canned foods, Coke and those soft drinks at home. Their kids eat those food[s] when their parents are not at home. Yeah, they also don't usually have meal[s] together as a family, too, because of their work schedules.

The theme ***Compulsive/criminal behaviors*** emerged primarily in the responses of those in the Parent Generation in reference to the time of their adolescence in the 1990s and early 2000s. These compulsive behaviors included aggressiveness, hypervigilance, sneaking out at night, running away, excessive drinking, substance abuse, and teen pregnancy in this age group. Additionally, individuals cited criminal behaviors such as shoplifting, stealing, drug dealing, gang violence, criminal delinquency, and repeated offenses. The respondents stated that they navigated life in the U.S. in the 1990s and 2000s alone as youths as a result of the dysfunction of their families and the lack of support they received at school and from local authorities. In the end, the participants stated that many youth ended up in correctional facilities and spent most of their life in jail. Participant P12G1 shared:

> At the initial resettlement, children aged 11-13 were bullied on the way to school and at school because of their language, skin color, and names. Their parents could not help them. In contrast, their parents expected them to support them. Those children were helpless and confused. They didn't have mentors at school nor support at home. Many of them dropped out of school, ran away from home, joined gangs, and were involved in so many antisocial activities because of a lack of guidance and support at home and in society.

Participant P13G2 shared:

> Peer pressure and lack of support in the home and [from] local authorities forced youth to join gangs, do drugs, commit crimes, [get] put in jail, and get deported. Those young people have the need to belong, and sometimes they have to force themselves to join a group for their safety. There are Blue and Red Khmer gangs. When you join one group, you are forced to bully or kill another group.

Participant P14E shared:

> As I know, Cambodian refugee teens of the 1980s and 1990s are in their 40s or 50s now. At the early stage of resettlement, because of [a] lack of support at home, school, and in the community, these teens were vulnerable to dropping out, joining gangs, abusing substances, and other criminal activities. They were caught and put in jail and served their [time].

The theme ***School problems*** inevitably emerged in the responses of those who went through childhood and adolescence during the 1990s and early 2000s. Due to dysfunctional home situations where parents could not serve as a source of support as a result of mental health conditions and acculturation stress, their children's school problems proved predictable and unavoidable. Note that the parents of these youth were preliterate farmers who never attended school or knew English, so they did not possess the ability to help their children with schoolwork. With limited support and a lack of trauma-informed care in the school systems these refugee youth attended, many of these adolescents dropped out or got expelled due to an inability to stay caught up in school or for amassing an inordinate amount of tardies. Participant P17G1 shared:

> I feel so sorry for those kids of the '80s and '90s. They were put into school according to their ages. They didn't know English at all. They were bullied because of their language. Coming back home, parents were not there. Both parents went to work most of the time, struggled with their adjustment, too, and could not help the kids with schoolwork. Some kids went to school with no spirit in their body and looked sleepy most of the time. I was the one whom the teachers called when our Cambodian kids had school-related problems. I always had to explain [to] those teachers about those kids' home[s] and parents. They just didn't understand why the parents didn't care.

P13G2 shared:

> Parents always expect children to come home after school. They don't understand that their children need to do extracurricular activities or do more research in the library. Imagine coming home from school and your parents blame you for wasting time at school, doing nothing at school every day and for not helping the family. Parents just know that they value education for their children, but they don't understand the time investment during the process of learning. A part of it may be because many parents never went to school themselves. It's really hard to blame the parents, but you see the struggles, right?

The theme ***Combined maladaptive and adaptive coping strategies*** surfaced in participants' responses in two categories: maladaptive coping and adaptive coping strategies. Maladaptive coping strategies entailed gambling, excessive drinking, and drug abuse in the Grandparent and Parent Generations. Some individuals in the Grandchildren Generation also mentioned drinking and drug abuse. Participant P16E shared:

> I have known many Cambodian families; as you know, my wife is a former Cambodian refugee, too. I noticed that mostly Cambodian men drink at least three times per week with the same peers. They drink the most expensive liquor, and they drink until they pass out. None of them think that this is addiction. They consider it as a lifestyle and it's normal for them. There were recent cases that they just dropped dead because of overusing alcohol when they also have [other] health condition[s].

Participant P13G2 shared:

> Marijuana, meth, and opium are used in some people's daily life; not many people documented this. If you visit some Cambodian families, you'll notice in their backyard some marijuana and opium plants. Some people have the license to grow some plants due to their physical health pain; however, some people grow more than they are allowed to for business. Sometimes, they put marijuana in their soup or food and they say that it makes their food tastier–no wonder they hear voice[s] and [have] hallucinations sometimes.

Participant P15G2 shared:

> Gambling, drinking, substance use/abuse, and homelessness are very common in [the] Cambodian community. Elders use gambling and drinking to cope when their mental health is triggered. The younger generation drink, use/abuse substances when they are stressed. Those who are homeless are usually overdosed with substances, live with mental health issues, and are in their 20s or 30s.

On the other hand, many in the Grandparent and Parent Generations also employ adaptive coping strategies including participating in community gardening, volunteering at Buddhist temples, joining meditation groups as well as dancing groups or exercise groups, and cooking with other community members. Participant P2G1 shared:

> We organized dancing groups in our organization. We have about 30-40 elders who come for the dancing on a daily basis. We play Khmer music for them to dance. It's just [a] way for them to get out of their home and connect with people their age. Some of our staff volunteer to pick them up, and some of them are brought here by their family members.

Participant P18G2 shared:

> In our organization, we created community gardening and exercise groups for our elders. We give them taxi vouchers to come to join the activity. They really enjoy coming together and do[ing] the gardening and exercising together. We believe that these groups really help our elders.

Participant P6G2 shared:

> The older generation relies much on their spirituality. Temple becomes their spiritual home. They go to the temple very often to connect and practice meditation. My parents also go there and shared with me that meditation with their groups help[s] them a lot. I hope that there are sustaining meditation groups to support our elders.

The theme ***Resilience*** surfaced on a regular basis despite all the adversity that this population has experienced. Most participants reported three types of resilience: *resilience of Khmer youth, family resilience, and community resilience.* Most participants cited the resilience of Khmer youth even though many of them hailed from dysfunctional families whose parents did not possess the ability to help them. Participant P8G2 shared:

> Many youths of the 1990s were from very dysfunctional families. However, some of them are like lotus [that] comes out of the mud. They graduated from college with very limited support and became successful in their career.

Participant P6G2 shared:

> Despite everything, there's a strong desire to survive and succeed. They're a younger generation that came out great despite not enough support from parents. It's very impressive to witness.

Participant P10G2 shared:

> These youth, especially the firstborn child, had to reverse their role at home to keep their family function[ing]. The firstborn usually became the parent of the younger siblings and their own parents when their parents lived with disability funding. A few of them are very resilient. They graduated from college and became high[ly] skill[ed] professionals.

Participant P15G2 shared:

> I'm the youth of early 1990. I arrived in America when I was 14. My father was alcoholic and was very aggressive toward my mother. There were a lot of issue[s] at home, but I tried to focus on my study[ing]. There's not much I could do, so I channeled my energy toward study[ing]. I successfully graduated from a Master's in Human Services with [an] emphasis in Counseling Psychology. Now I am advocating for youth to go to college, get [a] degree, and break the cycle of poverty in their family.

The second type of resilience that most participants reported is community resilience. Most participants agreed that Cambodian communities in the U.S. exhibit a sense of resilience reflected in their use of Buddhist temples as community centers and teaching venues across the U.S. Cambodians come together during cultural events to celebrate and share food with each other. They also share with each other their achievements as well as the problems they experience in their families when they meet at the temple. Cambodians use the temples to connect with other Khmer people, culture, history and, significantly, their home that is an ocean away. Moreover, they also use the temple to reconcile the grief and loss of their important family members. Most importantly, the majority of these cultural classes such as Khmer language classes and dancing classes take place at Buddhist temples. These resources vary across locations based on the availability of local resources. Participant P11G2 shared:

> Temple is the center where Cambodian families come together to celebrate traditional ceremonies and share about what happen[s] in their families. You get to hear all types of

> problems at the temples. For example, grandparents come to complain about their children and grandchildren. Parents come to complain about their struggle in parenting. People are very receptive to learning at the temples.

Participant P12G1 shared:

> Temples are where people come to connect and share about what's going on with them. Our elders seek spiritual help from Buddhist monks. Sometimes, I got the monks [to] refer clients to me. To me, temples are very important places for Cambodian refugees. They are healing places where people connect to their culture, people, and food.

The third type of resilience reported is family resilience which does not exist in every family, but does exist in some. Family resilience occurs based on the degree of loss, trauma exposure, mental and physical health conditions of the family members–especially parents, and the level of support for local resettlement. Some participants reported that their parents' education level and their modeling in navigating acculturation stress falls into the category of family resilience. Participant P9G1 shared:

> Both my parents were educated. They told me to pursue my studies and learn to be independent even though I'm a woman. They are my role models. Both my parents worked before the genocide. My dad was a professor, and my mom worked in the rural development ministry.

Participant P12G1 shared:

> I was 24 and married with two small children when I resettled [in] America. My parents were educated and lived in Phnom Penh. I graduated high school and went to midwife school prior to [the] Khmer Rouge regime. I volunteered as a midwife in refugee camps, too. Soon after I arrived in America, I went to study English for the first time, but I picked it up quickly because I know French. Then, I went to college to get a bachelor's degree in human services. It was a very difficult journey as a newly resettled refugee to navigate the education system in America.

Category: Couple Relationships. Cambodian traditional couple relationships dramatically shifted when these refugee couples arrived in the U.S. Back in Cambodia prior to and during the genocide regime, couple relationships centered on patriarchy or male-dominant rules. In the family, men shouldered the responsibility for earning an income by working outside

of the home while women mastered the tasks related to homemaking and working inside the home. In short, men served as the head of the family and made all of the household's important decisions. In contrast, the traditional rules do not apply in the U.S. Thus, men experienced a crisis in terms of their role in the family due to the fact that women could work inside and outside of the home. Some men found it difficult to accept that they now had to perform jobs in the household previously assigned to women. In regard to relationships, most participants reported two main themes: gender role tensions and gender revolution.

The theme ***Gender role tensions*** emerged in the responses of most participants identifying with the Grandparent and Parent Generation. This gender role tension stemmed from three main causes. First, men experienced a male role crisis. Traditionally, these men–raised to function as providers for the family–arrived in the U.S. and experienced acculturation and resettlement stress. In addition to that, they carried the lingering effects of a range of traumatic events experienced during the wars and genocide. Due to the fact that more men died during the wars, data showed that more women resettled in the U.S. Participant P12G1 shared:

> You know what? There were more Cambodian women than men who resettled in the U.S. There were so many single mothers with their kids. This was because many men were killed and executed during the wars and genocide. When they arrived here, both men and women had to work outside the house to pay the bills. Thus, they experience[d] the dramatic change of traditional gender roles, but many men could not accept it at first.

Secondly, many women assumed men's roles as they worked outside the home and earned an income for the family. For the first time, women realized that they needed the men to help them with the housework since they also spent the majority of their time working outside the home. Some men received disability incomes and stayed at home, but still refused to help with housework. Participant P8G2 shared:

> I was fortunate to be able to work remotely since [the] early 2000s. Most of my work has been usually done by phone and virtually. I conducted research on barriers to accessing

> health and health promotions among Cambodian[s] in the U.S. We have collaborators across the country. My point is that my wife works outside while I work from home. At the early stage of our resettlement, my wife asked me to help with cooking and cleaning because I worked from home. There's a lot of tension between us, and it took me years to accept that because I didn't want my wife to get angry when she came home from work.

Thirdly, communication issues developed between men and women in their Couple Relationships because men refused to accept the shift in gender roles in the U.S. due to how they forged their perspective in a different context. As a result, some of the men opted for avoidance while others utilized passive-aggressive communication. Most noticeably, some men became very aggressive in the communication methods they used with their partner. Participant P3G2 shared:

> I was born seeing my parents very disconnected as a couple even though they lived in the same house. My parents stayed in a separate room; they just cut off from each other. They were together because they had no choice and wanted us, the children, to have a complete family.

Participant P2G1 shared:

> I worked with so many Cambodian couples throughout the years. They usually came to me when they had conflict. Some men had affairs outside the house here in the U.S. Some went to Cambodia and got married to a younger wife. When their wives created a condition that they cannot have an affair in their marriage, they don't follow and they still stay in their marriage and want to [get] revenge [on] their wives. It could be a hateful revenge. It's very complicated with older couples. Younger couples won't stand that. They just get [a] divorce because they know their rights.

These gender role tensions also led to other consequences in Couple Relationships. First, infidelity occurred because men deemed themselves useless in their family, but helpful in another family. This also led to many men returning to Cambodia and marrying a younger wife. Participant P13G2 shared:

> I worked with some older couples. They don't usually seek for couple[s] therapy, but because I provide individual therapy to the wife, I suggested that they also need couple[s] therapy. This is how I offer couple[s] therapy to some couples. Among these couples, their relationships are very toxic. [The] husband went to Cambodia and got married to a young wife. Another husband has [an] affair wherever he goes. The wife cried and

> wanted to commit suicide. Because they are old and they believe in traditional marriage, divorce is not an option for them.

Secondly, domestic violence also happened because anger and aggression took over when men could not reconcile with their male role crisis in conjunction with their cumulative mental health issues. Domestic violence occurred on a regular basis at the beginning stage of resettlement, according to participants who worked as domestic violence case managers. Participant P9G1 shared:

> I was a domestic violence case manager for about 10 years in [the] early 2000s. Domestic violence was severe during those years. I had a case where a husband hit the wife on the head with a pestle, attempting to murder her. Her skull was severely crushed. That happened in front of a 5-year-old child who cried and ran outside to ask for help from the neighbors. The child was removed, the father was arrested, and the mother was sent to the hospital. That's so sad.

Thirdly, divorce became an option when women no longer had to depend on men financially and the absence of happiness in their relationship. Many women, especially those younger ones, filed for divorce and entered into intercultural marriages. Typically, older women chose to remain in their marriage despite their discontent with their spouse. Participant P1G2 shared:

> Younger couples tend to get [a] divorce when they were not happy in their marriage. Cambodian men did not treat women with respect. In America, they could not practice the same rules. When women worked outside and American men treated them with more care and respect, guess what happened [Laughs]? They got divorced, and they got in [a] relationship or remarried with American men. In contrast, older couples tend to stay together even though they are not happy together.

The theme ***Gender revolution*** emerged in the reports of participants who worked as case managers and community experts, specifically from the beginning of the Cambodian refugee resettlement. These participants stated that many women started to know their rights after moving to the U.S. These women worked outside the home and also interacted socially with colleagues after work. When at home, they asked their husbands to share household

responsibilities. Some men balked at accepting this change which caused stress on the couple's functional relationship. On the other hand, some men refused to accept this necessary change in order to maintain a healthy couple relationship; this decision often led to infidelity, domestic violence, and divorce. Participant P11G2 shared:

> Some men cannot accept that women are more capable and competent in term[s] of earning the income and raising children. There's a lot of conflict in the relationship. Even though domestic violence was kept silent, it existed. A lot of divorces happened. After divorce, many men return[ed] to Cambodia to remarry and to continue their traditional patriarchy role, while many women got into [an] intercultural marriage. Cambodian couple relationship[s] and marriage [has] become more diverse now.

Category: Parent-Child Relationships. After resettlement in the U.S., Cambodian refugee parents functioned in survival mode as they attempted to build their family from scratch. In addition to that, they experienced extreme acculturation stress due to language, transportation, and cultural barriers. Most importantly, many of them battled severe mental health and physical health issues and ended up relying on disability incomes to live. Many of these individuals could not perform their parental roles in the U.S. due to their struggles with their health and identity, coupled with their relocation to a new country where they had limited education, resources and support. These factors set the stage for four themes: *gender revolution, harsh parenting practices, intergenerational disconnection, and a need for effective parenting practices.*

The theme ***Gender revolution*** also surfaced in parent-child relationships–particularly in father-daughter relationships, according to most participants. Traditional gender rules that stemmed from a patriarchal culture failed to apply to the process of raising children in the U.S. At the early stage of resettlement, many parents struggled with this reality and became very angry when their children did not follow their rules. According to the participants, some common gender-related rules materialized in parenting practices, for example: "Be home before sunset!" and "Daughters should not be outside at night!" Upon disobeying the rule, daughters received

more criticism than the sons, especially by the father. To break the patriarchy rule and claim their rights, many daughters moved out of the house, entered an intercultural marriage or joined the army in the early stage of the resettlement. Participant P12G1 shared:

> I saw a family in which the daughter asked to work nightshift while she went to college. The parents were on disability incomes, and the daughter had to work to support herself when she went to college. The parents did not allow the daughter to work because they were worried about her safety. It took me months [to] explain and reassure them that the daughter had to work and that she was not in danger. In another family, the father kept criticizing his daughter for going out in the evening with her friends until the daughter decided to move out of the house. Another daughter joined the Army, and her father criticized that his daughter went there because there were a lot of men there. Even in my family, my mother did not allow my daughter to go to her high school evening dance because she believed that it's not what the girls should do. I had to explain [to] my mom and let my daughter go.

Participant P10G2 shared:

> "Be home before sunset!" is a rule I observed in many families I worked with. Sometimes, children asked, "Why is [this] the rule?" and parents could not explain it. I ran many parents' groups, too, over the years, so I had a chance to explore the meaning of the rule with the parents. Many of them just used the rule without knowing the meaning. This rule was created during the wars. As you know, Cambodia went through many wars in the past. It was not safe to be outside the home at night. Thus, parents created the rule to make sure their children were safe and inside at night. However, the rule does not work in the U.S. as the context here is very different. These parents did not have time to reflect on the changes as they were so trapped in fear and survival mode.

The theme ***Fear-based parenting practices*** became common in Cambodian households mostly out of fear and parents operating in survival mode. Because of the mental health and socioeconomic status of the parents, many of them did not understand how to parent with love. Parents often got triggered when they did not see their children at home after school and in the evening. In this state of frustration and stress, they responded with verbal and behavioral aggression toward their children. At the early stage of resettlement, parents all too often beat their children when they got angry. As they learned about child protection laws and other consequences in the U.S., they opted for verbal aggression as a method of disciplining their

children. Beating children out of anger was a very common parenting tool that saw continued use in the latter years of resettlement in some families–an issue they typically failed to discuss. Participant P10G2 shared:

> I shared this out of my experience working and being a part of the community since the beginning. Yes, they beat their children when they got frustrated–and they got frustrated easily. We studied the effect of trauma exposures, and you may know why they got triggered easily. They beat their children with whatever they could grab at the moment. It could be the belt, barbecue tong, broom, etc. They just did not know how to communicate their fear and concern of safety to their children.

Participant P17G1 shared:

> Yeah, they beat their children when they got angry. I believe that beating children was still there, but not severe and too much, as at the beginning of resettlement. Some children were removed from the family because their teachers reported the marks and bruises on the children's body. Sometimes, children were found locked outside the house at night. I worked with the school for some time, and these were the cases they usually asked me to translate.

