Factors in the Healthcare Experience of Cambodian Americans and the Impact of Trauma:

A Qualitative Analysis

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Abstract

Factors in the Healthcare Experience of Cambodian Americans and the Impact of Trauma:

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Background: Cambodian Americans have relatively poor mental and physical health outcomes compared to the general U.S. population and other Asian American subgroups. Additionally, many services such as screenings and mental health treatment are underutilized. Barriers such as cost, low-English proficiency, and acculturation stress impact their ability to access healthcare. However, there is a lack of research on the holistic healthcare experience of Cambodian Americans.

Purpose: This study aimed to further explore the 1) health beliefs and values of Cambodian-Americans, 2) perceived factors that affect their healthcare experience, and 3) perceived factors that affect their health care seeking behavior.

Methods: Purposive and convenience sampling were used by members of the Khmer Health Board to conduct 3 focus groups and 30 interviews with Cambodian Americans in the Seattle Metropolitan area for a total of 50 participants ranging from 19 to 75 of age.

Results: A qualitative analysis identified challenges navigating the health system, socio-cultural influences, and historical trauma as major themes that informed Cambodian Americans health beliefs, healthcare experience, and healthcare seeking behavior.

Implications: This study found that the experience of historical trauma not only contributes to health outcomes such as post-traumatic stress disorder, but can be a mediating factor in healthcare utilization. When also considering the preference participants showed towards wellness activities among peers, efforts to culturally-tailor health services should also consider community-level interventions and how to avoid potential re-traumatization of patients.

Introduction

Background

The first major wave of Cambodian refugees arrived in the U.S. as a result of the Khmer Rouge genocide. An estimated 2 million people died, nearly a quarter of the nation's population (Chan, 2015). The Khmer Rouge communist party came to power in 1975 and ruled until Vietnamese forces deposed the government in 1979 (Chan, 2015). During this four year period, hundreds of thousands of Cambodians settled in Thai refugee camps to escape the conflict. A period of intense immigration of nearly 160,000 Khmer people began in 1980 under U.S. government resettlement programs and continued into the early 1990's (Chan, 2015). The U.S. Cambodian population has since grown from 206,000 in 2000 to 330,000 in 2015. (Lopez et al., 2017).

Health Disparities

Despite being a fast growing Asian American minority group and 40 years of major presence in the U.S., Cambodian Americans have consistently been shown to have poor health outcomes compared to the general U.S. population and other Asian American subgroups (Wong, 2010; Sharif, 2018). Additionally, they have among the highest rates of poverty and lowest rates of educational attainment. For instance, 62% of foreign-born Cambodian Americans only have a high school education or less compared to 29% of all Asians (Lopez et. al, 2017). However, even when adjusted for sociodemographic factors such as income, Cambodian Americans still experience among the highest prevalence of poor mental health and physical health (Sharif, 2018). Major health issues include chronic diseases such as hypertension, diabetes, hepatitis b virus infection, cervical cancer, and liver cancer (Wagner 2013; Taylor 2012). While some studies have focused on the health of Cambodian Americans, specifically disaggregated from other Asian groups, there is still a dearth of literature on the variety of healthcare experiences and perspectives of Cambodian Americans.

Barriers

One possible factor of the continued poor health outcomes is effectiveness of the U.S. healthcare system to address the specific health needs of Cambodian Americans. Underutilization of the healthcare system has been identified as a factor in a multitude of studies looking at different health conditions. Mental health utilization, for instance, is among the lowest for Cambodian Americans despite rates of post-traumatic stress disorder and anxiety as high as 88% in some communities (Thikeo, 2015). Additionally, important preventative services such as screening rates for hepatitis B and HPV are low despite high prevalence in the population. Cambodian immigrants are 25 times more likely to have chronic HBV infection than the general U.S. population, a major factor in liver cancer cases and deaths

(Burke, 2011). Similarly, cervical cancer has the highest incidence among Asian American women yet low screening rates and low HPV vaccination for at risk patients (Ho, 2018). Overall, despite consistent evidence that Cambodian Americans face higher than average poor health outcomes, they are not accessing or receiving the necessary care. The declining or low rates of many of these preventable diseases in the general U.S. population only serves to highlight the health disparities among Cambodian Americans.