The meaning of parenting among these refugee parents correlated with having food on the table, children attending school, and children staying at home after school. Parents who had jobs worked double shifts to make sure that food was on the table for their children, while parents who lived on disability incomes got food stamps to help meet their children's needs. This interpretation left no room for reflection or revision due to the lingering effects of wars, displacement, and living in perpetual survival mode. To achieve success in school, a career, and life in the U.S., refugee children required more than food and housing from their parents. These children needed guidance and role models in regard to how to live, approach the rigors of school, and pursue a career–all necessities that their parents did not have the ability to offer. Participant P4G2 shared:

> They didn't spend time with their children. They worked outside most of the time. They didn't eat meal[s] together, too. There's no parent-child time at all. They also didn't understand that children had to be at school for some extracurricular activities. They just wanted their children to [be] home after school. When children came home, they had

> nowhere to go beside[s] watching TV in the living room. Some families shared a bedroom and common space, and there's no privacy at all.

Participant P2G1 shared:

> These parents could not help their children with homework. When school sent a report or letter to parents, they didn't know and didn't check, too. You know, they know just conversational English and they never went to school themselves. We had two volunteers in our organization who supported those children with homework. There's a limit of our support, too, because there were more kids that couldn't have access to us, and we are just a nonprofit organization.

The barriers to effective parenting cited in this research include low educational level, socioeconomic status, mental health status, and quality of the relationship of the parents. These refugee parents experienced all these barriers which contributed to ineffective parenting implemented in another culture. These parents struggled in all aspects of their life in a new country with very limited culturally responsive support available to them since the initial resettlement. Moreover, they failed to receive enough individual and family level support from local authorities since their initial resettlement. Therefore, Cambodian parenting had a limited chance for improvement without professional assistance (i.e., parenting-focused programs or groups) from the appropriate agencies and professionals in the community. Participant P12G1 shared:

> The most important factor that contributes to success or failure of refugee children in their development is their parents. According to my observation, about half of the children made it, while half did not make it with the adjustment. Those who made it have parents who had some education and could pick up English and employment skills quickly. In contrast, those children who could not make it have parents who were on disability–either mentally or physically or both–and had no education. If parents received enough support at the initial resettlement, children and the whole family would have benefited from it, too. The support to parents, level of education of parents, and mental health status of parents at initial resettlement defined how well the families functioned.

The Grandparent and Parent Generations also cited incidents of parent-child relationship breakups due to the barriers erected from ineffective parenting. Some children decided to move

out and others completely severed ties with their parents due to their inability to carry out parental responsibilities, deemed as second-level family separation. Participant P11G2 shared:

> Cambodian refugees experienced losses and family separation, so their wish is always about family reunion. However, a lot of children decided to leave home because there are a lot of unresolved problems in terms of mental health and family relationships. Children said that they must leave home for their mental health. This added to another layer of pain and heartbreak for refugee parents who have already suffered from a lot of pain and separations.

Participant P15G2 shared:

> I happened to have a few cases at [a] nursing home. There's an uncle who live[s] there alone with multiple physical and mental health conditions. I asked him about his family, and he told me that he has three adult sons. They just moved out after graduation from college for their work in different states. They never contacted him nor visited him and he also didn't know where they are now. It's very sad to hear.

The theme ***Intergenerational disconnection*** surfaced in the reports of participants from the Parent Generation. Individuals in this group cited three main communication barriers– language, culture, and intergenerational interests–that they observed in community members. Respondents in the Grandparent Generation primarily speak Khmer, while those in the Parent Generation typically speak English and some Khmer. However, those in the Grandchildren Generation cannot speak Khmer and expressed that they could not relate to what happened to their grandparents and parents during the wars in Cambodia and migration. Participant P13G2 shared:

> I believe that grandparent[s] and grandchildren don't understand each other much. I observed it in my session that they speak two different languages to each other. When they weren't clear if they understood the message, they didn't clarify; they just leave it there.

Participant P11G2 shared:

> I notice that in our community, grandparent[s] and grandchildren cannot relate to one another anymore. Grandparent[s]' heart is in Cambodia and with Cambodian culture while grandchildren are more Americanized and cannot relate to Cambodian culture. Grandparent[s] speak only Khmer and grandchildren speak only English. The two

> generations have become very distant now and I'm worried about the disconnection. Of course, grandparent[s] did involve in raising grandchildren when they were little, but as they have grown up, they become disconnected with the grandparent[s].

Secondly, these three generations seem to have different cultures where those in the Grandparent Generation follow Cambodian culture and individuals affiliated with the Grandchildren Generation follow American culture. Only those respondents in the Parent Generation understand the need to follow both cultures. Thirdly, the three generations voiced different intergenerational interests. For example, grandparents articulated an interest in their home country and mentioned the importance of sending resources back to their home country. Parents stated an interest in helping to ensure that their children achieve success in American culture, and grandchildren cited the importance of embracing individualism and living an independent life. Participant P11G2 shared:

> Grandparents focus more on Cambodian culture as their heart is in Cambodia. Parents focus more on raising their children by integrating both cultures and making sure that their children survive in American culture, but also don't lose their identity as Cambodian. That's still a struggle for the parents. [Those in the] Children Generation become more individualistic because that is what they learn at school. Children ask for more privacy and independence. The interdependence of collectivistic culture is not present much in [the] Children Generation.

The theme ***Need for effective parenting practices*** emerged in the responses of most participants. According to these individuals, due to changes and shifts in timing, the expressed current needs of parents included effective parenting skills for traditional and nontraditional families and sustainable parent support groups in the American context. The need exists for effective parenting skills among current parents who experienced their childhood during the wars, in addition to living in refugee camps and at initial resettlement. Unlike their parents, many of these Cambodians live in non-traditional forms of families, such as intercultural marriage. These respondents stated a need for trauma-informed parenting skills, culturally responsive

parenting skills, information regarding parenting different age groups, and effective intercultural parenting skills in the American context. Participant P11G2 shared:

> I'm in an intercultural marriage. My husband is White, and we have teenager daughter. Our parenting goal is to make sure that our daughter is successful in [the] American context. To be honest, I'm very concerned about the loss of Khmerness in my daughter. I notice that she is more interested in being American than being Khmer, while she is also aware that she is raised by a Khmer mother. There are many parents my age who are in [an] intercultural marriage and face similar concern[s] like me.

Participant P6G2 shared:

> I am the second-generation Cambodian refugee. I was born in a refugee camp, Khao Dang, in Thailand. I got married to a White American with a college-age daughter. I myself don't speak much Khmer, but I feel a deep connection to Khmer culture. I try to speak Khmer whenever I see Khmer people, but it's not understandable most of the time [sobs]; I'm worried that we lost this language and culture. I'm worried that my daughter['s] generation cannot connect to this culture and language anymore.

The need for sustainable parent support groups emerged as parents shared their concerns related to their parenting and their children's development during cultural events held at the temple. Following the events, the parents exit without finding any proper solutions or professional interventions. Formal parent support groups do not exist for these parents in their community. Participant P11G2 shared:

> I noticed that there are no formal parent support groups in our community. As I observe[d] during important cultural events at the temple and other informal social gatherings, parents shared the problems in their families–especially related to their children and their school performance. I can see that they do need a sustainable formal support group with the presence of a professional. Otherwise, there is no use for them [to] just talk about the same problems repeatedly.

Category: Context. In this category, eight themes emerged in the participants' responses: *mental health stigma, chronic lack of education, poverty cycle, deportation, lack of supportive services, culturally tailored support services, clashing belief systems, and the need to bridge mainstream culture and Cambodian communities*.

The theme ***Mental health stigma*** remains a major issue among Cambodian families, according to most participants, which they summed up as a lack of awareness, understanding, and vocabulary related to mental illnesses and emotional expressions. With depression or anxiety symptoms present in the family, these symptoms often received the labels of being lazy or being impulsive. Moreover, when a family member receives a diagnosis of mental illness, that individual tends to seek support in silence without letting neighbors know. Some family members ignore their mental health condition until it moves to crisis stage before they seek support. As a result, the initial contact for mental health assistance primarily occurs in emergency rooms, police stations, and jails. Participant P16E shared:

> There's still [a] stigma of mental health among [the] Cambodian community. You may notice the first encounter when they seek for support is in the emergency room or police station or in jails. They leave their problems there until they become very severe before they seek for help.

Participant P11G2 shared:

> The stigma of mental health among our community is still very strong. It is usually a crisis case when they seek for help, and when they need to seek for help, they will seek it in silence. They try to make sure that their neighbors don't know about it.

The theme ***Chronic lack of education*** surfaced in the reports of Cambodian refugee families due to barriers at multiple levels. At the community level, this population failed to receive culturally responsive support from local educational institutions. Schools did not provide support to Cambodian refugee children/youth who lacked awareness of their migration history, their parents' level of education, and their cultural background. On top of this, some key informants reported that about a decade ago the school system approved a budget cut for a program that supported Cambodian students and their families. Participant P10G2 shared:

> In the 1990s and early 2000s, when Cambodian children or youth had school-related problems, schools referred them to my organization. Mostly, those kids were suspected as being tardy. Then, we went to school, talked to school counselors, examined students'

> records, [and] did psychological assessment. What we found was that those kids mostly came from very dysfunctional families, so working with those kids alone was not enough. At that time, once we opened a case for a student, we could open cases for other members of the family. Now, we could not do that anymore because of the budget cut and insurance policy. We are not able to help Cambodian kids and youth like before.

At the family level, those in the Grandparent Generation who resettled in the U.S. are preliterate farmers living with disability incomes. This made it more difficult for parents who were children and youths during the initial resettlement to achieve success in their educational journey, especially without the support of their parents and professionals in the school system. As a result, many dropped out and ended up in correctional facilities due to their criminal records and active participation in gang violence. Participant P2G1 shared:

> You may already know that most parents [raised during] those time[s] were from farmer background[s]. They never went to school themselves; they don't even read or write in their own language. How could they help their children when they need support at school? When the teachers sent school reports to the parents, parents didn't know what it meant, so they just ignored it. Schools also didn't make more effort to understand these parents. You see why it was hard for those kids to be successful in school?

On an individual level, the data showed that those in the Grandparent Generation possessed little to no education; the Parent Generation acquired some education with many dropouts; and those in the Grandchildren Generation fared far better in terms of education. However, many participants agreed that even with an increase in the number of Cambodians acquiring an education, the rate remains very low compared to that of other Southeast Asian refugee families since not many in the Grandchildren Generation pursue college or graduate school. Participant P11G2 shared:

> I would say that there's an improvement in terms of education among our community. I can see that more and more [in the] Grandchildren Generation graduate from high school, some move on to college and not many to graduate school. Comparing to other Southeast Asian populations, especially Vietnamese, our education rate is still very low.

The theme ***Poverty cycle*** still serves as a major concern for many Cambodian refugee families in the U.S. Two main factors–parent's factor and social factor–contribute to this poverty cycle. First, the parent's factor consists of the individual's education, mental health, and employment and social skills. A lack of education, employment skills, and social skills contributed to acculturation stress and the extreme poverty prevalent among members of the Grandparent Generation at their initial resettlement. They also experienced financial hardship, amassed debts and worked double shifts in assembly jobs–all while failing to designate any time for their family and children. Most importantly, they lived with untreated mental health and physical health conditions. All of these contributing factors made it difficult for them to break the cycle of poverty in their families. Participant P17G1 shared:

> All of us resettled here very poor. I arrived here since 1975 with other former military families, but I had only one [piece of] luggage and my two small children. I had to start working immediately to pay the bills. Many of those who came in the 1980s and 1990s had severe mental health and physical health illnesses, so they were qualified for disability supports. Their families were very dysfunctional as adults could not help [their] children.

Participant P2G1 shared:

> A lot of our parents work double shifts and they rarely spend time with their children. Even though they work so hard, many of them are still in debt and still live in public housing. I don't support living in public housing since they are trapped living in poor living condition[s]. I think some people make the wrong investment, too, as they don't prioritize the quality of their life and their children here, but they invest in buying property in Cambodia.

Participant P8G2 shared:

> Many second-generation Cambodian refugees still live in surviving mode. They work double shifts, about 70 hours a week, to earn a living. They focus more on earning income even though they earn a little more than in the past. The downside is that they don't have time to spend with their children. When the children come home from school, they don't usually see their parents there. Children need that sense of belonging and love from their parents, but they cannot find it at home. So, they go to find it from their friends which can be dangerous when they don't have good friends. I believe that the youngest generation are still affected by poverty.

Secondly, the social factor stems from the U.S. government neglecting to support this population at the start of resettlement, in conjunction with a failure to address their unique barriers of adjustment and acculturation. The U.S. authorities did not provide adequate assistance to these individuals from the time the resettlement process began. Some participants stated that the U.S. government did help them obtain housing, initial entry-level jobs, and some basic necessities, such as food stamps and household supplies. However, they added that the U.S. ignored their issues related to mental health, physical health, family separation, losses resulting from exposure to civil wars, genocide, and the lingering effects of living in refugee camps for more than a decade. Participant P17G1 shared:

> I agreed that Cambodian refugees were helped at the initial resettlement with the basic needs [for] living, food stamps and housing supplies. Children were helped to register in school, and parents who could work were helped with the job training and finding entry-level job[s], like cleaning dishes in a restaurant, cleaning bathrooms, and assembly jobs. However, these people experienced extreme losses and trauma during the genocide which were completely ignored. The grief and pain got stuck in their body and brain, and they didn't [have] time and support to process that. They just kept working and working until now.

Participant P1G2 shared:

> I don't think issues that our population experienced got resolved by themselves. There's not been any interventions, especially prevention interventions from the local government. If you look at the current problems, like substance abuse, especially excessive drinking and gambling among our elders and their children, too, who are parents now, for some reasons, these are helpful for them to deal with their stress level. It's better than killing themselves, right [Laughs]?

The theme ***Deportation*** remains a pressing concern among the population, especially those in the Parent Generation who were children or youth at the time of their initial resettlement. According to all participants, these children/youth of the 1980s and 1990s experienced many problems related to education, family, status of citizenship, mental health, and peer pressure. Without the support from parents, schools, and local governments at the initial

resettlement, many of these individuals struggled to navigate life which resulted in them dropping out of school, joining gangs, spending most of their lives in correction facilities, and ending up on deportation lists. Participant P12G1 shared:

> Back in the ’80s and ’90s, when the refugees newly arrived, they placed children into school based on their ages. Regardless of their language barrier, they just put them with other local children their ages. Those children got picked on, jumped at, beat up, and bullied on the way to school and at school. They were called stupid because they didn’t speak the language, so they had to group up. They learned from other gangster groups who came ahead of them, like Hispanic gangsters. They kept recruiting people and promised them that they would be protected when they got bullied. The intention was to protect each other. However, they also committed crimes because they had to, then they ended up in jail. Some of them tried to finish high school in jail. Some of them left the jail and tried to make a living, but still many of them were deported back to Cambodia. That’s so sad.

Participant P13G2 shared:

> Most of those who were deported were teens in the ’80s or ’90s. They lacked guidance at home and support from local authorities. They were minors and ended up committing minor to major crimes. It’s not fair to blame them because they were very young without receiving proper support. They already served the terms and still ended up being deported. They were deported to die in Cambodia because they don’t know the language nor have relatives there. That’s why I always try to join the force advocating for these people.

Participant P14E shared:

> Had local authority provided enough supports at initial resettlement considering the genocide history and family separation seriously, the children and teens of the 1980s and 1990s wouldn’t have ended up committing crimes or other antisocial activities and being on deportation lists. Local authority focuses more on eliminating problems they face rather than preventing problems from happening. I think this pattern should be changed.

The theme ***Barriers in accessing health services*** emerged in participants’ responses in terms of physical health, mental health, and community services. The respondents reported that despite the many services provided in locations where Cambodian refugee families resettled in the U.S., the availability of these services may vary based on the size of the community. Even though a host of services exist for these families, multiple barriers–language, culture,

transportation, insurance–may limit or prohibit their access to these services. These barriers prevent many families from getting the assistance they need for themselves and their families.

A few nonprofit organizations in each Cambodian community operate with staff who strive to support these communities by removing barriers to access health services. These organizations offer case management, home visitation, legal services, translation services, and psychiatric services. However, the level of support provided by these organizations is minimal in terms of the demand and needs in the community. Participant P8G2 shared:

> Actually, here in America, there are many services available, but the question is how they can have access to those services when they need them. The barriers to access are still very concerning among our community. Many elders don't speak the language nor know the culture, so these prevent them from seeking for help. Not many of them have the insurance that is qualified to get those services. Most of the time, they normalized their problems; most importantly, they don't even know what they need and if the services are available. There's still a lot of work to [raise] awareness of health and mental health in our community. We also need the professionals who can bridge the gap of the community and the mainstream culture. That's why our organization tries to advocate for more community health workers who know both languages and cultures.

Participant P10G2 shared:

> We need more professionals who speak Khmer to work with our elders. These professionals need to know simple Khmer language to talk to them as they never went to school and don't know formal Khmer language. Some insurance companies provide translation, but it's not effective because the translators speak Khmer that our elders still don't understand. They are not going to seek therapy with Western professionals because they don't know the language. They are not going to tell the truth. I don't think this Western style of therapy works for our people. Sometimes, I did the assessment with them when they were waiting in the doctor's office and sometimes in the community settings, such as their home and temples. We have to be flexible and focus on what work[s] for them.

The theme ***Lack of culturally tailored services*** emerged in the responses of all the participants when asked about the offered services specifically structured to meet the needs of Cambodian refugee families. In other words, the respondents stated that many services remain inaccessible to the Cambodian refugee population due to a lack of understanding and cultural

knowledge exhibited by the local providers. On a broader societal level, the data shows that services related to mental health, family relationships, education, and legal consultation in the case of deportation have yet to undergo any changes in order to adapt them for this specific population. At the community level, some nonprofit organizations employ staff who strive to design specific programs for elders, youth, and parents, yet leave couples-focused services off the list. The missing services include those culturally responsive services related to mental health, family relationships (i.e., parent-child, couples, intergenerational relationships), deportation-focused, and education-focused for school-aged and college-aged groups. In summary, the barriers to access persist which lead to health disparities among this population.

Participant P11G2 shared:

> Trauma-informed care and cultural sensitivity need to be introduced to professionals in legal, education, and mental health fields. Those who do law enforcement should take the history of mental health and trauma in consideration. Those who create programs and design curriculum[s] should practice trauma-informed care and cultural sensitivity as their population can be people who are affected by trauma. Clinicians should know their clients' history of resettlement, culture, and values. These professionals should learn a different unique way [not the standard one] when working with ethnic minority populations, such as Cambodian families.

Participant P7E shared:

> [The] resettlement country should have given mental health support to Cambodians at their initial resettlement, given the fact that they experienced the war, genocide, torture, and all kinds of horrific experiences in their country. School[s] should have been more trauma-informed and offered adequate guidance to refugee children and their parents. That would have prevented a lot of dropping out and gang affiliations and other criminal activities among those teenagers. Community workers and teachers should have been trained to work with refugee families, so these families could have been supported more effectively with their adjustment.

Participant P8G2 shared:

> There are a lot of health resources in Connecticut, Massachusetts, and Rhode Island. However, language [and] transportation are the barriers to access, especially among older adults who cannot speak English nor drive. Primary care providers and mental health professionals sometimes fail to provide interpretation services to Khmer patients. Even

> though they have the interpretation service, Khmer patients don't ask for it because they don't know. Moreover, sometimes the quality of the interpretation itself is not good enough to convey the right message to the patients; that can be very dangerous. There was once when a Cambodian patient [who] didn't know that their bladder was removed after 15 years–due to translation.

Participant P14E shared:

> Not all Cambodian refugees have American citizenship after 40 years of resettlement. Because of language barriers and lack of education, parents could not support their children to get American citizenship. When those children ended up committing crimes and were in jail, they are more likely to be on the deportation list. Once they are on the list, they usually receive a public lawyer to defend their case if they have American citizenship while there are many of them who don't have a lawyer to defend them. When they have a lawyer to defend them, they have more [of a] chance of not being deported. However, because public lawyers usually have too many cases and because they lack understanding about the history and culture of Cambodian refugees, they unintentionally offer advice that leads to deportation.

Participant P16E shared:

> There are extreme needs for college guidance as these Cambodian young adults do not have parents who know how to navigate [the] education system in the U.S. Many of them have the mindset that their parents cannot afford college, so they just finish high school and move on to labor jobs. Knowing due dates and requirements of college admissions is very important for professionals who help these young adults.

The theme ***Clashing belief systems*** of the Cambodian refugee population centers primarily on Buddhism. Many Cambodian elders also believe in Karma and superstition. Most participants reported that these elders trust the insights of the Buddhist monks more than the therapists. Talking about science without connecting it to their religious belief is not helpful for them. Some families shifted their belief system to Christianity at the beginning of the resettlement because most of their sponsors worked in religious-based organizations. This shift created some tension and conflict in the community. Service providers need to know the belief system of these individuals and its meaning for each generation in order to care for this population. Participant P12G1 shared:

> Our Khmer people–especially elders–are Buddhist, and they believe in everything. We have to know that it may take decades or even generations to make them believe in science. I am a bit old, in my late 60s, so they listen more to my advice. Younger professionals may find it harder to give them advice about their mental health and family issues. They look at your age, not your expertise. Guess what? They trust Buddhist monks more than the therapists [Laughs].

Participant P10G2 shared that:

> Our elders believe in Karma, too. It took me years to learn more about Karma and Buddhist philosophy because I wanted to simplify what I need[ed] to tell them in their language. I learned that there are three types of Karma: verbal, thinking, and behavioral Karma. There was a case where a parent kept cursing their kid and their kid became aggressive. The parents told me that the kid was very rude, then I discussed verbal Karma with them. I told them that "When you use bad words, you will receive bad outcomes. Like when you curse your kid, you cannot expect positive behavior from your kid. So what do you want from your kid?" Then, the parent got it. They know that they need to use nice words to get positive behaviors from their kid.

The theme ***Need to bridge mainstream culture and Cambodian community*** surfaced in the responses offered by some very experienced participants who placed these needs into two categories: the need for the Cambodian community to reach out to the mainstream culture and the need for the mainstream culture to reach out to the Cambodian community. In order for the Cambodian community to connect with the mainstream culture, more Cambodian professionals must join the workforce. A logical first step is to offer educational opportunities for Cambodian community members in higher education. On the other hand, in order for the mainstream culture to connect with the Cambodian community, the mainstream culture must exhibit sincere efforts to improve the life of this disenfranchised population by engaging in more community outreach, increasing funding to support the population in educational and community settings, and offering more trainings in trauma-informed care and Cambodian history of migration/resettlement in all settings that provide health services to this population. Participant P11G2 shared:

> I think there is a need for the dialogue between [the] Cambodian community and the mainstream culture. To do that, it requires the effort of both sides. [The] Cambodian community needs to connect to the mainstream culture, and that's why we need more

> trained Cambodian professionals to join the workforce. The mainstream culture also needs to do more community outreach and try to get to know more about our culture, history, and family needs. I think what you are doing now is very important to inform the mainstream culture about the needs of our community across system levels.

Researcher's Reflections and Critical Analysis of Domain III

By the time Cambodian refugees arrived in the U.S., their extremely poor mental health and physical health issues were visibly obvious. This is the part that I, and other Cambodians who stayed behind, missed. We always assumed that Cambodians who relocated to the U.S. lived a great life. In contrast, I learned from the literature that the third and fourth waves of Cambodian refugees who gained admission to the U.S. were the most adversely affected refugees–psychologically and physically–in comparison to other Indochina refugee populations, such as those from Vietnam and Laos. Even though I noticed that many health scholars attempted to call for immediate mental health and health interventions during initial resettlement, I could not hide my shock when I learned about the tremendous scarcity of interventions to support this population since resettlement. It makes me question the current infrastructure of resettlement policies and the amount of attention given to the human rights of displaced populations.

On an individual level, these Cambodian refugees arrived with a sense of hope, ready to start a new life in the most affluent country in the world. They came with nothing and, in most cases, without an intact family. With only their lives, these Cambodians began the process of building a new life from scratch. During the first few months of the resettlement, they received housing, job training, and food. However, after a few months of resettlement when the reality of living in this new fast-moving society took hold, these refugees began to experience a range of adjustment and acculturation problems. Unacquainted with the English language or the U.S. culture, they also realized that even their living quarters–from inside to out– proved foreign.

These individuals had to force themselves to work double shifts in entry-level jobs to ensure that they earned enough money to pay the bills and support their family. Many of these refugees found themselves too sick–both mentally and physically–to work and lived on disability incomes.

I have lived in Cambodia and in the United States. Having talked with many Cambodian refugee families who resettled to this country, I have been amazed by their resilience despite having minimal support from the resettlement infrastructure and their survival skills. I had the opportunity to live in a Cambodian resettlement community and witnessed on a personal level their commitment to staying alive and working to support their families even though they continued to live with physiological responses to traumatic stress exacerbated by current life stressors.

At the family level, in terms of parent-child relationships, parents continued to struggle with working long hours to ensure the survival of the family, while children often appeared lost both at school and at home because of the dysfunctionality of their family unit already operating in crisis mode. The community had a high number of single-mother households run by women who witnessed and endured horrific traumatic events during the war and migration; these females now had the task of raising young children and adolescents on their own in the U.S., a country they did not know. Without proper interventions from the resettlement country and its resources and power to make a difference, these families found it virtually impossible to recover from these war-related adversities on their own.

I can only imagine how difficult it was for parents, especially a single parent who lived with PTSD, poverty, acculturation stress and lacked English-speaking skills, to tackle the task of raising young children in a developed country like the U.S.–alone. I came to this country as a

graduate student with far more preparation than these Cambodian refugees, and I can still remember how stressful it was. I stand in amazement at their strength, but also feel a sense of regret that their mental health and family needs remain unaddressed after 40-plus years post-resettlement. The ongoing deportation of individuals who were children and adolescents during initial resettlement provides additional evidence of the negligence of the resettlement country, instead of the shortcomings of the families and the individuals themselves.

In terms of couple relationships, older Cambodian couples experienced tension in their relationships as each couple dealt with identity and role crises, in addition to acculturation stress. Cambodian couples hailed from a patriarchal society where men understood their roles as the leaders of the family who generated income for the household, while women took on all of the tasks associated with homemaking. However, both men and women had to work very hard to ensure the survival of their family. Research shows that many men scraped by on disability income, while women worked long hours outside of the home. Men's refusal to help with housework due to their upbringing generated conflict and tension between these couples.

I did not know about these couple relationships in the U.S. where women had an opportunity to work outside of the home and earn income for the family. I also see the double burden they experienced and the struggles with patriarchy that percolated inside their homes. This dynamic also helped me to understand why passive communication styles in Cambodian couples led to addiction, violence, and infidelity among older couples as well as divorce among younger couples. Some couples readjusted their roles and developed more egalitarian partnerships. However, other couples failed to accept the change in gender roles and added to the statistics of high rates of infidelity and divorce. For example, many men returned to Cambodia to marry younger wives, an issue that I witnessed firsthand in Cambodia. I noticed that younger

women in Cambodia had a dream to marry any Cambodian who had lived in the United States because they did not know the other side of the reality. On the other hand, many Cambodian women in the U.S. have entered intercultural marriages as part of their journey to reclaim their rights and promote a gender revolution. I have noticed shifts taking place toward greater egalitarianism in Cambodia's patriarchal culture in couple relationships in the U.S. as compared to present-day Cambodia.

At the community level, the larger U.S. resettlement infrastructure and health system still neglects the psychological impact of prolonged trauma exposure of Cambodian refugee individuals, couples, and families. Failing to address the mental health issues of this population 40-plus years after resettlement has culminated in multiple problems in couple and parent-child relationships. Intergenerational transmission of psychopathology, addiction, and physical illnesses remains highly prevalent. I would like to emphasize the need for a task force to keep strongly advocating for this population in an effort to bring their hidden issues to light and to voice their concerns that remain unspoken. I also think that the biggest barrier for this population is the ongoing impoverishment due to a chronic lack of education that stems from untreated mental illness and a lack of trauma-informed care in educational institutions and society in general. The findings of this current study provide another call for immediate action from government, research donors and also scholars in the field of traumatic stress and working with refugees in order to tailor individual, family, and community-based interventions to address the mental health and family relationship issues of these Cambodian refugee families.

The next chapter will present a summary of findings, in addition to discussions of these findings in relation to existing literature, as well as clinical and research implications.

CHAPTER 5

DISCUSSION

"Refugees are mothers, fathers, sisters, brothers, children, with the same hopes and ambitions as us—except that a twist of fate has bound their lives to a global refugee crisis on an unprecedented scale."

KHALED HOSSEINI

Novelist, UNHCR Goodwill Ambassador

The aim of this study was to conduct a mental health and family relationship needs assessment from the perspective of ***key informants*** who are former Cambodian refugees themselves—both Cambodian (n=15) and expatriate professionals (n=3)—working with Cambodian refugee families since the initial resettlement to the U.S. In this chapter, I will first present the summary of findings. Then, I plan to discuss the links between the current findings and extant literature, as well as to elaborate on implications for clinical practice and research related to systematic preventive interventions for war-torn and trauma-affected refugee populations.

Summary of Findings

It is important to remember that Cambodian refugees gained admission to the U.S. in four waves after forcible displacement to the refugee camps in Thailand between 1975-1994 prior to resettlement in the U.S. and various other countries in search of safety for themselves and their families. Those who came to the U.S. as part of the fourth wave between the 1980s and1994

were predominately preliterate farmers and reported to have severe mental and physical health problems at the initial resettlement due to their exposure to severe traumatic events during the Genocide Regime and as a result of prolonged adverse living conditions in refugee camps in Thailand. After resettling in the U.S., these refugees conducted themselves in an ongoing survival mode pattern while deeply entrenched in poverty. Key informants of this study reported that about half of these refugees successfully made this adjustment despite the hardships at the beginning. The other half failed to acculturate after 40-plus years of resettlement, primarily due to the severity of their mental and physical health conditions and the lack of support they received from local resettlement infrastructures during the initial phases of resettlement. Below is a summary of the current needs of Cambodian families across five cities in the U.S. as reported by key informants participating in this study.

The current needs assessment revealed *untreated mental health issues* among the populations after 40-plus years of resettlement. Those identified in the Grandparent and Parent Generations reported living with untreated PTSD, depression, anxiety disorder, and other comorbidities related to mental and physical health. The Grandchildren Generation raised in severely disrupted or maladapted families reported that they experienced high levels of depression, anxiety disorders, and behavioral problems that affected their performance in school. The majority of current parents who arrived as children and adolescents eventually dropped out of school, joined gangs, ran away from home, spent most of their lives in jail or at risk of deportation. With little intervention from the local government or health communities, these individuals resorted to both maladaptive coping (i.e., excessive drinking, drug abuse, gambling, etc.) and adaptive coping (i.e., joining community gardening groups, meditation groups, exercise groups, dancing groups, or volunteering at the temple, etc.) to deal with their cumulative

stressors. Most importantly, intergenerational transmission of traumatic stress remains uninterrupted and unrecognized by the population itself. Therefore, an urgent need exists for psychoeducation about traumatic stress and its impact on individuals and their relational health; this need requires implementation across generations at the individual, family, and community levels.

Specifically, according to the key informants, these refugees need individual-based interventions that are responsive to the experiences of each generation. Family-based interventions could potentially address parent-child relationships, parent-couple relationships, and intergenerational disconnection, especially between grandparents and grandchildren. Community-based interventions would aid this population which still expresses the need to connect to their culture, history, and language. The removal of barriers to accessing health services would mean that far more Cambodians could receive the health services they need. Moreover, a taskforce composed of mental and relational health experts, educational, legal and policy advocates, along with Khmer professionals who know the language, history and culture of each generation, could offer an effective way to mobilize the resources and strategies needed to provide sustainable prevention and intervention services for Cambodian refugees. Lastly, the situation requires that continuous dialogues about pressing issues and needs of Cambodian communities take place between the mainstream culture and members of the Cambodian communities, so that the Cambodian communities have a chance to express their concerns and needs to the mainstream White-European culture. This will also give the mainstream White-European culture a chance to conduct community outreach and fund projects that address the issues and needs of Cambodian communities.

Links to Literature

Context of War, Migration, and Resettlement of Cambodian Refugees

Continuous trauma exposures. Refugees aspire to rebuild themselves to the best of their ability and to support their families. Human-made and natural disasters occurred in their home countries and forced them to relocate to a foreign setting (Ballard et al., 2020; UNHCR, 2022). They experienced adversity in all aspects of their lives, including mental health, family relationships, finances, malnutrition during the migration process and prolonged family separation (McGuire et al., 2021; Slobodin & de Jong, 2015a, Wiene et al., 2004). Once they arrived in the resettlement country, these refugees had to restart their lives from scratch while often trapped in survival mode and battling persistent poverty for generations (Berman & Tran, 2008; Marshall et al., 2005; Wycoff et al., 2011). Depending on their mental health status, education levels, systems of social support, as well as resettlement infrastructure support, the majority of these individuals failed to make this transition and successfully acculturate into a new setting (Hanson-Bradley & Wieling, 2020; Shannon et al., 2012; UNHCR, 2022). As a result, many refugees who moved from Cambodia to the U.S. where they resided for 40-plus years reported that during the initial resettlement, they did not possess the job skills nor the physical and mental health necessary to adjust to such a fast-moving society as the U.S. (Kulig, 1996; Wycoff et al, 2011) A history of severe trauma exposure, family separation, low educational levels, insufficient job skills at pre-migration, in addition to limited family support presented significant challenges for the Cambodian refugees' resettlement (Chan, 2015; Kiernan, 2002; Kulig, 1996; Marshall et al., 2005). Additionally, language barriers and a lack of access to transportation exacerbated those challenges for Cambodian refugees at post-resettlement (Berthold et al., 2014). In the current needs assessment, key informants reported that not

knowing English posed the biggest barrier to successful acculturation among Cambodian refugees. Specifically, without the ability to speak English, Cambodian refugees inhibited their ability to communicate their needs and to problem-solve effectively during the initial resettlement. The Cambodian refugees who had some education, especially those who had a history of learning French in Cambodia, could acquire English skills quicker which assisted them with acculturation and helped their children adjust better (Berthold et al., 2014; Chan, 2015; Kulig, 1996; Marshall et al., 2005). In contrast, those preliterate farmers without any history of education struggled during pre-migration to acculturate and support their children. Key informants in this study also reported that about half of this group never acculturated—which added to the struggles facing this set of aging Cambodians who resettled in the U.S. Consistent with the existing literature, refugees who wrestle with adjustment—post-resettlement—continue to face more traumatic stress, such as feelings of alienation and a lack of social support (Birman & Tran, 2008; LeMaster et al., 2018; Weine et al., 2004), as well as racial discrimination and oppression in the larger U.S. societal context (Chang et al., 2008). Additionally, a lack of systemic supports from the resettlement infrastructure also contributes to unsuccessful acculturation among newly resettled communities (Shannon et al., 2012), which later leads to complicated mental health and relational consequences as well as the comorbidity of those conditions (Berthold et al., 2014; Berthold et al., 2019; Hinton et al., 2000; Hinton et al., 2011; Mollica et al., 1998; Mollica et al., 1987; Murray et al., 2010; Wieling et al., 2020).

Continuous disruptions to the family system. In the context of war-related migration, not all refugees left the country with their family members; some stayed behind and others died pre-migration (Slobodin and de Jong, 2015a). In order to deal with disruption of a normal family system, especially a family system of refugees who belong to a collectivistic culture, requires

adjustment time and resources from the resettlement environment to support them in their transition to a new setting (Nickerson et al., 2011; Slobodin & de Jong, 2015b; Hanson-Bradley & Wieling, 2020; Shannon et al., 2012; Wieling et al., 2020). The family system's adjustment frequently entails managing symptoms of complicated grief and ambiguous loss due to the absence of significant family members and memories associated with the past family system (Boss, 2006; Hanson-Bradley & Wieling, 2020). In the case of Cambodian refugee families, due to the prolonged civil war and genocide coupled with years of waiting in the refugee camps, these refugees arrived in the U.S. with severely disrupted family systems (Kiernan, 2002, 2012; Mollica et al., 2014; Sack et al. 1995, 1996). Key informants reported that many single mothers resettled with their young children as a result of losing their spouses in the war (Mollica et al., 1987). Some families came with only a few members, some adolescents came with siblings and without parents, while some refugees came alone. These family formations did not represent a traditional Cambodian family structure. The statement "I'm from a broken family" was extremely common among this population during their initial resettlement. Due to poverty and the need to transition quickly to survive in the U.S., many Cambodian families lacked the necessary time to process their traumas, grief, and ambiguous losses (Birman & Tran, 2008; Boss, 2006; Marshall et al., 2005). These findings are consistent with the existing literature that highlighted severe disruptions in the family system among displaced war-affected refugees, particularly in family roles and responsibilities, communication styles and intergenerational connections (Wiene et al., 2004) that led to acculturation difficulty without effective family-level interventions (Mcllwaine & O'Sullivan, 2015; Mak & Wieling, 2022; Nickerson et al., 2011; Williams & Berry, 1991).

Continuous lack of resettlement infrastructure support systems. The prevalence of health disparities is highly common among ethnic minority populations in the U.S. (Fiscella et al., 2002; Mirza et al., 2014). In other words, the health system itself is difficult to access and navigate for people who are not members of the dominant group and lack sufficient resources. In this study, key informants reported that overall health-related services are available to the general population, but not many minority people, including Cambodian refugees, know how to gain access—a problem exacerbated by a lack of access to health insurance. Ethnic minority refugees who gained admittance to the U.S. did not come with health insurance, so they had to apply for citizenship or pay to utilize the benefits of the health insurance system (Mirza et al., 2014). It could take these refugees years to become eligible for health insurance and to have access to overall health services. By the time they obtained access to insurance, they typically found that service providers did not understand their culture, history, and problems (Mirza et al., 2014; Reihani et al., 2021). In the case of Cambodian refugees, key informants reported that many people died at home during initial resettlement because they did not have money to go to the hospital or know how to navigate the insurance system. Even though many Cambodian families are eligible to benefit from health services now, they still encounter language, transportation (Berthold et al., 2014), and cultural barriers that prevent them from gaining access to overall health services (Mollica et al., 2002). Key informants also added that Cambodian refugees do not feel understood by service providers who often do not understand the interpreters' language even when they do receive the service. A gap often exists between the level of Khmer spoken by preliterate elder Cambodians and interpreters. This highlights the need for trauma-informed care, service providers who have cultural competency and sensitivity, and a greater number of service providers who are Cambodian. With only a few nonprofit organizations available to address

these barriers to health access, these providers can only accomplish so much with limited funding and resources.