Cultural and structural barriers are often examined as a mediating factor in healthcare experiences, health beliefs, and health knowledge due to the relatively recent and large migration of many Cambodian Americans to the U.S. Cultural and social norms around sexual and mental health for example can play a role in the willingness to seek care from health professionals. One study found that Cambodian American females and those who had higher levels of acculturation were more likely to access mental health services, possibly indicating that gender roles and the higher acceptability of mental health care in the U.S. may be a factor in decisions to seek care (Thikeo, 2015). Culturally stigmatized or taboo topics is one factor for why Cambodian Americans may be underutilizing healthcare services.

Lack of knowledge on communicable and chronic disease etiology has also been shown to be a barrier for accessing care. A qualitative study on the understanding of liver disease and HBV found a lack of consensus on terminology and wide range of beliefs due to a combination of Buddhist, Khmer, and Western biomedical beliefs that made screening and treatment difficult (Burke, 2011). Other health system barriers to HBV screening included language barriers, cost concerns, and difficulty navigating the U.S. healthcare system. Many of these studies have concluded that there is a need for cultural tailoring, promotion, and culturally trained providers as solutions to reach the Cambodian American population.

Trauma & Healthcare Interaction

The effect of trauma and intergenerational trauma on health has generally been discussed in the context of mental health outcomes among Cambodian Americans, but not generally explored in connection to healthcare interaction. Many Cambodian Americans are affected by the experience of trauma, especially older adults. Cambodian American refugees experienced an average of 15 different traumas with higher numbers associated with PTSD (Berthold, 2018). Further understanding of the legacy of the Cambodian civil war and trauma-related barriers to receiving care is needed as Khmer refugees age and continue to have health issues that go unaddressed. Additionally, the focus has traditionally been on older adults and first generation Cambodian Americans with little formal research on how second generation Cambodian Americans experiences of health and healthcare may differ.

A possible theory is that trauma may contribute to a distrust of the healthcare system as a result of the Khmer Rouge's anti-Western propaganda and indoctrination. One study found an association between health indicators and trust in the healthcare system. Cambodian American participants who trusted only traditional medicine, indicating a distrust of western medicine, had poorer health outcomes than those who incorporated both health systems (Wagner, 2013). Cultural differences and beliefs may not act necessarily as a barrier to health, but as symptoms of underlying distrust for Western medicine. Many studies point out that physicians should culturally tailored interventions and care to address knowledge gaps or unequal health outcomes in Cambodian Americans but do not really explore the impact of physician bias from the viewpoint of the patient.

Conceptual Framework & Purpose

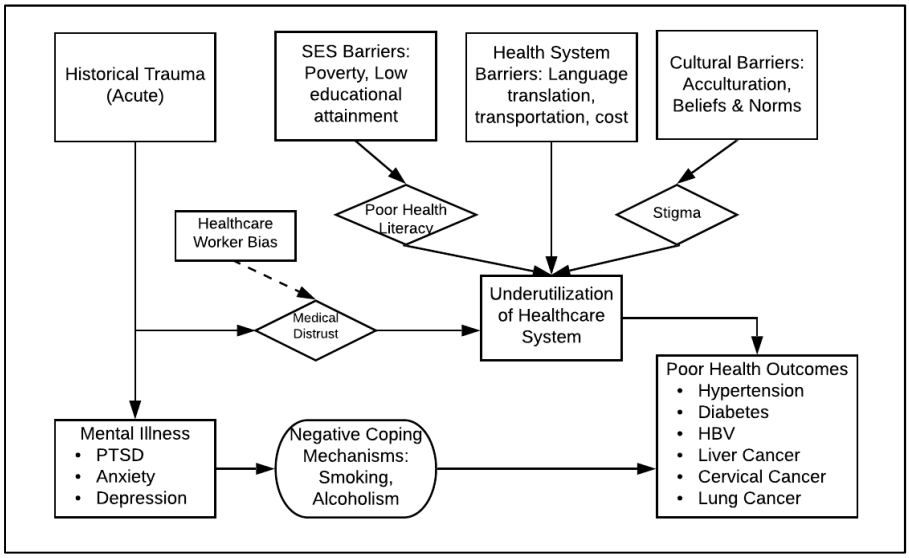

Figure 1. Conceptual Model

Previous research, both qualitative and quantitative, has established a foundational understanding of poor health outcomes, cultural factors, and basic access barrier for Cambodian Americans. However, the link between interactions with the healthcare system and health outcomes. The aims of study are to further explore the 1) health beliefs and values of Cambodian-Americans, 2) perceived factors that affect their healthcare experience, and 3) perceived factors that affect their health care seeking behavior.