Impact of Cumulative Trauma Exposures on Individuals

Mental health crisis. In this study, key informants reported that PTSD, depression, anxiety disorders and, in some cases, severe mental illnesses such as schizophrenia and psychotic disorders, continue to plague Cambodian refugees, especially those who lived in extremely disruptive families. Respondents also reported that mental illnesses remain an issue across three generations, but most notably among the Grandparent and Parent Generations. On the other hand, members of the Grandchildren Generation born in the U.S. commonly battle depression, anxiety disorders and behavioral problems. Health professionals and refugee scholars reported the emergence of these mental health conditions at three periods: at the Cambodian initial resettlement, a decade after the resettlement, and two decades after the resettlement in the U.S. (Mollica et al., 2014; Mollica et al., 1998; Mollica et al., 1997; Mollica et al., 1987; Wycoff et al., 2011). This present needs assessment in 2023 further exposes the fact that the mental health and relational needs of this population failed to receive sufficient attention. Some key informants reported that many grandparents (age: 80+) who were adults during the time of the war and most likely affected by trauma symptoms continue to battle mental illnesses and comorbid conditions and, unfortunately, go to their deathbeds with these untreated conditions. Existing literatures among war-affected refugee populations also highlighted ongoing cumulative mental health crises as refugees continue to wrestle with untreated mental illnesses, while the resettlement countries often fail to address refugees' mental health needs resulting from exposure to trauma at pre-migration and during migration, along with acculturation stress at post-resettlement (Shannon et al., 2012; Shannon et al., 2014; Slobodin & de Jong, 2015a). This implies that newly

resettled refugees often remain trapped in a cycle of mental health illnesses, such as living with PTSD, anxiety disorders, complicated grief, psychosis, and suicide risk for generations with no hope of resolving this ongoing problem without culturally responsive effective multi-level interventions (Hanson-Bradley & Wieling, 2020; Kim, 2016; Nickerson et al., 2011; Sangalang et al., 2019).

Adverse physical health and nutritional problems. Due to prolonged malnutrition and harsh labor conditions during the Genocide Regime and life in the refugee camps (about a decade in total), the physical health condition of many Cambodians remains poor. A key informant who has worked with the refugees since the refugee camp time reported that the examination of physical health and body age of Cambodian women during initial resettlement revealed that Cambodian refugee women in their 40s typically have the physical health of 60-year-old women. In addition to managing poor health, these Cambodian refugees had to take entry-level jobs to ensure the survival of their families in the U.S. Some Cambodian refugees reported that they were too sick to work and sought disability funding. In this study, the most common physical health illnesses reported among Cambodian families, especially among the Grandparent and Parent Generation, included diabetes type II, hypertension, high blood pressure, stroke and, in some cases, heart attacks—the same physical illnesses reported by Mollica and colleagues in 1998 as well as Berthold and colleagues in 2014. Additionally, good nutrition and eating a healthy diet still poses problems for Cambodian refugees, especially among elders and the Parent Generation, as reported by key informants in this research study. Many older Cambodians suffer from the residual effects of malnutrition on their physical health that they endured during the genocide. The topics of nutrition and a healthy diet has a link to the culture's meaning-making process: a healthy diet to Cambodians can equate with having access to food

from their culture or that generates a memory of being together with their family. To support the population in developing a notion of nutrition and eating a healthy diet would entail training professionals to grasp the meaning attached to the food Cambodians eat. Existing studies on physical health conditions among war-affected refugees also noted adverse chronic health conditions (e.g., diabetes type II, high cholesterol, hypertension, obesity, and tuberculosis) and limited access to health services in the resettlement countries, such as the U.S., the Netherlands, and Australia (Gerritsen et al., 2004; Gerritsen et al., 2006; Harris & Zwar, 2005; Taylor et al., 2014). These refugee populations continue to face chronic physical health conditions and nutrition problems despite the years of post-resettlement.

Comorbidity of overall health conditions. Cambodian refugees in the biggest cities in the U.S. continue to exhibit poor health overall (Sharif et al., 2018). According to this current study, comorbid health conditions, especially in the areas of mental health and physical health, continue to plague Cambodian refugees. Both inside and outside clinical settings, key informants reported that the comorbidity of PTSD and other anxiety-related disorders, such as high blood pressure, stroke, and diabetes type II remain high. Some key informants reported the challenges and the accompanying confusion for the Cambodian population when they receive multiple diagnoses from their health providers. These individuals reported the side effects that go along with taking multiple medications; to combat this problem, they usually stop taking the prescription or decrease the dosage without reporting it to their healthcare providers. The findings of this study reflect a consistency with the findings of previous studies conducted among Cambodian refugees, specifically those that took place over two decades ago which highlighted the comorbidity of mental health and physical health conditions across multiple diagnoses (Berthold et al., 2014; Hinton et al., 2011; Mollica et al., 1998). Without effective

communication between service providers who assess multiple types of health conditions and deliver diagnoses to the patients, the refugee populations stand at risk of developing severe side effects when they take multiple medications. Thus, it is essential that healthcare providers who work with refugee populations understand the complexity of the impact of trauma exposure during the war on these individuals' mental and physical health conditions in order to address their health issues effectively (Gerritsen et al., 2004; Gerritsen et al., 2006; Harris & Zwar, 2005; Taylor et al., 2014). Cambodian refugees often describe their ailments as a situation where their "heart almost jumps out of their chest" or their "vision suddenly becomes blurry." As a result, they ask for medication to address those conditions (Hinton et al., 2000). However, these descriptions may allude to trauma responses triggered by stressful events, such as not seeing their children return home after school or a recent argument with their spouse. Of course, they may also have multiple health conditions—rarely one condition—such as high blood pressure, diabetes type II, and cardiovascular diseases, such as heart conditions and hypertension (Berthold et al., 2014; Sharif et al., 2018). Therefore, it is vital to understand the complexities and comorbidities of health conditions when working with Cambodian refugees and other war-affected refugees.

Uninterrupted intergenerational transmission of psychopathology. The long-term effects of trauma exposures and family disruptions, especially prolonged and severe trauma exposures, on individual mental health and family relationships do not tend to dissipate without well-planned multi-level effective interventions supported by a culturally responsive infrastructure (Mak & Wieling, 2022; Shannon et al., 2012; Shannon et al., 2014, 2015). In the current needs assessment, all key informants agreed that most of the Cambodian Grandparent Generation still suffers from PTSD, depression, anxiety disorders, and unresolved grief due to

becoming targets during the Genocide Regime. Key informants also reported that many Cambodians now belonging to the Parent Generation who arrived in the U.S. as minors also suffer from similar mental health issues as those in the Grandparent Generation. Even though some of them managed to make the transition, others battle the same mental health conditions as their parents. The Grandchildren Generation reported a better state of being in terms of their mental health. However, informants who work closely with the Grandchildren Generation in higher education settings shared that they see these individuals wrestle with depression and anxiety. Therefore, the reports from multiple key informant perspectives who work in various professional settings support what the literature shows in relation to the consequences of war-related trauma exposures and forced displacement: Cambodian refugee families, especially those experiencing severe family disruptions, remain trapped in cycles of poverty and an intergenerational transmission of psychopathology (Betancourt et al., 2015; Birman & Tran, 2008; Daud et al., 2005; Field et al., 2013; Sack et al., 1995, 1996; Wycoff et al, 2011).

Impact of Cumulative Trauma Exposures on Family Relationships

Disrupted families. Disrupted families refer to those whose members cannot perform their designated roles and responsibilities in order to maintain a healthy functioning family unit (Becvar & Becvar, 2013). Parents who fail to carry out their family roles due to mental or physical health conditions end up leaving their children to navigate life by themselves; this constitutes a disrupted family which leads to a family role crisis and role ambiguity (Wiene et al., 2004). In the case of Cambodian refugee families, many struggled to function sufficiently during the initial resettlement due to the absence and/or death of significant family members resulting from the war, migration and their disability status. Once they had to rebuild their family unit in the U.S., the family system did not function properly due to the fact that some minors no longer

had parents or had parents struggling with disabilities who did not have the necessary tools or understanding to survive in the U.S. Oftentimes, the oldest children or the oldest family members assumed the leading roles to help their families function properly. However, not many families succeeding in making this adjustment primarily because adult family members struggled to acculturate while younger children could not yet take on these leading roles and responsibilities. Both the literature and this current study showed that many children and youth whose parents could not perform their parental roles faced problems at school, dropped out of school, joined gangs, abused substances, and many spent most of their lives in correctional facilities (D'Avanzo et al., 1994; Mollica et al., 1997, Chang et al., 2008; Wiene et al., 2004). Therefore, during the initial resettlement, disrupted families in which both parents and children needed support to navigate their lives in a foreign setting became far too common; unfortunately, the psychological and relational impact of growing up in a disrupted family still persists in the Cambodian refugee population.

Couple relationship tension and an internal gender revolution. During the early stages of resettlement, many Cambodian couples complied with the traditional gender roles in their relationships in which men took the leading role of generating family income. This status quo encountered challenges and broke down in the new resettlement context. In the U.S., women also had to work outside of the home to ensure the survival of the family, so it meant that they could not be responsible for all the housework in addition to their paid employment. Many men refused to accept this gender role change which fostered unresolved tensions in their relationships. Most key informants reported that men struggled the most in terms of an internal gender revolution and in making the adjustment to living in the U.S. during the early stages of resettlement. The findings from this research study also showed that older couples did not have

an effective way to communicate about the shifts in traditional gender roles; this sometimes led to infidelity, and some men even returned to Cambodia to marry a younger wife. On the other hand, younger couples made attempts to communicate and strive for more equal partnerships. Some achieved success by doing so, while others did not which led to divorce. When this situation unfolded, some Cambodian women sought second marriages in intercultural relationships, according to the data. A few key informants in this study who work with Cambodian couples reported that some older couples continue to stay in their marriages despite the tension because they do not know how to communicate effectively. Specifically, informants noticed that these couples tend to stay together, communicate using a passive-aggressive style, and separate emotionally from each other. This also impacts their parenting practices and overall mental health functioning. The findings of this study align with the research in studies conducted in 1994 and 2011 among Cambodian families in two U.S. cities; these highlighted a high level of family stress, infidelity, financial issues, aggressive behaviors (D'Avanzo et al., 1994), anger outbursts, parenting stress and problems for children when at school (Hinton et al., 2011). Both key informants of this study and in previous studies mentioned anger outbursts which often led to domestic violence as very common among Cambodian families and couples (Hinton et al., 2011; Nickerson & Hinton, 2011). Studies done among other war-affected refugee populations also noted anger outbursts, a key symptom of PTSD, as contributing factors to intimate partner violence and all types of child abuse (Catani et al., 2008; DeMaria et al., 2017; Sriskandarajah et al, 2015; Saile et al., 2013).

Need for more effective parenting practices. Parenting is a very challenging task. The context of forced displacement makes this process even more difficult, especially when refugee parents must struggle with their new identity, focus on the survival of their family, and deal with

adjusting to a new resettlement country (Hanson-Bradley & Wieling, 2020; Shannon et al., 2012; Shannon et al., 2014, 2015; Wieling et al., 2020). In the case of Cambodian refugee families, many of these parents were preliterate farmers who endured multiple trauma exposures during the genocide and migration, so many felt helpless as parents during the initial resettlement (Sack et al., 1995, 1996; Wycoff et al, 2011). Specifically, they did not know how to learn the new language or culture, understand their children's school or even how to conquer the issue of transportation in this new setting (Berthod et al., 2014). Key informants of this study described parenting practices as mostly fear-based and bereft of equal partnership as parent-couple relationships struggled with an ever-present tension and a lack of problem-solving skills. Most key informants cited an ongoing need to support parents who raise children in the U.S. Notably, these individuals called for increased attention to parenting practices for specific types of parents, such as single mothers, parents whose husbands have another household in Cambodia and also intercultural parents.

The injustice of Cambodian refugee deportations. The reference to "injustice" serves as a challenge to examine the Cambodian refugees selected for deportation and the refugee communities who currently populate a U.S. deportation list. In the case of Cambodian deportations, those at risk for deportation are typically former refugees who arrived in the U.S. as children and adolescents from highly disrupted families due to family separation and severe poverty, post-resettlement (Chheang & Connolly, 2018). The existing literature highlighted risk factors (i.e., adverse childhood experiences, poverty, and delinquent peers) that put refugee minors at risk for criminal behaviors and delinquency; thus, these behaviors represent common experiences of refugee minors who failed to receive adequate support from their parents and other support systems (Beaver, 2009; Beaver & Connolly, 2013). In other words, these escalating

delinquent behaviors needed attention much earlier. Researchers have ample documentation of the risk factors for this population. The maladaptive trajectory of these youth and families needed an intervention to avoid more long-term relational and social consequences. According to key informants of this study, Cambodian refugee minors also struggled with acculturation just as their parents did during their initial arrival. Specifically, they attended schools in their resettlement areas based on their ages and typically in high-crime neighborhoods overrun by gangs. At school, they faced bullying because of their native tongue, skin color, and names. Because their parents could not come to their aid and the assistance they received at school proved ineffective, they often joined gangs to experience a sense of belonging and find a support system. Once they joined gangs, they often engaged in crimes, such as stealing, drug dealing, destroying public properties, and even murder. This resulted in time as minors spent in correctional facilities, thus limiting their chances of obtaining U.S. citizenship. After the enactment of the 1996 immigration law, these individuals were at risk for deportation, regardless of their service completion. The U.S. government deported over 800 Cambodians since 2002 and approximately 2000 Cambodians have their names on the U.S. deportation list at this time (Resources for Southeast Asian Refugees Facing Deportation [RSARFD], 2022). All key informants agreed that Cambodian refugees currently in their 40s or 50s are not “bad people.” Instead, the majority were minors during the initial resettlement who did not receive proper support from their parents (who also struggled), their schools, and the local immigration infrastructure. The pressing issue of deportation causes another level of family separation among the Cambodian refugees who have experienced severe multiple family separations through the war, death of loved ones, and migration since the pre-migration period. Specifically, both the family members who were deported and the remaining family members in the U.S. experienced

frozen grief, ambiguity in their family roles, and a sense of betrayal (Chhuon et al., 2022). Therefore, deportation of Cambodian refugee families should be carefully evaluated in terms of human rights implications as it is brutal and painful for the families who already lived through so much loss and lack of support systems from resettlement countries.

Barriers to Accessing Overall Health

Lack of healthcare insurance. Inadequate health insurance is a key barrier to overall health services among ethnic minority populations (Mirza et al., 2014). Specifically, the barrier stems from the limited awareness of insurance regulations among individual and service providers, in addition to limited funding in the social system to support minority populations. In the case of refugee populations who recently resettled in a new country, they need extra support from the social system in order to navigate the healthcare system and to communicate their needs effectively so they can obtain health services (Reihani et al., 2021). Respondents in this study reported that Cambodian refugees face these same barriers to health services since they do not know how to navigate the system using the social welfare opportunities provided to them. Elder refugees have additional language, cultural and transportation barriers which requires even more support from family members and social systems. Additionally, they often have health insurance that requires them to travel—possibly for hours—to the agencies that accept their insurance. The data in this research study included reporting that stated that Cambodian youth attending high school tend to be less likely to seek mental health services due to the fact that school counselors are not always responsive to their needs. On the other hand, in order to access services outside of their school, they must use their parents' health insurance or their parents' consent to engage in therapy. This discourages young people to ask for mental health support because they do not want their parents to know about their mental health status. Thus, health insurance policies that

lack trauma-informed and culturally responsive components pose significant barriers for refugee populations to obtain access to overall health services.

Lack of culturally tailored services. War-affected refugee populations who resettled in the U.S. are diverse, with different histories, cultures, and various health conditions—pre-migration (Mirza et al., 2014; Reihani et al., 2021). Service providers often lack the training to provide culturally responsive care to specific ethnic minority refugee population, and the larger social system does not offer enough funding to address health disparities among refugee populations (Mirza et al., 2014). The existing literature also pointed to cultural, language, and financial barriers that prevent Cambodian refugees from seeking mental health services despite their consistently high rates of PTSD and major depressive disorder (Wong et al., 2006; Wong et al., 2015). Cultural beliefs and stigma related to mental health conditions serve as key barriers to accessing services among various resettled refugee populations (Shannon et al., 2015). Failing to address these barriers can lead to ongoing refugee health crises and persistent intergenerational transmission of psychopathology since they cannot access health services that provide culturally-responsive solutions to their individual and family needs. This study exhibited that, within the Cambodian community itself, some nonprofit organizations put forth efforts within their capacity to respond to the needs of elders, youth, and parents. For elders, individuals working for these agencies tend to focus on assisting them with physical health services; for youth, they focus on identity development and career planning; and for parents, they focus on assisting them with school-related problems. Informants reported that couple-focused services do not exist in the Cambodian community, with the exception of domestic violence prevention programs that teach about the law and consequences of domestic violence. These services vary according to the size and the location of the Cambodian population in a particular area. Smaller cities may offer

limited services, while bigger cities may provide a wider range of services. In the larger U.S. society and global context, few initiatives exist that tailor services—particularly at the family level—to specific ethnic minority refugee populations (Mak & Wieling, 2022; Mirza et al., 2014; Slobodin & de Jong, 2015a; Reihani et al., 2021), and that includes Cambodian refugees. Despite the lack of initiatives and funding support to develop culturally responsive services in all aspects of U.S. society, this country has been the resettlement site for diverse ethnic minority populations for centuries.

Investment in capacity building and education of Cambodians to become resources in their own communities. Because of poverty, a lack of opportunity in higher education, limited guidance at home, along with societal level discrimination and disenfranchisement, few Cambodians attained a high level of professional skills that would allow them to use those skills and give back to their community. Cambodian professionals with high skill levels remain underrepresented in all disciplines and professional segments in the U.S. This study's respondents reported that only one or two Khmer doctors practice in each major Cambodian city; on the other hand, smaller cities have none. Cambodian elders prefer to see Khmer doctors overseeing a foreign doctor with an interpreter in order to provide an environment where they can articulate their symptoms in their own language and feel understood culturally and historically. In terms of mental health providers across the country, only a handful of licensed social workers, therapists, and psychologists who work alongside case managers can provide care to the Grandparent Generation. This is alarming data based on the enormous needs for mental health treatment and family therapy among the Cambodian refugee population. For sustainable development, key informants in this study stated that they believe that offering younger Cambodian community members opportunities to work alongside local experts and to

pursue higher education and acquire training in physical and mental health care as well as community services is the best way to position them to give back to their community. Moreover, offering them education in Khmer culture, language, and the history of Cambodians' migration will help them better understand the refugee population's needs. These informants believe that the younger generations of Cambodians represent the hope for the sustainable development of their community.