Methods

This particular study is a qualitative analysis of a subset of data that was collected for a larger community-based participatory research study by the Community Health Board Coalition (CHBC) on the health needs and priorities of several different ethnic populations in the Seattle-Metropolitan area, including the Cambodian American community. The CHBC is a grassroots organization of 11 ethnic

health boards. The study and data instrument was designed with input from members of the different participating health boards and data collection was delegated to each health board to conduct in their own communities using methods that suited their needs. This study analyzes a subset of the data that was collected by the Khmer Health Board in the Cambodian American community.

Study Setting

Nearly 20,000 Cambodian people live in Washington, approximately 0.3% of the state population (U.S. Census Bureau, 2015). The study is set in the greater Seattle metropolitan area which includes King, Pierce, and Snohomish county, the counties that have the first, second, and third largest Cambodian populations respectively (CAPAA, 2019). After Los Angeles, and Boston, Seattle is the city with the third highest Cambodian population in the U.S. at 15,000 (Lopez et. al., 2015). Some of the largest Cambodian communities are concentrated in South Seattle in neighborhoods such as White Center, Holly Park, Rainier Vista, South Park, and Mt. Baker. After Seattle, Tacoma has the second highest population in Washington with approximately 3,384 Cambodians (U.S. Census Bureau, 2015).

Interview Guide Design

The original study used an Interview guide which consisted of 15 questions on the topics of health needs and priorities, factors that influence health and health care access, connection to community, community strengths, health behavior, trauma, and medical distrust. Five were yes or no questions that included prompts for further follow up and explanation from the interviewee. Although they were not formally categorized by topic, questions fell into the major domains of health beliefs, healthcare seeking behavior, and healthcare experience.

Health belief questions cover topics relating to perceived influences on the health of individuals and the wider community and values about what is important. It also includes descriptions of health etiology, and perceived factors influence their health and the health of the community. Health beliefs may help provide context behind participant's healthcare experiences, facilitating factors that could positively improve their experience or utilization of services, and other barriers to health. Connections between health beliefs and healthcare experience can be made both explicitly by the participant and implicitly in the analysis. Healthcare seeking behavior questions are aimed at understanding what impacts an individual's decision to use health services or seek treatment while health care experiences questions ask about specific interactions with the health system. These questions address the primary research aims by directly asking participants about their behaviors, barriers they face, and interactions with the health system.

Not all topics covered in the original interview guide pertain to the primary research questions. For the purpose of the analysis, the full dataset will be included as participant responses to other questions may still be relevant and inform the results. The following eight interview questions are the ones that are most pertinent to the primary research questions of this study and can be categorized under the three domains as:

Health Beliefs:

- Question 1: What do you and people in your community need to stay healthy?
- Question 2: Thinking of health broadly, what are the priorities in your community?
- Question 4: Are there any stressors that affect your community's health?
- Question 8: What are the strengths and forms of overcoming adversity in your community?
- Question 9: Has trauma made you or others in your community sick?

Healthcare Seeking Behavior:

- Question 7: Do you avoid health care services? If so, why?
- Question 5: Are there challenges for you and your community to access health care?
- Question 9: Has trauma impacted people's ability to access healthcare?

Healthcare Experience:

- Question 10: Do people in your community tend to have more positive or negative experiences with healthcare?
- Question 12: Is it difficult to establish providers from within your community? Outside your community?

Common definitions of health and trauma were developed and included in the interview guide. Health was defined to participants as a state of complete physical, mental, and social well-being. The interview guide described trauma as the results from an event, series of events, or set of circumstances experienced by an individual or community that is physically or emotionally harmful or life-threatening with lasting adverse effects on the individual's or community's functioning and mental, physical, social, emotional, or spiritual well-being.

Selection of Subjects

Study participants were recruited using the formal and informal networks of Khmer Health Board members who have ties to the Seattle-King County Cambodian community. Purposive and convenience sampling was used to capture specific groups based on age (young, middle aged, and elderly populations) and role in the community (advocates, health professionals, etc.).

The main community organizations and groups recruited were students at the UW, residents at Mount Baker Village housing, and a community group at Southwest Youth and Family Services. KHB board members used their informal or professional networks to first contact a community leader with access to these groups such as a case worker at Mount Baker Village or a UW Khmer Student Association officer. Convenience sampling was then used by advertising the opportunity to the communities through methods such as facebook posts, email lists, and cold calling until the goal of 60 participants was reached.

The criteria for participants included:

1. Self-identification as being of Khmer descent
2. Over the age of 18
3. Living in the Greater Seattle Area (King, Pierce, Snohomish County)

There were 35 individual qualitative interviews and 3 focus groups conducted using the interview guide. One focus group consisted of 8 participants from Mt. Baker Village Housing in South Seattle. The second focus group had 15 participants that were part of a community group at Southwest Youth & Family Services. The last focus group was made up of students from the Khmer Student Association at UW and had two participants. Thirty-five other participants were individually contacted for interviews and were community contacts of members of the Khmer Health Board. Overall, there were a total of 60 participants.

Data Collection

Data collection took place between October 24th, 2019 and December 8th, 2019. Interviews and focus groups ranged from 30 minutes to 1.5 hours. The focus groups were conducted face-to-face and took place in person. Two Khmer Health Board members facilitated the first focus group of 8 participants, 3 board members facilitated the second focus group with 15 partcipants, and 1 board member faciliated the third focus group with 2 participants. Interviews with separate individuals were conducted by one board member each and were completed both in person, face-to-face, or through phone interviews.

The protocol for a typical subject were as follows:

1. Participants receive the IRB Informed Consent document and are read the details of the study, emphasizing the voluntary nature of the study and ability to decline answering questions
2. After verbal consent is given, the participant were read the interview questions and notes taken by the facilitator giving the interview
3. After the interview was over, participants received a $50 gift card as compensation

Six Khmer Health Board members participated in data collection and worked to complete 34 individual qualitative interviews and 3 focus groups using one semi-structured interview guide with 15 questions. Two of the interviewers from the Health Board are certified Khmer interpreters and helped interpret for participants with limited English proficiency. Participants were not able to be audio recorded as per the IRB approved guidelines for the research project. The interpreter would recite the interview question in Khmer and then interpret participants' responses back in English. Notes were taken from the English translation of the responses. In cases where the participant mainly spoke Khmer and an interpreter was notetaker and facilitator, notes were transcribed in English.

Qualitative Analysis

Out of the 60 original participants in the original study, 50 were included in the analysis. Ten transcripts were excluded due to poor quality of the data. The criteria for exclusion included multiple unexplained yes or no responses, unsure or declined to answer responses, and one word or short responses. The responses were cross-referenced with other transcripts to ensure that no new information was being excluded from the analysis. Overall, there were 3 focus group transcripts consisting of 25 participants and 25 individual interview transcripts that were included in the analysis for a total of 28 transcripts.

An inductive thematic analysis was conducted on the transcripts using a two-phase coding process. In the first phase of coding, 3 transcripts with the richest data were chosen to do initial line-by-line coding using holistic and descriptive coding. This first phase resulted in 90 primary codes. In the second phase, the codes were compared and refined with some larger code categories added and some codes becoming subcodes. From this process, a codebook consisting of 47 primary codes and 15 subcodes for a total of 62 codes was generated with definitions and was then used to code the rest of the transcripts.

For the final analysis, codes were grouped under the three core categories of health belief, healthcare experience, and health seeking behavior. Within each core category, codes with similar concepts were grouped together which resulted into a total of 10 subcategories. Different code reports for each core category were then generated to reveal more abstract relationships between the core and sub- categories. Finally, sub-categories with similar or related concepts were grouped to discern major themes across the core categories.

Table 1. *Code Categories*

Core Category	Code	Subcategories	Themes
Health Beliefs	Preventative care	Conceptualization of health and well-being	Socio-cultural Influences Historical Trauma
	Environment		
	Exercise		
	SES Factors		
	Health needs		
	Nutrition/eating patterns		
	Health priority: low		
	Health education		
	Etiology		
	Community services and resources		
	Mental health	Health Concerns	Historical Trauma Socio-cultural influences
	Mental health: depression		
	Mental health: PTSD		
	Chronic disease		
	Stressors		
	Aging and isolation		
	Health priority		
	Cultural beliefs: collectivism	Cultural belief system	Socio-cultural influences
	Cultural beliefs: stigma		
	Cultural beliefs: traditional medicine		
	Cultural beliefs		
	Community building	Mediating Social Factors	Socio-cultural Influences
	Community building: events		
	Community building: spaces		
	Community connection		
	Community discord		
	Community strengths		
	Cultural disconnect		
Healthcare Experience	Access barrier	Barriers to access	Challenges Navigating the Healthcare System Socio-cultural Influences
	Access barrier: cost		
	Access barrier: health system		
	Access barrier: language		
	Lack of cultural competence	Quality of care	Challenges Navigating the Healthcare System Historical Trauma
	Medical distrust		
	Provider identity		
	Provider trust		
	Medical bias		
	Inadequate services		
	Experiences of trauma		
	Patient-provider relationship		
	Efficacy		
	Efficacy: misdiagnosis		
	Efficacy: customer service		
	Health literacy	Resource navigation	Challenges Navigating the