Slow Development Within Cambodian Communities

Trapped in a cycle of poverty. War-affected refugees resettle in a new setting with minimal resources in all aspects of their lives and often become trapped in survival mode due to poor economic well-being (Deenanath et al., 2020) which refers to individuals' ability to purchase necessities for themselves and their family members to ensure a stable quality life (OECD, 2013). In the context of forced displacement and post-resettlement, economic well-being may not be achievable for generations without additional support from the broader system (Deenanath et al., 2020). In 2012, Cambodians in California were reported living below the federal poverty line with many of them relying on public assistance, social welfare, and social security incomes to survive (Hing, 2005; Kwon, 2012; Sakamoto & Woo, 2007). In this study, key informants reported that Cambodian refugees who resettled in the U.S. came with nothing. During the initial resettlement, they received help with some basic needs and entry-level job training. Their next primary concern was to provide food and shelter for their families. The individuals who farmed for a living in Cambodia found the process of paying bills in the U.S. and using unfamiliar modern financial banking systems extremely stressful. Most importantly, they did not know English nor have any history of going to school in Cambodia which made it virtually impossible to serve as role models for their children, in addition to aiding them in

finding financial and professional success in the U.S. Therefore, because of language barriers, acculturation stressors, untreated metal illnesses, and chronic lack of education, many Cambodian families find themselves trapped in a poverty cycle for generations.

Lower rates of higher education. All key informants in this study agreed that third-generation Cambodian refugees are in a better place in terms of their education and social status compared to their Grandparent and Parent Generations. However, about 55 percent of the Cambodian population graduated from high school while 16 percent of them completed a bachelor's degree and five percent completed a postgraduate degree by 2019 (Budiman, 2021). Most importantly, this younger generation, usually first-generation college students, reported that they struggled with their studies. Compared to other Asian Americans, Cambodian college students struggled with English proficiency and standardized test performance (Chhoun et al., 2010; Sakamoto & Woo, 2007). In this study, a few key informants who work with Cambodian youth preparing to attend a university claimed that many of the younger generation have a strong desire to pursue higher education; barriers, such as a lack of college planning, limited access to career guidance and financial planning for college, and the absence of family and community role models, often derail this process. After high school, without enough support, many of these younger Cambodians just follow the path of their parents and work double-shift entry-level jobs to earn a decent salary; as a result, they spend the majority of their time working. At the same time, some strive to attend college to avoid their parents' vocational path with a commitment to use education to break out of their family's cycle of poverty. Usually first-generation college students, these youth need unique support from educational institutions to achieve success in higher education and their careers.

Lack of dialogue about community needs and pressing issues between the mainstream culture and the Cambodian community. Informants of this study reported two main barriers that prevent meaningful dialogue about community needs and pressing issues between the mainstream Euro-White American culture and the Cambodian community. First, a limited number of community members possess the professional skills necessary to work in positions with policy-level impact and advocate for their community. This highlights the need for more task force teams with adequate skills across different disciplines, such as mental and physical health, family science, education, human services, law and public policy to work in the mainstream White-European culture and to foster dialogue about the issues they encounter in their community, the actions they take, and the resources they need to address those issues. Secondly, the mainstream White-European culture needs to increase community outreach to specific ethnic minorities communities. The U.S. is a large and diverse country, so it is important for community members to speak up in order to inform more privileged segments of the population about their community needs. Respondents in this study reported that many national agencies that address health and mental health disparities make claims in their mission about enhancing community outreach, but actual progress has been minimal with respect to Cambodian families.

Need for Fostering Resilience Across System Levels

Resilience in the context of forced displacement is a very complex concept. According to Ungar (2013), resilience is not an individual factor, but dependent on the context and culture of refugee individuals and families. In this sense, resilience refers to the ability of an individual, family or community to use its internal resources (i.e., strong sense of self, strong family bond, resourceful and nurturing environment) to enhance its physical, relational, and community health

in an effort to cope, adapt to, and bounce back from adversity (Masten, 2021; Ungar, 2013). Refugees are, undoubtedly, very resilient because they survived the horrific atrocities that transpired during pre-resettlement and still carry with them a strong commitment to staying alive, supporting their families, and contributing to their community. However, at post-resettlement, they fail to receive adequate support from the resettlement infrastructure in order to bounce back quickly from pre-resettlement adversities they experienced (Shannon et al., 2012). Moreover, protective, risk, and promotive factors require attention in order to examine systemic resilience (Masten, 2021; Ungar, 2013). To support refugee families, professionals and policymakers need to nurture all levels of their resilience—individual, family, and community—since one level of resilience affects all the others (Lehrner & Yehuda, 2018; Masten, 2021; Ungar, 2013; Ventriglio & Bhugra, 2015). Cambodian refugees came to the U.S. with a strong commitment to restart their lives and place their families in a better position to thrive. Because they encountered enormous structural barriers, such as limited support from the resettlement country to address the inherent risk factors (i.e., individual mental and physical health after trauma exposures and migration) and a system that did not foster protective and promotive factors (i.e., supporting parents in the parenting process at post-resettlement, promoting family financial well-being, and encouraging higher educational attainment among younger generations to obtain highly-skilled jobs), these refugees found it virtually impossible to bounce back in order to achieve resilience at the individual, family, and community levels—40-plus years post-resettlement.

Implications

Clinical Implications

The current needs assessment among Cambodian refugee families in the U.S. revealed significant compelling ongoing deficiencies in terms of mental health and relational services

among the population. Key informants who were former refugees themselves and who have worked with their own population in all migration stages agreed that the Cambodian refugee community reflects an ongoing need for culturally tailored, individual-based, family-based, and community-based interventions. Individual-based interventions could address the refugees' mental health conditions, especially for the grandparents who arrived as adults and the parents who arrived as children, in addition to those individuals exposed to multiple traumatic events during the genocide, who lived in refugee camps, and who navigated initial resettlement in the U.S. with limited support from the resettlement country. For example, the use of family therapy approaches, especially postmodern frameworks such as narrative therapy in combination with trauma-informed care may allow the population to express their complicated grief and painful emotions of concrete and ambiguous losses, as well as holding spaces for ongoing family separations in the case of deportation and family conflict. Family therapy could be supportive in helping to create safer spaces for the population to let their lived experiences be heard, validated, and potentially reconciled with their past, while promoting the development of reconstructed and preferred narratives to flourish. To date, this population exhibits a consistently high prevalence of mental illnesses, such as PTSD, major depressive disorder, anxiety disorder and, in some cases, schizophrenia and psychosis across generations. Intergenerational psychopathology continues after 40-plus years of resettlement.

On the other hand, family-based interventions such as effective parenting practices for different types of family systems (i.e., single-mother households, intercultural households, and same-sex parent households) are vitally needed in order to promote the successful development of younger Cambodians due to the fact that Cambodian families in the U.S. have become quite diverse. Specifically, Cambodians in intercultural and same-sex relationships as well as

nontraditional family structures need unique support to navigate the communication practices and value systems between cultures in an effort to foster healthy development of their families and children. For those hailing from disrupted families with intergenerational conflicts and resentment due to cumulative traumatic stress, the need exists to reconcile intergenerational family relationships between parents and children, husbands and wives, as well as grandparents and grandchildren as they continue to live together. Lastly, Cambodian deportation remains a pressing community issue. In addition to the deportation of many Cambodians, others on deportation lists include parents, spouses, and significant family members. These deportee families also desperately need culturally tailored family-based interventions to support them in dealing with family separation and mental health.

Finally, in the context of forced displacement and resettlement, creating a home-like community in a foreign country is crucial for displacement populations. In the case of Cambodian refugees in this study, respondents reported that they like to visit Buddhist temples where they can connect with their culture, food, and people who speak their own language and understand their personal history. Community-based interventions could foster solidarity and a sense of belonging and home among community members. Some cultural events organized by Buddhist temples help bring the community together, but a need still exists for more sustainable and transparent community-based interventions administered by professionals in collaboration with Buddhist temples.

In conclusion, it is important for professionals and clinicians who work with trauma-affected refugee populations to receive training in traumatic stress and its direct and long-lasting impact on the individuals, families, and the community. Those professionals interested in working with these populations must have a systemic orientation and the ability and willingness

to look across ecological system levels in order to address mental health and relational issues as well as to nurture multilevel resilience among the population in the aftermath of trauma exposures. These professionals will need to attend training sessions about the history of migration, cultural values, and family values. If possible, they should learn the refugees' language or work in collaboration with local Cambodian experts to build rapport, gain trust and provide effective services in response to the needs of these displaced war-affected populations. As the U.S. resettles refugees from diverse countries, it is crucial for mental health training institutions to educate clinicians to become effective systemic preventionists so that they can use culturally responsive treatments to assist populations affected by traumatic stress and displacement.

Research Implications

The objective of this current needs assessment is to address gaps—such as the lack of culturally-responsive family-based and community-based interventions—in the refugee family literature. Therefore, the key findings support the development of feasibility studies to adapt evidence-based systemic interventions in addressing mental health and relational impacts of war-affected Cambodian refugee families in the U.S. According to the findings of this needs assessment, key informants reported that Cambodian parents struggle in their parenting and are often not skilled in effective parenting methods that foster healthy development of their children. Cambodian parents typically share their parenting struggles in informal social gatherings without benefitting from proper professional support. Key informants of this study added that there is a strong need for more formal parenting support groups or interventions as parents want to see their children become successful in their development in the U.S. Moreover, because of the need to interrupt intergenerational transmission of psychopathology, the need for effective parenting

practices, and the need to reconcile family relationships (i.e., couple, parent-child, and intergenerational relationships), conducting feasibility studies of culturally adapted evidence-based systemic interventions such as parenting interventions are a needed next step for the population. After completing feasibility studies, if findings support the feasibility of the interventions for the population, this will validate the need for more studies and support the development and validation of measures specific to Cambodians.

Next, multi method approaches (i.e., qualitative, quantitative, and mixed methods) should be integrated with the golden standard randomized control trials (RCTs) in the context of Cambodian refugee families who still struggle with various aspects of their lives (i.e., mental health, acculturation, education, employment, finances, and family relationships). The integration of qualitative methods, such as Community Participatory Research, Ethnography, and Phenomenology are essential to incorporating local cultural voices and empowering community members to advocate for their families at the policy level. Specifically, the use of multi-method approaches are helpful in addressing barriers in conducting RCTs (e.g., high dropout rates and difficulty tracking progress over time) aiming to support refugee populations post resettlement. Postmodern paradigmatic approaches and critical methodological frameworks have demonstrated success in supporting prevention and intervention efforts with specific attention to translational sciences that inform effective and sustainable dissemination and implementation strategies.

Reflexivity

The opportunity to conduct this needs assessment was enriching and life-transforming to me as a systemic thinker and family scientist in the context of forced displacement. First, I clearly saw the experiences of Cambodian refugees post-genocide, living in refugee camps, and adapting to a new context of post-resettlement in the U.S., which I had very limited knowledge

of prior to conducting this study. Second, I appreciated the enthusiasm and openness of key informants who volunteered to participate in the study. They attended the interview well-prepared with interview questions printed and ready to elaborate on their answers. Third, I felt honored and grateful to hear the life experiences and perspectives of key informants from different fields of expertise representing five U.S. states, which helped me to understand persistent mental health and relational needs among Cambodian refugee families across the U.S. Even though I did not have the chance to conduct focus group interviews with community members as originally planned, the in-depth and rich interviews with 15 out of 18 key informants who were former Cambodian refugees and who went through all stages of migration filled all the gaps and addressed the key aims of this study. Below, I will present my reflections and insights gained throughout the process of this study.

Participant recruitment process. I started to recruit participants by sending emails to various organizations that work with Cambodian families across the U.S. I did not have much hope at the beginning that many people would participate in the current needs assessment because I did not have many connections in the U.S.-based Cambodian community. I was wrong. I immediately heard from three volunteers in my first round of emails. These initial participants shared that they volunteered because they deemed this needs assessment as very important and said they had been waiting for someone to conduct it for a long time. Surprisingly, I got more referrals from these participants and more from the second round of participants. This helped me to appreciate the power of snowball sampling as a recruitment method.

During the recruitment process, I also realized that it was very time-consuming but also necessary to show respect to participants by texting and calling them to introduce myself and my project verbally. I realized that I had to do a great deal of self-disclosure in terms of my family,

education, career, and my development stage with the participants since they wished to know more about me before disclosing their experiences. At one point, I started to question whether I was disclosing too much because I am not used to talking about myself so much to individuals that I just met. However, I understood that self-disclosure was a necessity in order to build rapport in this context. Most importantly, I also found that all participants who volunteered for this study valued education. They told me that they had been waiting for someone young who was still pursuing academic studies and could go on to treat mental illnesses and develop support for their communities. I noticed their commitment and hope for the future of Cambodian families.

Interview process. During the interview process, I noticed that the impact of some of these interviews stayed with me for a few days, leaving me with a heavy heart. I tried to avoid those feelings by distracting myself and keeping myself busy since I thought I did not have time for those feelings, but they did not go away. As I sat down and reflected on this, I came to the conclusion that I admired those interviewees who still have a strong desire to help others even though they have lost so much and witnessed the awful events that happened to their close family members. For me, hearing their narratives, I felt the pain, the anger, the grief, and the scream for justice during the genocide. I admire their courage to continue living and serving others even though some of them are not well themselves. As I checked if they have the support of mental health professionals, I was glad to learn that they have ongoing supervision with more experienced professionals to support their work. On my part, my advisor, Dr. Elizabeth Wieling, always checked in with me and consistently encouraged me to reflect and track my feelings during our weekly advising meeting even though I ignored those heavy feelings at first.

Transcribing and the data analysis process. During the transcription of the interviews and data analysis, I realized that I did not think about an interview the same way as when I was interviewing the participant the first time. The more I revisited a transcript and multiple transcripts while conducting the analysis, the more it enhanced my perspective and understanding. For example, multiple participants talked about the shift of traditional gender roles, the collapse of patriarchal attitudes in the U.S., internal gender revolution within the community, couple conflict, infidelity, domestic violence, divorce, intercultural marriages, and more egalitarian partnerships when they referred to the complex interrelationships among resettlement factors experienced by Cambodian refugee families. This helped me see the beauty of multiple perspectives even more. I also wondered what it would be like if I had a chance to conduct multiple interviews at different times with the same participant and could monitor potential growth.

Member checking process. During the member checking, I emailed the de-identified demographic information and the main findings to each participant to determine whether to exclude or include anything I missed. Most participants were very generous and shared more about themselves, and a few responded that they agreed with my reported findings. This made me wonder if I accurately represented what they said or if they were just placing a great deal of trust in me or if they thought the findings were sufficient for now or if they had become so busy that they did not have time to review the findings. Many participants also told me repeatedly that what they shared with me about the community may sound terrible and that they wished to emphasize that the people they described as belonging to “dysfunctional families” were mostly former refugees, not recent immigrants. Many severely disrupted families who resettled in the U.S. 40-plus years ago have yet to acculturate due to mental health conditions, family conflict,

and a lack of effective support systems. In sum, when I learned that the fact that about half of Cambodian refugees who resettled in the U.S. between 1975-1994 have failed to acculturate and the intergenerational psychopathology, addiction, lack of education, and the cycle of poverty still persists, I became even more determined to collaborate with more experienced scholars in traumatic stress and refugee well-being to respond to the needs of this population. I also wish to work in a broader refugee context because I strongly believe that justice and human rights should be for everyone, regardless of their race, gender, religion, and social status. My hope is that forced displacement will decrease, and families all over the globe will have the opportunity to live happily in their natural settings.

Conclusions

After 40-plus years of resettlement in the U.S., Cambodian refugee families continue to struggle with the mental health and relational consequences of trauma exposures during the Genocide Regime, living in refugee camps, and navigating early resettlement. The current ethnographic mental health and relational needs assessment conducted among 18 mental health, educational, and legal professionals who were former Cambodian refugees and who work with Cambodian refugee families in all stages of migration revealed the ongoing unaddressed need for the treatment of mental illnesses (i.e., PTSD, depression, anxiety disorders, and other psychotic disorders), particularly among the Grandparent and Parent Generations who lived in very disruptive families. The intergenerational transmission of psychopathology remains uninterrupted. Maladaptive coping strategies such as substance abuse and gambling function as alternatives for mental health treatment. Conflicts and disconnection in the family, especially between parents and children, spouses, and grandparents and grandchildren raise concerns as each family member continues to deal personally with mental health conditions and identity

crises in the resettled country. The exigent need exists for culturally tailored systemic interventions designed to address individual mental health, family conflict, and disconnection. The time has come to eliminate barriers to accessing overall healthcare, such as language, transportation, cultural knowledge, a lack of trauma-informed care, a lack of psychoeducation about mental health, particularly trauma exposures, and the lack of a task force of highly skilled Cambodian professionals who work collaboratively with local experts. Fostering systemic resilience at all levels is a necessity for Cambodian refugee communities across the U.S. in order to support them in the rebuilding and healing processes in the aftermath of severe trauma exposures and resettlement. Lastly, supporting younger community members in ways that allow them to gain easier access to higher education will help them break the cycle of poverty in their families and, in turn, become advocates for their community.

What Cambodian refugees experienced at pre-migration, during migration, and post resettlement in the U.S. is not estranged from the experiences of other war-torn displaced refugee families that account for a big portion of the world population. They endure the mental health and relational consequences of multiple trauma exposures, family separation, complicate grief, disruptions to personal and family development, and limited social support systems that go on uninterrupted for generations. It is important to highlight that many of the adversities that refugee families experience years post resettlement could have been prevented had the immigration infrastructure been more effective. Hence, this study serves as another call -- after multiple calls -- for action to implement prevention science, particularly, early inventions at all system levels to promote individual and relational healing in the aftermath of trauma exposure and displacement. Refugee families have the right to have access to all health and social services to support themselves and their families to bounce back from adversities. As long as they are

offered adequate resources and culturally responsive supports that promote their resilience across system levels during initial resettlement, they are able to successfully acculturate and become great human resources to resettlement countries.

REFERENCES

Arnsten, A. F. (2009). Stress signalling pathways that impair prefrontal cortex structure and function. *Nature reviews neuroscience*, *10*(6), 410-422. http://dx.doi.org/10.1038/nrn2648

Aucion, K. J., Frick, P. J., & Bodin, S. D. (2006). Corporal punishment and child adjustment. Journal of Applied Developmental Psychology, 27, 527-541. http://dx.doi.org/10.1016/j.appdev.2006.08.001

Ballard, J., Mehus, C., Deenanath, V., Utrzan, D., & Didericksen, K. W. (2020). From there to here: The journey of refugee families to the United States. In J. Ballard, E. Wieling, C. Solheim, & L. Dwanyen. *Immigrant and refugee families: Global perspectives on displacement and resettlement experiences*, 30-72. University of Minnesota Libraries Publishing.

Beaver, K. M. (2009). Biosocial criminology: A primer. Dubuque, IA: Kendall Hunt.

Beaver, K. M., & Connolly, E. J. (2013). Genetic and environmental influences on the development of childood antisocial behavior: Current evidence and directions for future research. In C. L. Gibson & M. Krohn (Eds.), Handbook of life-course criminology (pp. 43-55). New York, NY: Springer.

Becker, G., Beyene, Y., & Ken, P. (2000). Health, welfare reform, and narratives of uncertainty among Cambodian refugees. *Culture, Medicine and Psychiatry*, *24*(2), 139-163. https://doi.org/10.1023/A:1005674428261

Becvar, D. S., & Becvar, R. J. (2013). *Family therapy: A systemic integration* (8th ed.). Boston, MA: Pearson Education.

Berthold, S. M., Kong, S., Mollica, R. F., Kuoch, T., Scully, M., & Franke, T. (2014). Comorbid mental and physical health and health access in Cambodian refugees in the US. *Journal of community health*, *39*(6), 1045-1052. http://dx.doi.org/10.1007/s10900-014-9861-7

Berthold, S. M., Loomis, A. M., Kuoch, T., Scully, M., Hin-McCormick, M. M., Casavant, B., & Buckley, T. (2019). Social disconnection as a risk factor for health among Cambodian refugees and their offspring in the United States. *Journal of immigrant and minority health*, *21*(2), 290-298. https://doi.org/10.1007/s10903-018-0760-3

Berthold, S. M., Wong, E. C., Schell, T. L., Marshall, G. N., Elliott, M. N., Takeuchi, D., & Hambarsoomians, K. (2007). US Cambodian refugees' use of complementary and alternative medicine for mental health problems. *Psychiatric Services*, *58*(9), 1212-1218.

Betancourt T. S., Frounfelker, R., Mishra, T., Hussein, A., & Falzarano, R. (2015). Addressing health disparities in the mental health of refugee children and adolescents through community-based participatory research: A study in 2 communities. *American Journal of Public Health, Supplement*, *3:S*,475-82. https://doi/full/10.2105/AJPH.2014.302504

Bernal, G., & Adames, C. (2017). Cultural adaptations: Conceptual, ethical, contextual, and methodological issues for working with ethnocultural and majority-world populations. *Prevention Science*, *18*(6), 681-688. http://dx.doi.org/10.1007/s11121-017-0806-0

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial

treatments with Hispanics. *Journal of abnormal child psychology*, *23*(1), 67-82. https://doi.org/10.1007/BF01447045

Bezo, B., & Maggi, S. (2015). Living in "survival mode:" Intergenerational transmission of trauma from the Holodomor genocide of 1932–1933 in Ukraine. *Social Science & Medicine*, 134, 87-94. http://dx.doi.org/10.1016/j.socscimed.2015.04.009

Birman, D., & Tran, N. (2008). Psychological distress and adjustment of Vietnamese refugees in the United States: Association with pre- and postmigration factors. *American Journal of Orthopsychiatry*, *78*(1), 109-120. http://dx.doi.org/10.1037/0002-9432.78.1.109

Birman, D., Trickett, E., & Buchanan, R. M. (2005). A tale of two cities: Replication of a study on the acculturation and adaptation of immigrant adolescents from the former Soviet Union in a different community context. *American journal of community psychology*, *35*(1-2), 83-101. https://doi.org/10.1007/s10464-005-1891-y

Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss.* New York, NY: W.W. Norton.

Braga, L.L., Mello, M. F., & Fiks, J. P. (2012). Transgenerational transmission of trauma and resilience: a qualitative study with Brazilian offspring of Holocaust survivors. BMC Psychiatry, 12, 1-11. https://doi.org/10.1186/1471-244X-12-134

Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen, G.H. Elder, Jr., & K. Luscher (Eds.), *Examining lives in context. Perspectives on the ecology of human development* (pp. 619-647). Washington, DC: American Psychological Association.

Bronfenbrenner, U., & Ceci, S. J. (1994). Nature-nurture reconceptualized in developmental perspective: A bioecological model. *Psychological Review, 101*(4), 568-586. https://doi.org/10.1037/0033-295X.101.4.568

Bronfenbrenner, U., & Morris, P.A. (2006). The bioecological model of human development. In R.M. Lerner (6th Eds.), *Handbook of child psychology. Volume 1: Theoretical models of human development*, 793-828. Hoboken, NJ: John Wiley & Sons, Inc.

Budiman, A. (2021, April 29). *Cambodians in the U.S. fact sheet.* Pew Research Center. https://www.pewresearch.org/social-trends/fact-sheet/asian-americans-cambodians-in-the-u-s/

Carlson, E. B., & Rosser-Hogan, R. (1991). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *The American Journal of Psychiatry, 148*(11), 1548–1551. https://doi.org/10.1176/ajp.148.11.1548

Carlson, E. B., & Rosser-Hogan, R. (1993). Mental health status of Cambodian refugees ten years after leaving their homes. *American Journal of Orthopsychiatry*, *63*(2), 223-231. https://doi.org/10.1037/h0079422

Carspecken, P. F., & Apple, M. (1992). Critical qualitative research: Theory, methodology, and practice. *The handbook of qualitative research in education*, 507-553. Sage publication.

Catani, C., Jacob, N., Schauer, E., Kohila, M., & Neuner, F. (2008). Family violence, war, and natural disasters: A study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC psychiatry*, *8*(1), 1-10. https://doi.org/10.1186/1471-244X-8-33

Catani, C., Schauer, E., Elbert, T., Missmahl, I., Bette, J. P., & Neuner, F. (2009). War trauma, child labor, and family violence: Life adversities and PTSD in a sample of school

children in Kabul. *Journal of Traumatic Stress: Official Publication of The International Society for Traumatic Stress Studies*, *22*(3), 163-171. https://doi.org/10.1002/jts.20415

Chan, S. (2015). Cambodians in the United States: Refugees, immigrants, American ethnic minority. In: *Oxford Research Encyclopedia of American History*. New York: Oxford University Press. https://doi.org/10.1093/acrefore/9780199329175.013.317

Chan, S. (2004). *Survivors: Cambodian Refugees in the United States* (Vol. 138). University of Illinois Press.

Chan, S., & Kim, A. U. (Eds.). (2003). *Not just victims: Conversations with Cambodian community leaders in the United States* (Vol. 146). University of Illinois Press.

Chandler, D. P. (1979). The tragedy of Cambodian history. *Pacific Affairs*, *52*(3), 410-419.

Chandler, D. (1994). The tragedy of Cambodian history Revisited. *SAIS Review*, *14*(2), 79-90.

Chenail, R. J., Reiter, M. D., Torres-Gregory, M., & Ilic, D. (2020). Postmodern Family Therapy. In K. S. Wampler, R. B. Miller, & R. B. Seedall. *The Handbook of Systemic Family Therapy*, 1, 417-442. London. Wiley Blackwell.

Chheang, D., & Connolly, E. J. (2018). A review of the historical, criminological, and theoretical understandings of the Cambodian American population: a call for more comprehensive research. *International journal of offender therapy and comparative criminology*, *62*(9), 2624-2649. http://doi.org/10.1177/0306624X17732579

Chhuon, V., Aleixo, M., & Solheim, C. (2022). Ambiguous loss for Cambodian American deportees and their families. *Journal of Immigrant & Refugee Studies*, 1-13. https://doi.org/10.1080/15562948.2022.2061668

Chhuon, V., Hudley, C., Brenner, M. E., & Macias, R. (2010). The multiple worlds of successful Cambodian American students. *Urban Education*, *45*(1), 30-57. http://doi.org/10.1177/0042085909352583

Chi-Ying Chung, R. (2001). Psychosocial adjustment of Cambodian refugee women: Implications for mental health counseling. *Journal of Mental Health Counseling, 23*, 115-126.

Cohen, J. A., Perel, J. M., Debellis, M. D., Friedman, M. J., & Putnam, F. W. (2002). Treating traumatized children: Clinical implications of the psychobiology of posttraumatic stress disorder. Trauma, Violence, & Abuse, 3, 91-108. https://doi.org/10.1177/15248380020032001

Coli, C., & Magnuson, K. (1997). The psychological experience of immigration: A developmental perspective. In A. Booth, A. Crouter, & N. Landale (Eds.), *Immigration and the family: Research and policy on U. S. immigrants* (pp. 91-131). Mahwah, NJ: Erlbaum.

Daud, A., Skoglund, E., & Rydelius, P. A. (2005). Children in families of torture victims: Transgenerational transmission of parents' traumatic experiences to their children. *International Journal of Social Welfare*, *14*(1), 23-32. https://doi.org/10.1111/j.1468-2397.2005.00336.x

D'Avanzo, C. E. (1997). Southeast Asians: Asian-Pacific Americans at risk for substance misuse. *Substance Use & Misuse*, *32*(7-8), 829-848. https://doi.org/10.3109/10826089709055861

D'Avanzo, C. E., & Barab, S. A. (1998). Depression and anxiety among Cambodian refugee women in France and the United States. *Issues in Mental Health Nursing*, *19*(6), 541-556. https://doi.org/10.1080/016128498248836

D'Avanzo, C. E., Frye, B., & Froman, R. (1994). Culture, stress and substance use in Cambodian refugee women. *Journal of studies on alcohol*, *55*(4), 420-426. https://doi.org/10.15288/jsa.1994.55.420

Deenanath, V., Lo, N., Mao, D., Ballard, J., & Solheim, C. (2020). Economic well-being, supports and barriers. In J. Ballard, E. Wieling, C. Solheim, & L. Dwanyen. *Immigrant and refugee families: Global perspectives on displacement and resettlement experiences*, 73-98. University of Minnesota Libraries Publishing.

DeMaria, R., Weeks, G. R., & Twist, M. L. (2017). *Focused genograms: Intergenerational assessment of individuals, couples, and families* (Ed.). New York: Routledge.

de Silva, P. (1999). Cultural aspects of posttraumatic stress disorder. In W. Yule (Ed.), *Post traumatic stress disorders: Concepts and therapy*,116-137. New York, NY: John Wiley.

Domenech-Rodríguez, M., & Wieling, E. (2005). Developing culturally appropriate, evidence-based treatments for interventions with ethnic minority populations. *Voices of color: First person accounts of ethnic minority therapists*, 313-333. Sage publications.

Elbert, T., Schauer, M., Ruf, M., Weierstall, R., Neuner, F., Rockstroh, B., & Junghöfer, M. (2011). The tortured brain: Imaging neural representations of traumatic stress experiences using RSVP with affective pictorial stimuli. *Journal of Psychology, 219*(3), 167-174. http://doi.org/10.1027/2151-2604/a000064

Elsaesser, C., Gorman-Smith, D., Henry, D., & Schoeny, M. (2017). The longitudinal relation between community violence exposure and academic engagement during adolescence:

Exploring families' protective role. Journal of Interpersonal Violence. http://doi.org/10.1177/0886260517708404

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*, *365*(9467), 1309-1314. https://doi.org/10.1016/S0140-6736(05)61027-6

Field, N. P., Muong, S., & Sochanvimean, V. (2013). Parental styles in the intergenerational transmission of trauma stemming from the Khmer Rouge regime in Cambodia. *American Journal of Orthopsychiratry*, 83, 483-494. https://doi.org/10.1111/ajop.12057

Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G. (2002). Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findings from a National Sample. *Medical Care*, *40*(1), 52–59. http://www.jstor.org/stable/3767958

Fossion, P., Leys, C., Vandeleur, C., Kempenaers, C., Braun, S., Verbanck, P., & Linkowski, P. (2015). Transgenerational transmission of trauma in families of Holocaust survivors: The consequences of extreme family functioning on resilience, sense of coherence, anxiety and depression. *Journal of affective disorders*, *171*, 48-53. https://doi.org/10.1016/j.jad.2014.08.054

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings*. New York: Pantheon Books.

Freedman, J. & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. New York: Norton Company.

Gergen, K. J. (1985). *Social constructionist inquiry: Context and implications. In The social construction of the person* (pp. 3-18). New York: Springer.

Gerritsen, A. A., Bramsen, I., Devillé, W., van Willigen, L. H., Hovens, J. E., & Van der Ploeg, H. M. (2004). Health and health care utilisation among asylum seekers and refugees in the Netherlands: design of a study. *BMC Public Health*, *4*, 1-10. https://doi.org/10.1186/1471-2458-4-7

Gerritsen, A. A., Bramsen, I., Devillé, W., van Willigen, L. H., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social psychiatry and psychiatric epidemiology*, *41*, 18-26. https://doi.org/10.1007/s00127-005-0003-5

Gershoff, E. T. (2002). Corporal punishment by parents and associated child behaviors and experiences: A meta-analytic and theoretical review. *Psychological Bulletin, 128*(4), 539–579. https://doi.org/10.1037/0033-2909.128.4.539

Gewirtz, A., Forgatch, M., & Wieling, E. (2008). Parenting practices as potential mechanisms for child adjustment following mass trauma. *Journal of Marital and Family Therapy, 34(*2), 177-192. https://doi.org/10.1111/j.1752-0606.2008.00063.x

Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of Consulting and Clinical Psychology, 78*(5), 599–610. https://doi.org/10.1037/a0020571

Goodman, D. R. (2013). The transgenerational trauma and resilience genogram. *Counseling Psychology Quarterly*, *26*, 386-405. https://doi.org/10.1080/09515070.2013.820172

Halpern, E.S. (1983). *Auditing naturalistic inquiries: The development and application of 166 a model.* (Unpublished doctoral dissertation). Indiana University, Bloomington, IN.

Hanson-Bradley, C., & Wieling, E. (2020). Mental health. In J. Ballard, E. Wieling, C. Solheim, & L. Dwanyen (Eds.). *Immigrant and refugee families: Global perspectives on displacement and resettlement experiences*, 99-124. Minneapolis: University of Minnesota Libraries Publishing.

Harris, M., & Zwar, N. (2005). Refugee health. *Australian Family Physician*, *34*(10), 825–829. https://doi.org/10.1177/1755738015596028

Herman, J. (1997). *Trauma and recovery*. New York: Basic Books.

Heuveline, P. (1998). 'Between One and Three Million': Towards the Demographic Reconstruction of a Decade of Cambodian History (1970–79). *Population studies*, *52*(1), 49-65. https://doi.org/10.1080/0032472031000150176

Hing, B. O. (2005). Deporting Cambodian Refugees: Justice Denied? *Crime & Delinquency*, *51*(2), 265-290. https://doi.org/10.1177/0011128704273468

Hinton, D. E., Barlow, D. H., Reis, R., & de Jong, J. (2016). A transcultural model of the centrality of "thinking a lot" in psychopathologies across the globe and the process of localization: A Cambodian refugee example. *Culture, Medicine, and Psychiatry*, *40*(4), 570-619. https://doi.org/10.1007/s11013-016-9489-4

Hinton, D. E., Nickerson, A., & Bryant, R. A. (2011). Worry, worry attacks, and PTSD among Cambodian refugees: A path analysis investigation. *Social science & medicine*, *72*(11), 1817-1825. https://doi.org/10.1016/j.socscimed.2011.03.045

Hinton, D., Ba, P., Peou, S., & Um, K. (2000). Panic disorder among Cambodian refugees attending a psychiatric clinic: Prevalence and subtypes. *General hospital psychiatry*, *22*(6), 437-444. https://doi.org/10.1016/S0163-8343(00)00102-X

Hoffman, M. A., & Kruczek, T. (2011). A bioecological model of mass trauma: Individual, community, and societal effects. *The Counseling Psychologist*, *39*(8), 1087-1127. https://doi.org/10.1177/0011000010397932

Karenian, H., Livaditis, M., Karenian, S., Zafiriadis, K., Bochtsou, V., & Xenitidis, K. (2011). Collective trauma transmission and traumatic reactions among descendants of Armenian refugees. *International Journal of Social Psychiatry*, *57*(4), 327-337. https://doi.org/10.1177/0020764009354840

Kellerman, N. P. E. (2001). Transmission of Holocaust trauma-An integrative view. *Psychiatry: Interpersonal and Biological Processes*, *64*, 256-267. https://doi.org/10.1521/psyc.64.3.256.18464

Kiernan, B. (2002). *The Pol Pot regime: Race, power, and genocide in Cambodia under the Khmer Rouge, 1975-79*. Yale University Press.

Kiernan, B. (2012). The Cambodian Genocide, 1975–1979. In *Centuries of Genocide* (pp. 331-368). Routledge.

Kim, I. (2016). Beyond trauma: Post-resettlement factors and mental health outcomes among Latino and Asian refugees in the United States. *Journal of immigrant and minority health*, *18*(4), 740-748. https://doi.org/10.1007/s10903-015-0251-8

Kozlowska, K., Walker, P., McLean, L., & Carrive, P. (2015). Fear and the defense cascade: clinical implications and management. *Harvard review of psychiatry*, *23*(4), 263-287. https://doi.org/10.1097/HRP.0000000000000065

Krogstad, J. M. (2019, October 7). *Keys facts about refugees to the U.S.* Pew Research Center. https://www.pewresearch.org/fact-tank/2019/10/07/key-facts-about-refugees-to-the-u-s/

Kukla, A. (2000). Social constructivism and the philosophy of science. New York, NY: Routledge.

Kulig, J. (1996). Cambodians. In J. Lipson, S. Dibble, & P. Minarik (Eds.), *Culture & nursing care: A pocket guide* (pp. 55-63). San Francisco, CA: UCSF Nursing Press.

Kwon, S. A. (2012). Deporting Cambodian refugees: Youth activism, state reform, and imperial statecraft. *Positions: East Asia Cultures Critique, 20(*3), 737-762. https://doi.org/10.1215/10679847-1593519

Landau, J., Mittal, M., & Wieling, E. (2008). Linking Human Systems: Strengthening individuals, families, and communities in the wake of mass trauma. *Journal of Marital and Family Therapy*, *34*(2), 193-209. https://doi.org/10.1111/j.1752-0606.2008.00064.x

Lehrner, A., & Yehuda, R. (2018). Trauma across generations and paths to adaptation and resilience. *Psychological trauma: theory, research, practice, and policy*, *10*(1), 22. https://doi.org/10.1037/tra0000302

LeMaster, J. W., Broadbridge, C. L., Lumley, M. A., Arnetz, J. E., Arfken, C., Fetters, M. D., Jamil, H., Pole, N., & Arnetz, B. B. (2018). Acculturation and post-migration psychological symptoms among Iraqi refugees: A path analysis. *American Journal of Orthopsychiatry, 88*(1), 38–47. https://doi.org/10.1037/ort0000240

Letzter-Pouw, S. E., Shrira, A., Ben-Ezra, M., & Palgi, Y. (2014). Trauma transmission through perceived parental burden among Holocaust survivors' offspring and grandchildren. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(4), 420-429. http://dx.doi.org/10.1037/a0033741

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. New York, NY: SAGE Publications, Inc.

Lindert, J., Schouler-Ocak, M., Heinz, A., & Priebe, S. (2008). Mental health, health care utilisation of migrants in Europe. *European Psychiatry, 23*(S1), S114-S20. http://dx.doi.org/10.1016/S0924-9338(08)70057-9

Madison, D. S. (2005). *Critical ethnography: Method, ethics, and performance*. Thousand Oaks, CA: Sage.