	Acculturation		Healthcare System
	Health insurance coverage		
	Avoidance	Decision-making behaviors	Challenges Navigating the Healthcare System
	Delay of care		
	Convenience		Socio-cultural Influences
	Peer learning	Alternative healing strategies	Socio-cultural Influences
Healthcare Seeking Behavior	Social support		Historical Trauma
	Talk therapy		
	Trauma healing		
	Mental health: coping strategies		
	Intergenerational trauma	Historical trauma	Historical Trauma
	Impact of trauma		
	Impact of trauma: cognitive functioning		
	Impact of trauma: emotional		
	Negative coping mechanisms		
	Intergenerational tension		

Findings

Participant Demographics

A total of 50 Cambodian Americans were included in this study. Participants ages ranged from 19-75 with an average age of 46.5. 37 participants were female while 13 were male. 31 participants are immigrants or refugees with the average age at immigration/arrival in the U.S. of 29.8. Additionally, the average age of immigrants was 60.5 while the youngest immigrant was 28 years old. Focus group 1 had 8 participants with 5 females, 3 males, an average age of 63.6, and an average age at immigration of 30.3. Focus group 2 had 15 female participants with an average age 62.4, and an average age at immigration of 32.8. In the third focus group the two female participants were both 19 years old.

Table 2. *Participant Demographics (N=50)*

		n	%
Gender	Male	13	26
	Female	31	62
Age Group	19-37 (Young adult)	21	42
	38-56 (Middle-aged)	9	18
	57-75 (Older adult)	20	40
Immigrant Status	Yes	31	62
	No	19	38
	Mean Age at Immigration	29.8	--
Employment Status	Yes	26	52
	No	24	48
Public Benefits Status	Yes	23	46
	No	27	54
Regular Nurse or Doctor	Yes	36	72
	No	10	20
	Declined to Answer	4	8

Themes

Participants overall healthcare experience are characterized by three major themes: challenges navigating the health system, socio-cultural influences, and historical trauma.

Theme 1: Challenges Navigating the Health System

Participants commonly encountered challenges using health services which manifested in the sub-themes as access barriers, health literacy & self-efficacy, and provider cultural competence.

1.1 Access Barriers

Many of the reasons participants gave for being deterred from using health services derived from accessibility issues due to cost and health insurance coverage. Despite many participants listing use of preventative care as important for overall health, many of the participants were concerned about the cost of healthcare while two participants specified that they avoid healthcare services due to the co-pays being too high. Possible cost associated with health services factored highly in people's decisions to delay care or prioritize their health. While most participants were not specifically against using healthcare services, the potential for getting billed too much led to many claiming they would not go until they were very sick. Among the alternative strategies they used traditional health services were traditional medicine, over-the-counter medicine, or waiting out the sickness.

Having health insurance coverage was related to keeping up regular visits to the doctor for a few participants. However, the presence of health insurance can be undermined by inadequate coverage or confusion about what services are covered. Some interviewees conveyed a lack of motivation to go to a doctor's visit if other extended services such as prescription medication would not be covered by insurance, rendering seeking treatment futile.

A shortage of Khmer interpreters was a major barrier for older adults. Phone interpretation was seen as inferior with one participant saying that it is "hard to connect through phone translation, it's not personable and harder to communicate and see what the real issue is" (FG3, young adult). While children are sometimes available to act as interpreters, patients can still experience difficulty understanding due to the use of medical terminology. For some participants, this impacted their perception of the efficacy of going to see a provider and discouraged them from making regular visits.

1.2 Health Literacy & Self-Efficacy

For many of the older participants, health literacy and acculturation were closely tied concepts. Higher levels of acculturation, which included language ability, corresponded to being better able to navigate and understand a Western health system. However, even those with better English proficiency

found aspects of the health system to still be too complex. As one participant put it: “forms are difficult to understand and written poorly even for those who can read or understand English” (P2, age 26).