Mak, C., Lewis, D. C., & Seponski, D. M. (2021). Intergenerational Transmission of Traumatic Stress and Resilience Among Cambodian Immigrant Families Along Coastal Alabama: Family Narratives. *Health Equity*, *5*(1), 431-438. https://doi.org/10.1089/heq.2020.0142

Mak, C., & Wieling, E. (2022). A systematic review of evidence-based family interventions for trauma-affected refugees. *International journal of environmental research and public health*, *19*(15), 9361. https://doi.org/10.3390/ijerph19159361

Marshall, G. N., Berthold, S. M., Schell, T. L., Elliott, M. N., Chun, C. A., & Hambarsoomians, K. (2006). Rates and correlates of seeking mental health services among Cambodian refugees. *American Journal of Public Health*, *96*(10), 1829-1835. https://doi.org/10.2105/AJPH.2006.086736

Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C. A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *Jama*, *294*(5), 571-579. https://doi.org/10.1001/jama.294.5.571

Mason, L., & Brown, R. (1983). *Rice, rivalry, and politics: managing Cambodian relief*. Notre Dame: University of Notre Dame Press.

Masten, A. S. (2021). Resilience in developmental systems: Principles, pathways, and protective processes in research and practice. In M. Ungar. *Multisystemic resilience: Adaptation and transformation in contexts of change*, 113-134. Oxford University Press.

Magruder, K. M., McLaughlin, K. A., & Elmore Borbon, D. L. (2017). Trauma is a public health issue. *European Journal of Psychotraumatology, 8*, 1-9. https://doi.org/10.1080/20008198.2017.1375338

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner/Mazel.

McGuire, T., Yozwiak, D., & Aultman, J. M. (2021). The mental health of refugees during a pandemic: the impact of COVID-19 on resettled Bhutanese refugees. *Asian bioethics review*, *13*(4), 375-399.

McNamara, D. (1990). The origins and effects of 'humane deterrence' policies in southeast Asia. In G. Loescher & L. Monahan (Eds.). *Refugees and International Relations*, 123-34. New York: Clarendon.

Meyer, S. R., Yu, G., Rieders, E., & Stark, L. (2020). Child labor, sex and mental health outcomes amongst adolescent refugees. *Journal of adolescence*, *81*, 52-60. https://doi.org/10.1016/j.adolescence.2020.04.002

Mirza, M., Luna, R., Mathews, B., Hasnain, R., Hebert, E., Niebauer, A., & Mishra, U. D. (2014). Barriers to healthcare access among refugees with disabilities and chronic health conditions resettled in the US Midwest. *Journal of immigrant and minority health*, *16*, 733-742. https://doi.org/10.1007/s10903-013-9906-5

Mollica, R. F., Brooks, R., Tor, S., Lopes-Cardozo, B., & Silove, D. (2014). The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand. *International Journal of Social Psychiatry*, *60*(1), 6-20. https://doi.org/10.1177/0020764012471597

Mollica, R. F., Cui, X., McInnes, K., & Massagli, M. P. (2002). Science-based policy for psychosocial interventions in refugee camps: A Cambodian example. *The Journal of nervous and mental disease*, *190*(3), 158-166.

Mollica, R. F., McInnes, K., Pool, C., & Tor, S. (1998). Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence. *The British journal of psychiatry*, *173*(6), 482-488. https://doi.org/10.1192/bjp.173.6.482

Mollica, R. F., Poole, C., Son, L., Murray, C. C., & Tor, S. (1997). Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(8), 1098-1106. https://doi.org/10.1097/00004583-199708000-00017

Mollica, R. F., Wyshak, G., & Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *The American Journal of Psychiatry, 144*(12), 1567–1572. https://doi.org/10.1176/ajp.144.12.1567

Mortland, C. A., & Ledgerwood, J. (1987). Secondary migration among Southeast Asian Refugees in the United States. *Urban Anthropology and Studies of Cultural Systems and World Economic Development*, *16*(3/4), 291–326. http://www.jstor.org/stable/40553109

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250-260. https://doi.org/10.1037/0022- 0167.52.2.250

Muntarbhorn, V. (1992). *The status of refugees in Asia*, 113-120. Oxford: Clarendon.

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American*

Journal of Orthopsychiatry, *80*(4), 576-585. https://doi.org/10.1111/j.1939-0025.2010.01062.x

Nelson Goff, B. S., Ruhlmann, L. M., Dekel, R., & Huxman, S. A. (2020). Trauma, posttraumatic stress, and family systems. In K. S. Wampler, M. Rastogi, & R. Singh. *The handbook of systemic family therapy: Volume4: Systemic family therapy and global health issues.* London. Wiley Blackwell.

Nickerson, A., Bryant, R. A., Brooks, R., Steel, Z., Silove, D., & Chen, J. (2011). The familial influence of loss and trauma on refugee mental health: A multilevel path analysis. *Journal of traumatic stress*, *24*(1), 25-33. https://doi.org/10.1002/jts.20608

Nickerson, A., & Hinton, D. E. (2011). Anger regulation in traumatized Cambodian refugees: The perspectives of Buddhist monks. *Culture, Medicine, and Psychiatry*, *35*(3), 396-416. https://doi.org/10.1007/s11013-011-9218-y

Nickerson, A., Liddell, B. J., Maccallum, F., Steel, Z., Silove, D., & Bryant, R. A. (2014). Posttraumatic stress disorder and prolonged grief in refugees exposed to trauma and loss. *BMC psychiatry*, *14*(1), 1-11. https://doi.org/10.1186/1471-244X-14-106

Nwadiora, E., & McAdoo, H. (1996). Acculturative stress among Amerasian refugees: Gender and racial differences. *Adolescence*, *31*(122), 477-487. https://www.proquest.com/scholarly-journals/acculturative-stress-among-amerasian-refugees/docview/195936354/se-2?accountid=14537.

OECD. (2013). OECD Framework for Statistics on the Distribution of Household Income, Consumption and Wealth. OECD Publishing. http://dx.doi.org/10.1787/9789264194830-en.

Osborne, M. (1994). *Sihanouk: Prince of light, prince of darkness*. University of Hawaii Press.

Paat, Y. F. (2013). Working with immigrant children and their families: An application of Bronfenbrenner's ecological systems theory. *Journal of Human Behavior in the Social Environment*, *23*(8), 954-966. https://doi.org/10.1080/10911359.2013.800007

Peltonen, K., Qouta, S., Diab, M., & Punamki, R. L. (2014). Resilience among children in war: The role of multilevel social factors. *Traumatology, 20*(4), 232-240. https://doi.org/10.1037/h0099830.

Perlstein, P., & Motta, R. W. (2013). An investigation of potential Holocaust-related secondary trauma in the third generation. *Traumatology*, *19*(2), 95-106. https://doi.org/10.1177/1534765612449659

Persky, I., & Birman, D. (2005). "Ethnic" identity in acculturation re-search: A study of multiple identities of Jewish refugees from the former Soviet Union. *Journal of Cross-Cultural Psychology*, *36*(5),1–16. https://doi.org/10.1177/0022022105278542

Reihani, A. R., Zimmerman, H. G., Fernando, N., Saunders, D. R., Edberg, M., & Carter, E. (2021). Barriers and facilitators to improving access to healthcare for recently resettled Afghan refugees: a transformative qualitative study. *Journal of Health and Social Sciences*, *6*(1), 59-72. https://doi.org/10.19204/2021/bbr5

Resources for Southeast Asian Refugees Facing Deportation. (2022, November 10). *Status of ICE deportations to Southeast Asian countries*. RSARFD. https://www.advancingjustice-alc.org/news-resources/guides-reports/resources-southeast-asian-refugees-facing-deportation

Rosenau, P. M. (1992). *Post-modernism and the social sciences*. Princeton University Press.

Roth, M., Neuner, F., & Elbert, T. (2014). Transgenerational consequences of PTSD: risk factors for the mental health of children whose mothers have been exposed to the Rwandan

genocide. *International journal of mental health systems*, *8*(1), 1-12. https://doi.org/10.1186/1752-4458-8-12

Rousseau, C., Drapeau, A., & Platt, R. (2004). Family environment and emotional and behavioural symptoms in adolescent Cambodian refugees: Influence of time, gender, and acculturation. *Medicine, Conflict and Survival*, *20*(2), 151-165. https://doi.org/10.1080/1362369042000234735

Rowland-Klein, D., & Dunlop, R. (1998). The transmission of trauma across generations: Identification with parental trauma in children of Holocaust survivors. *Australian & New Zealand Journal of Psychiatry*, *32*(3), 358-369. https://doi.org/10.3109/00048679809065528

Sack, W. H., Clarke, G. N., & Seeley, J. (1995). Posttraumatic stress disorder across two generations of Cambodian refugees. *Journal of the American Academy of Child & Adolescent Psychiatry*, *34*(9), 1160-1166. https://doi.org/10.1097/00004583-199509000-00013

Sack, W. H., Clarke, G. N., & Seeley, J. (1996). Multiple forms of stress in Cambodian adolescent refugees. *Child Development*, *67*(1), 107-116. https://doi.org/10.1111/j.1467-8624.1996.tb01722.x

Saile, R., Neuner, F., Ertl, V., & Catani, C. (2013). Prevalence and predictors of partner violence against women in the aftermath of war: A survey among couples in northern Uganda. *Social Science Medicine*, 86, 17-25. https://doi.org/10.1016/j.socscimed.2013.02.046

Sakamoto, A., & Woo, H. (2007). The socioeconomic attainments of second-generation Cambodian, Hmong, Laotian, and Vietnamese Americans. *Sociological Inquiry*, *77*(1), 44-75. https://doi.org/10.1111/j.1475-682X.2007.00177.x

Scharf, M. (2007). Long-term effects of trauma: Psychosocial functioning of the second and third generation of Holocaust survivors. *Development and psychopathology*, *19*(2), 603-622. https://doi.org/10.1017/S0954579407070290

Schauer, M. & Elbert, T. (2010). Dissociation following traumatic stress: Etiology and treatment. *Journal of Psychology, 218*(2), 109-127. http://doi.org/10.1027/0044-3409/a00001

Scully, M., Kuoch, T., & Miller, R. (1995). Cambodians and sexual child abuse. In L. Fontes (Ed.), *Sexual abuse in nine North American cultures: Treatment & prevention* (pp. 97-126). Thousand Oaks, CA: Sage.

Shannon, P., Im, H., Becher, E., McCleary, J. S., Wieling, E., & O'Fallon, A. (2012). Screening for war trauma, torture, and mental health symptoms among newly arrived refugees: a national survey of US refugee health coordinators. *Journal of Immigrant & Refugee Studies*, *10*(4), 380-394. https://doi.org/10.1080/15562948.2012.674324

Shannon, P. J., Wieling, E., McCleary, J. S., & Becher, E. (2014). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative Health Research*, *25*(4), 443-457. https://doi.org/10.1177/1049732314549475

Shannon, P., Wieling, E., McCleary, J. S., & Becher, E. (2015). Beyond stigma: Barriers to discussing mental health in refugee populations. *Journal of Loss and Trauma*, *20*(3), 281-296. https://doi.org/10.1080/15325024.2014.934629

Sharif, M. Z., Biegler, K., Mollica, R., Sim, S. E., Nicholas, E., Chandler, M., Ngo-Metzger, Q., Paigne, K., Paigne, S., & Sorkin, D. H. (2018). A health profile and overview of healthcare experiences of Cambodian American refugees and immigrants residing in Southern California. *Journal of immigrant and minority health*, *21*, 346-355. https://doi.org/10.1007/s10903-018-0736-3

Shawcross, W. (1984). *The quality of mercy* (pp. 79-80). DD Books.

Siegel, L. J. (1998). Children medically at risk. In R. J. Morris & T. R. Kratochivill (Eds.), *The practice of child therapy* (2nd ed., pp. 325-366). Boston, MA: Allyn & Bacon.

Siegel, J. P. (2013). Breaking the links in intergenerational violence: An emotional regulation perspective. *Family process*, *52*(2), 163-178. https://doi.org/10.1111/famp.12023

Slep, A. M. S., & O'Leary, S. G. (2007). Multivariate models of mothers' and fathers' aggression toward their children. *Journal of Consulting and Clinical Psychology, 75*(5), 739–751. https://doi.org/10.1037/0022-006X.75.5.739

Slobodin, O., & de Jong, J. M. (2015a). Family interventions in traumatized immigrants and refugees: A systematic review. *Transcultural Psychiatry*, *52*(6), 723-742 https://doi.org/10.1177/1363461515588855

Slobodin, O., & de Jong, J. M. (2015b). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy?. *International Journal of Social Psychiatry*, *61*(1), 17-26. https://doi.org/10.1177/0020764014535752

Song, S. J., Tol, W., & Jong, J. (2014). Indero: Intergenerational trauma and resilience between Burundian former child soldiers and their children. *Family Process*, 53, 239-251. https://doi.org/10.1111/famp.12071

Spradley, J. P. (1979). *The ethnographic interview.* Wadsworth, Cengage Learning: Belmont, CA.

Srinivasa, M. R. (2007). Mass violence and mental health: Recent epidemiological findings. *International Review of psychiatry*, *19*(3), 183-192. https://doi.org/10.1080/09540260701365460

Sriskandarajah, V., Neuner, F., & Catani, C. (2015). Parental care protects traumatized Sri Lankan children from internalizing behavior problems. *BMC Psychiatry*, 15(203). https://doi.org/10.1186/s12888-015-0583-x

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Taylor, E. M., Yanni, E. A., Pezzi, C., Guterbock, M., Rothney, E., Harton, E., ... & Burke, H. (2014). Physical and mental health status of Iraqi refugees resettled in the United States. *Journal of immigrant and minority health*, *16*, 1130-1137. https://doi.org/10.1007/s10903-013-9893-6

Tudge, J.R.H., Mokrova, I., Hatfield, B.E., & Karnik, R.B. (2009). Uses and misuses of Bronfenbrenner's bioecological theory of human development. *Journal of Family Theory & Review*, *1*(4), 198-210. https://doi.org/10.1111/j.1756-2589.2009.00026.x

Tyano, S. Iancu, I., & Solomon, Z. (1996). Seven-year follow-up of child survivors of a bus-train collision. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(3), 365-373. https://doi.org/10.1097/00004583-199603000-00019

Ungar, M. (2013). Resilience, trauma, context, and culture. *Trauma, violence, & abuse*, *14*(3), 255-266. https://doi.org/10.1177/1524838013487805

United Nations High Commissioner for Refugees. (2022). *Refugee data finder*. UNHCR. https://www.unhcr.org/refugee-statistics/

U.S. Citizenship and Immigration Service. (2021, November 9). *Refugee timeline*. USCIS. https://www.uscis.gov/about-us/our-history/history-office-and-library/featured-stories-from-the-uscis-history-office-and-library/refugee-timeline

Utržan, D. S., & Northwood, A. K. (2017). Broken promises and lost dreams: Navigating asylum in the United States. *Journal of marital and family therapy*, *43*(1), 3-15. https://doi.org/10.1111/jmft.12188

Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Penguin Books.

Ventriglio, A., & Bhugra, D. (2015). Migration, trauma and resilience. In M. Schouler-Ocak. *Trauma and Migration:Cultural factors in the diagnosis and treatment of traumatized immigrants* (pp. 69-79). New York: Springer.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A.,...& Knafi, K. (2004). Family consequences of political violence in refugee families. *Family Process*, *43*(2), 147-160. https://doi.org/10.1111/j.1545-5300.2004.04302002.x

White, M. & Epston, D. (1990*). Narrative means to therapeutic ends*. New York: Norton Company.

Wieling, E., Utržan, D. S., Witting, A. B., & Seponski, D. M. (2020). Global mental health, traumatic stress, and displaced families. In K. S. Wampler, M. Rastogi, & R. Singh. *The handbook of systemic family therapy: Systemic family therapy and global health issues, 4,* 215-241. London. Wiley Blackwell.

Williams, C. L., & Berry, J. W. (1991). Primary prevention of acculturative stress among refugees: Application of psychological theory and practice. *American Psychologist, 46*(6), 632–641. https://doi.org/10.1037/0003-066X.46.6.632

Wong, E. C., Marshall, G. N., Schell, T. L., Berthold, S. M., & Hambarsoomians, K. (2015). Characterizing the mental health care of US Cambodian refugees. *Psychiatric Services*, *66*(9), 980-984. https://doi.org/10.1176/appi.ps.201400368

Wong, E. C., Marshall, G. N., Schell, T. L., Elliott, M. N., Hambarsoomians, K., Chun, C.-A., & Berthold, S. M. (2006). Barriers to mental health care utilization for U.S. Cambodian refugees. *Journal of Consulting and Clinical Psychology, 74*(6), 1116–1120. https://doi.org/10.1037/0022-006X.74.6.1116

Wycoff, S., Tinagon, R., & Dickson, S. (2011). Therapeutic practice with Cambodian refugee families: Trauma, adaptation, resiliency, and wellness. *The Family Journal*, *19*(2), 165-173. https://doi.org/10.1177/1066480710397131

Yehuda, R., Halligan, S. L., & Grossman, R. (2001). Childhood trauma and risk for PTSD: relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. *Development and Psychopathology*, *13*(3), 733-753. https://doi.org/10.1017/S0954579401003170

Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry*, *17*(3), 243-257. https://doi.org/10.1002/wps.20568

APPENDIX A

Informed Consent Form

UNIVERSITY OF GEORGIA
CONSENT FORM

Study: Mental Health and Relational Needs Assessment among Cambodian Refugee Families in the United States: A Transgenerational Ecological Perspective

Researcher's Statement
You are invited to be in a research study of Cambodian immigrant and refugee families in the U.S. You were selected as a possible participant because you are a) a professional who works with members of the Cambodian community and possesses knowledge related to family experiences within the community, b) a community leader who also possesses knowledge about the general functioning and wellbeing of Cambodian families, and/or c) a member of the Cambodian community who is knowledgeable about experiences related to the civil war, migration-related stressors, resettlement difficulties, and how these experiences may impact families. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Chansophal Mak, Department of Human Development and Family Science, University of Georgia under the supervision of Dr. Elizabeth Wieling, Director of Marriage and Family Therapy program, Department of Human Development and Family Science, University of Georgia.

Principal Investigators:

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Purpose of the Study
The purpose of this study is to explore mental health and relational needs assessment among Cambodian refugee/immigrant families resettled in the U.S. about four decades ago.

Study Procedures
If you agree to participate in this study, we would ask you to do the following things:
Those who qualify for participation based on categories a and b above will be asked to engage in a one-hour, in-depth individual interview about your perceptions of family dynamics, strengths, challenges, and needs within the Cambodian community. Interviews will be audio recorded to promote efficient and

accurate data collection and analysis, however data will remain confidential and personal identifiers will not be included in any official reports of the study.

Risks and Discomforts
It is possible that you might experience some psychological distress as a result of participation in this research study. This may be particularly true of the interview as some of the questions asked are sensitive. You may end your participation in the research study at any time, and if at any time you are uncomfortable during participation in the interview, please notify the researcher immediately. Due to the nature of the questions included in this survey, you may feel unsafe or be reminded of times that you felt unsafe. If you do begin to feel unsafe, please stop the survey and call either 911 or your local mental health providers.

Benefits
We hope that your participation in this study will serve to fuel more equitable war-affected traumatic stress intervention projects, ultimately benefitting the broader community, especially those that are most affected by traumatic stress at the individual, family, and community levels. Your participation in this initial study will give the researcher necessary information about the topic, and could lead to larger studies that would inform therapists' clinical work with individuals and families struggling with war-affected traumatic stress, intergenerational transmission of traumatic stress, as well as other positive changes that would benefit the broader community.

Alternatives
There are no alternatives to participating in the study.

Incentives for Participation
You will receive a $35 gift-card for participating in each interview.

Audio/Video Recording
The interview will be recorded in order for the researcher to later transcribe the interview, and will be kept for up to two (2) years.

Privacy/Confidentiality
The records of this study will be kept private. In any sort of report, we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely and only researchers will have access to the records. Any recordings of interviews or focus groups will only be accessed by the researchers, will be kept safe and secured, and will be destroyed after the study has been completed.

Voluntary Nature of the Study
Your involvement in the study is voluntary, and you may choose not to participate or to stop at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw from the study, the information that can be identified as yours will be kept as part of the study and may continue to be analyzed, unless you make a written request to remove, return, or destroy the information.

Contact and Questions
The main researcher conducting this study is Chansophal Mak, a doctoral student at the University of Georgia. Please ask any questions you have now. If you have questions later, you may contact Chansophal Mak at makchansophal@uga.edu or at (706) 207-3823. If you have any questions or concerns regarding your rights as a research participant in this study, you may contact the study advisor, Elizabeth Wieling, PhD., (ewieling@uga.edu) or the Institutional Review Board (IRB) Chairperson at 706.542.3199 or irb@uga.edu.

Research Subject's Consent to Participate in Research:
To voluntarily agree to take part in this study, you must sign on the line below. Your signature below indicates that you have read or had read to you this entire consent form, and have had all of your questions answered.

_____	_____	_____
Name of Researcher	Signature	Date
_____	_____	_____
Name of Participant	Signature	Date

Please sign both copies, keep one and return one to the researcher.

APPENDIX B

Recruitment Scripts

Study: Mental Health and Relational Needs Assessment among Cambodian Refugee Families in the United States: A Transgenerational Ecological Perspective

Email Script to Key Informants

Dear [name]

My name is Chansophal Mak and I am a doctoral candidate at the University of Georgia in the Department of Human Development and Family Science. I am currently conducting research about Cambodian immigrant and refugee experiences as they relate to war-related consequences on family adjustment and wellbeing. I am interested in continuing this research by conducting a needs assessment of the Cambodian population in the U.S., and believe you may be a great resource and individual to speak with given your experience working with/in the community. I am particularly interested in understanding your perspective on various aspects of both successes and challenges that may exist related to family functioning, family relationships, personal health, and overall wellbeing in the community. I play to meet with other professionals and community leaders who can provide similar information form different vantage points, and hop that this needs assessment will culminate into greater understanding about how to best serve families in the Cambodian community here.

Please let me know if you would be willing to engage in a one-hour individual interview about this critical topic. I would like to stress that your participation is completely voluntary (see attachment information sheet briefly detailing the project and outlining its voluntary nature). If you are interested, I would be happy to schedule our virtual meeting at a time that works best for you. Thank you, [name]. I look forward to hearing from you.

Sincerely,

Chansophal Mak (Principle Investigator)

APPENDIX C

Key Informants (KI) Interview Questions

Study: Mental Health and Relational Needs Assessment among Cambodian Refugee Families in the United States: A Transgenerational Ecological Perspective

Grand Tour:

1. **Could you please reflect and share what you see as the overall adjustment and wellbeing of Cambodian families who resettled in this area?**

   Follow-ups: generational differences, gender, family composition, SES, etc.

2. **What do you see as the most pressing ongoing needs of local Cambodian families?**
3. **What do you want to see happen/prioritized in regard to community needs?**

Professional Environment

1. What agency or organization(s) are you affiliated with that fosters your engagement with families in the Cambodian community? (**Note**: remind key informant that their name, identifiable information, and organizational affiliation will not be used in any official or published reports of the study)
2. What is the nature of the work you do when you engage with this population?
3. How long have you engaged in this work?
4. How often do you engage with the population?
5. How would you describe the setting in which your work is located (e.g., urban, rural, public, private)?

Family Dynamics and Relationships

General

1. What are common strengths you see within Cambodian families and within the community in general?
   a. What are some major successes you've observed within the Cambodian immigrant community?
2. What are some common challenges you've observed within families and in the community?
   a. Please describe any challenges that you think specifically pertain to individuals and/or families who have resettled more recently.

   b. Please describe any challenges you believe specifically pertain to individuals and/or families who have been resettled for a longer period of time.
3. What are some key characteristics you would use to describe the culture of the Cambodian community here? Broadly, how do elements of this culture impact family dynamics?

Parenting and Parent-child relationships

1. What are common disciplinary practices you see in Cambodian families?
2. How does culture influence Cambodian parent-child relationships?
3. How do Cambodian parents perceive the effectiveness of their parenting practices?
4. How do you think Cambodian children perceive their parents' disciplinary strategies?
5. What is your assessment of acculturation gaps among parents and children?
   a. Can you explain how these gaps impact parent-child relationships?
6. What are common stressors that influence parent-child relationships?
7. What are your observations of how parents describe parenting practices here versus those they displayed or witnessed back home?

Children/Adolescents

1. What is the typical role of children within the household?
2. How are children typically performing in school, from what you know?
3. Are there common factors that present challenges for student success in school?
   a. Are any of these factors related to family dynamics at home? If so, please explain how you think the two are connected (i.e., family dynamics and school challenges)
4. Are there any services you have observed/heard that children are not receiving at school that may alleviate potential challenges?
5. What are common conduct issues among youth?
   a. Where do you think these issues are stemming from? What are their greatest impacts?
   b. How is home/family life addressing these issues?
6. Where do children and adolescents who need help for various reasons seek help?
7. Are there community organizations that serve a great deal of youth in the community?

Couple/marital relationships

1. What are your perceptions of how different roles are carried out within families (e.g., husband/wife, mother/father)?
   a. Please describe how stringent or flexible these roles appear to be.

   b. Have you observed any discussions about the differences between how family roles are carried out in the U.S. versus how they were enacted back home? If so, please describe.
2. What is your perception of how gender influences these roles? Please also describe any observations about the role of power in these dynamics.
3. What is your understanding of how gender-based couple violence may or may not be impacting families in the community?

Personal Wellbeing

Mental Health

1. What kinds of mental health conditions (e.g., anxiety, depression, PTSD) have you observed or heard about existing within the community?
2. What are general community perceptions of mental health conditions?
   a. Is there any stigma? If so, how is it exhibited?
   b. Is stigma exhibited more frequently with regard to certain conditions over others?
3. Where do people normally seek help for issues related mental health?
4. What are some healing strategies you've seen Cambodian families use to cope with personal and/or family stress?

Substance Use

1. What are some patterns, if any, you've noticed related to alcohol use and/or abuse in the community?
   a. How does alcohol consumption impact family relationships and functioning?
2. What are some patterns, if any, you've noticed related to use and/or abuse of illegal substances?
   a. How do these patterns impact family relationships and functioning?

War-related Experiences

1. How do members of the community typically discuss the Cambodian genocide, and in what context do these conversations typically arise?
2. What are some general opinions of the impact of the genocide on personal wellbeing? What about its impact on family wellbeing?
3. How are community members still trying to rebuild and recover from the genocide and other related challenges (e.g., refugee experiences, migration stressors)?
4. Are there certain people you believe are suffering more from the crisis (e.g., those who came during certain periods, those who were a certain age during the genocide)?
5. How do families normally maintain contact with kinship back home? How do these interactions impact daily life of Cambodian here?

Community Needs/What can be done

1. In general, what needs are not being met in the community that could help families function more optimally?
2. What measures do you believe are being taken in the community to reduce issues related to mental health, relational difficulties, substance abuse, etc.?
3. What types of psychosocial interventions/services (e.g., programs to help families succeed in their relationships) have you seen directed toward families in the Cambodian community, even if they don't solely include Cambodian families?
    a. What factors have made these interventions/services successful?
    b. What are some opportunity spots for these interventions/services?
4. In what ways do you think specific elements of the Cambodian culture (i.e., beliefs, customs, norms) does/would impact use of psychosocial resources and their capacity for effectiveness?

Concluding

1. Is there any other information you believe would be useful to share that we have not had a chance to discuss?
2. Similarly, do you believe there are any solutions/recommendations to address any of the above challenges that we have not discussed?
3. What other professionals and leaders would you recommend that we talk to regarding the needs of the Cambodian community?
4. Are there any community members that you believe may be a great resource for this information, and who may be able to discuss these topics objectively in a focus group?

APPENDIX D

Domain Analysis Summary

Domain	Category	Theme
Premigration	**Impact on Self**	Exposure to Traumatic Events
		Psychological Trauma
		Gender-bias Education
	Couple Relationships	Disrupted Couple Relationships
		Communal Arranged Marriage
	Parent-Child Relationships	Fear-based Parenting Practices
		Fostering Independence in Family Values
	Context	Loss of Home and Community
		Separation Trauma
During Migration	**Impact on Self**	Ongoing Exposure to Traumatic Events
		Psychological Trauma
		Compromised Identity
		Grief and Loss
		Adverse Physical Health and Malnutrition
		Individual Resilience
	Couple Relationships	Disrupted Couple Relationships
	Parent-Child Relationships	Disrupted Parenting
		Single Mom Households
	Context	Extreme Poverty
		Continuous Family Separation
		Access to Education for Some
Post Resettlement in	**Impact on Self**	Psychological Trauma

the United States		
		Physiological Responses to Traumatic Stress
		Identity Issues
		Adverse Physical Health Conditions
		Nutritional Issues
		Compulsive/Criminal Behaviors
		School Problems
		A Combined Maladaptive and Adaptive Coping Strategies
		Resilience (Sub themes: resilience of Khmer youths, family resilience, and community resilience)
	Couple Relationships	Gender Role Tensions
		Gender Revolution
	Parent-Child Relationships	Gender Revolution
		Fear-based Parenting Practices
		Intergenerational Disconnection
		Need for effective parenting practices
	Context	Mental Health Stigma
		Chronic Lack of Education
		Poverty Cycle
		Deportation
		Barriers in Accessing Health Services
		Lack of Culturally Tailored Services
		Clashing Belief Systems
		Need to Bridge Mainstream Culture and Cambodian Community

APPENDIX E

Complete Domain Analysis

Domain	Category	Theme	Sub Theme	Frequency
Premigration (During the wars and genocide)				
	Impact on Self	Exposure to Traumatic Events	Lives during civil wars	30
			Lives during the genocide	40
			Close to death illness	14
			Close to death hunger	17
			Witnessing death of family and known people	24
			Experiencing torture	7
			Experiencing forced labor	26
			Experience gunshots, bombing	24
			Adverse life experiences	20
			Mass killing	15
			Adults were the target	26
			Being forced to leave the country	15
			Being forced to leave family behind	6
		Psychological Trauma	Stressful emotions	20
			Feeling shocked	15
			Feeling numb and frozen	15
			On denial	10
			On stress response mode	15

		Gender-bias Education	Education only for men	5
			Disrupted education	5
			Education at the Buddhist temples	
	Couple Relationships	Disrupted Couple Relationships	Family separation	10
			Death of a spouse	15
			Single mother household	18
			Remarrying	20
		Communal Arranged Marriage	Arranged marriage	5
			Forced marriage	4
			Fear-based marriage	3
	Parent-Child Relationships	Fear-based Parenting Practices	Harsh parenting in the countryside	10
			Disrupted parenting	18
			“Home before sunset” rule	5
			Offering inequal opportunity to girls and boys	5
			Survival mode parenting	7
			No family time	15
			No parent child time	
			Education only for men	10
			Dysfunctional family system	20
		Fostering Independence in Family Values	Nurturing parenting in the city	2
			Offering equal opportunity to both girls and boys	2
			Equal education opportunity	2

	Context	Loss of Home and Community	Loss of properties	20
			Loss of personal belonging	15
			Loss of family members	30
			Loss of familiarity	5
			Loss of jobs	5
			Loss of security	20
			Loss of normal family life	25
			Loss of culture	5
			Loss of trust	5
			Loss of hope	5
			"The world turns upside down"	4
			Harder lives for people from the city	5
			Mass execution of educators	35
		Separation Trauma	Mass family separation	30
			Working in different camps	27
			No family life	15
			Separating children and parents	10
			Separating siblings from different age groups	10
			Separating spouses	5
			Issues with trust	5
During Migration (Refugee camps)				
	Impact on Self	Ongoing Exposure to Traumatic Events	Harsh journey to refugee camps	23
			Lack of food	30
			Experiencing robbery	5
			Experiencing gun shots and bombing	8

			Risking life through land mines	4
			Harsh living in refugee camps	27
			Adverse physical health	34
			Severe malnutrition	28
			On going death	12
		Psychological Trauma	Stressful emotions	20
			Feeling on guard	15
			Complicated grief	12
			Extreme fear of second genocide	7
			Ambiguous hope	5
			Mental illness	10
			Somatic complaints	11
			Flashbacks	15
			Adjustment stress	25
		Compromised Identity	Fear of foreigners	5
			Identity as refugees	7
			Low self-esteem	5
			Changing identity	7
			Hiding personal information	5
		Grief and Loss	Complicated grief	12
			Painful emotions due to losses	11
			Unresolved losses	23
			“Loss everything”	14
			Ambiguous loss	21
		Adverse Physical Health and Malnutrition	Poor physical health	34
			Severe malnutrition	28
			Somatic complaints	11
			Multiple health conditions	20

		Individual Resilience	Survived Pol Pot regime	18
			Hard working	32
			Hope for a better life	15
			Value life and human services	19
	Couple Relationships	Disrupted Couple Relationships	Death of a spouse	15
			Single motherhood	25
			Remarrying	20
			Separated from a spouse	10
	Parent-Child Relationships	Disrupted Parenting	Single mother parenting	11
			Disrupted family system	34
			Lack of father figures	8
			Not family life	34
			No parent child time	22
			Survival mode parenting	18
			Role reversal	14
		Single Mom Households	Challenges of single moms	25
			Lack of father figure	18
	Context	Extreme Poverty	On survival mode	34
			Starting life from scratch	23
			Limited food supplies	37
			Becoming street vendors in exchange for food	12
			Prolong no income	15
		Continuous Family Separation	Receiving different sponsorships to different countries	6
			Family separation	12
			Unknown surviving family members	13

		Access to Education for Some	Going to school in refugee camps	4
			Scholarship opportunity in refugee camps	3
			General Khmer reading and writing classes	3
			English classes	4
Post Resettlement in the United States				
	Impact on Self	Psychological Trauma	Mental illnesses- Grandparents	43
			Mental illnesses- Parents	30
			Mental illnesses- Grandchildren	23
			Acculturation stress	35
			Somatic complaints	27
			Stressful emotions	34
		Physiological Responses to Traumatic Stress	Somatic complaints	27
			Flashbacks	22
			Rumination of thoughts_ Thinking a lot	32
			On guard	16
		Identity Issues	Identity Crisis_ Grandparents	27
			Identity issue_ Parents	18
			Gender role crisis	21
			Men role crisis	16
			Collapse of patriarchy in the family	20
		Adverse Physical Health Conditions	Adverse physical health_ Grandparents	43
			Adverse physical health_ Parents	39

			Chronic diseases	42
			Comorbid conditions	28
		Nutritional Issues	Lack of education on nutrition	19
			Need to redefine meaning of food and culture	11
		Compulsive/Criminal Behaviors	Compulsive behaviors among young people at initial resettlement	27
			Criminal behaviors among young people at initial resettlement	35
			Cause and effect of compulsive behaviors among youth	32
			Cause and effect of criminal behaviors among youth	32
		School Problems	Cause and effects of school problems at initial resettlement	36
			Lack of resettlement infrastructure supports	23
			Lack of parental involvement	43
			Lack support from school system	31
		A Combined Maladaptive and Adaptive Coping Strategies	Maladaptive coping strategies	38
			Adaptive coping strategies	23
		Resilience	Resilience of Khmer youth	35
			Family resilience	31
			Community resilience	40

	Couple Relationships	Gender Role Tensions	Men role crisis	16
			Women working outside	22
			Collapse of patriarchy within the home	20
			Passive communication	14
			Aggressive behaviors	35
			Anger outburst	37
			Violence	35
			Infidelity	25
			Divorce	35
			Remarrying	31
			Intercultural marriage among women	30
		Gender Revolution	Women working outside	22
			Women asking for equal partnership	26
			Women knowing their rights	27
	Parent-Child Relationships	Gender Revolution	Father-daughter tension	17
			Daughter asking for equal rights	16
			Cut-off	13
		Fear-based Parenting Practices	Harsh parenting practices at initial resettlement	23
			Parenting on survival mode	35
			No family life	34
			No parent-child time	37
			“Be home before sunset” rule	15
			Lack of supports for parents	18
		Intergenerational Disconnection	Intergenerational disconnection between	10

			grandparents and grandchildren	
			Different intergenerational interests	15
		Need for effective parenting practices	Need for effective parenting in the U.S.	19
			Need for effective inter-cultural parenting	15
			Need for effective same sex parenting	1
			Need for culturally responsive parenting	25
			Need for sustainable parent support groups	20
	Context	Mental Health Stigma	Stigma of not sharing family problems to others	26
			Lack of understanding of mental health	37
			Denying having mental illness	21
			Turning mental illness into somatic complains	38
		Chronic Lack of Education	Having no history of education_ Grandparents	41
			Language barriers	46
			Low rate of higher education	25
			Cause and effects of chronic lack of education	15
		Poverty Cycle	Cause and effect of poverty cycle	26
			Trapped in poverty cycle	29
			Lack of education	35
			Lack of financial planning	15
			Trapped in survival mode	34

			No role model in the family	20
			No family time	34
			Living with disability income	38
			Lack of ambition to be better than surviving	15
			Lack of support from bigger society	31
		Injustice of Deportation	Lack of resettlement infrastructure support at initial resettlement	32
			Lack of support for parents	18
			Lack of support at school	20
			Joining gangs for survival	34
			Lack of support at home	37
			From very disrupted families	38
			Crisis of minors of the 1980s & 1990s	41
			Living with criminal records	26
			Citizenship issues	20
			1996 Deportation law	15
			Cause and effects of deportation	38
			Vulnerable population for deportation	25
			Adverse childhood experience	35
		Barriers in Accessing Health Services	Insurance policy	17
			Language barriers	46
			Transportation barriers	40
			Cultural barriers	43
		Lack of Culturally Tailored Services	Lack of culturally tailored individual-	34

			based mental health treatments	
			Lack of culturally tailored family-based interventions	32
			Lack of culturally tailored community-based interventions	23
		Clashing Belief Systems	Belief in Karma	26
			Belief in Buddhism	37
			Belief in everything	20
		Need to Bridge Mainstream Culture and Cambodian Community	Need for continuous dialogues between White Euro centric culture and Cambodian community about the needs of the community	10
			Need for taskforce groups	27
			Need for more collaborations	13
			Need for Cambodian taskforce groups	24
			Need for investing in intellectual development of Cambodian younger generations	26