Another component of health literacy is the knowledge of one's health, health concepts, and available resources. There is a lack of understanding about the different aspects of healthcare, such as insurance, as well as where to find and apply for resources that can aid people’s ability to access health services. The level of health literacy influenced participants' sense of self-efficacy in their interactions with providers. For those with low health literacy, there can be a power imbalance in the patient-provider dynamic.

An unequal power imbalance can lead to patients being unable to properly communicate their health concerns and have their needs addressed during a visit with a provider. Many participants expressed that their health concerns were being overlooked or that they were not being diagnosed properly but were fearful of challenging the authority of the provider. Youth, who in general were non-immigrants and more acculturated, had less issues with advocating for themselves:

> “I feel that I have a good understanding about my health and I know what I want to improve on for myself. If my provider doesn’t align their practice with what my health goals are then I have the confidence to seek out a different provider.” (P33, age 26)

Low health literacy can not only undermine the accessibility of health resources that are available, but can also lead to negative experiences during interactions with the healthcare system.

1.3 Provider Cultural Competence

Poor communication from providers and low cultural competence also discouraged many participants from accessing health care due to negative interactions. Providers failure to tailor explanations to the patients led to misunderstandings and less efficacious advice. Patients recounted not being able to fully understand the treatment they received because the doctor gave too much information or used complex language. In a few cases, this interfered with their treatment as some participants later learned that they ended up misusing medication or even felt that they had been overprescribed. Some felt that providers did not understand their cultural or historical backgrounds, which led to poor advice, such as nutrition guidelines that conflicted with people’s cultural practices.

Some participants also experienced feelings of dismissal, belittlement, and judgement from providers. A few brought up health concerns during visits that the provider never addressed. One participant witnessed how some people in their community were “afraid to be honest with their providers because of fear of judgement from them, such as if they take an herbal supplement or use

coining as a method to relieve pain" (P33, age 26). The negative experiences with providers contributed to fears of communicating health concerns and can possibly lead to missed diagnoses.

Theme 2: Socio-cultural Influences

Participants commonly referenced socio-cultural influences in their lives which have affected their health and healthcare in both negative and positive ways. These influences can be characterized by the sub-themes of stigma and social support.

2.1 Stigma

Cultural stigmas around some health topics were perceived to be a barrier to accessing care. Mental health was revealed to be a major health priority throughout most of the interviews. Younger participants especially conveyed the prevalence of mental health issues among themselves and in their families. However, they observed that prevailing silence and avoidance around the topic prevents people from admitting that they suffer from mental illness or openly discussing it in the community. One participant notes that there is a negative perception about mental health saying: "people don't like to talk about it or think it is negative and you are seen as "crazy" (P7, age 29). The idea of the Cambodian community being close-knit was even a source of concern for some as it can exacerbate stigma for fear of gossip and rumors spreading.

Due to the lack of acceptance around mental health, some youth found it difficult to open up and talk about the issue with family members. One participant pointed towards a larger cultural issue that impacts decisions to seek care:

> "People are taught to stay strong, power through issues, bottle up feelings, don't show weakness, only show your best self... going to a doctor can be seen as showing weakness." (P18, age 20)

Additionally, for youth, sexual and reproductive health came up as a topic that they avoid bringing up with parents due to cultural stigmas. For one participant this led to them being afraid of their parents finding out if they've gone to the doctor, only becoming comfortable seeking out sexual and reproductive health services after leaving for university.

2.2 Social Support

Common to all participants was the primacy of social support and reliance on family and other people in the Khmer community to influence overall well-being as well as in navigating, accessing, and interacting with the healthcare system. Many cited contacting close friends or family as their first step in their care seeking process and showed a preference for advice from peers whom they trusted before

health professionals. Generally, people were more open to advice from people within the Khmer community.

The role of children and people in the younger generation as navigators was evident among all ages of participants. One of the youth participants demonstrated this by describing their role as an interpreter for their grandparent's primary care appointments which directly contributed to them having a positive experience in healthcare. Some of the older participants reported having difficulties navigating the healthcare system or even delaying care if they did not have someone available for support. One participant said of what they would do if they were sick: "if you cannot speak language or have no children to call or they do not pick up the phone, then you are stuck" (FG2, older adult).

Both youth and older generations believed that community groups, cultural gatherings, and physical meeting spaces were major factors in fostering a network of social support. Elders expressed concern about feeling lonely and isolated but that socializing with others in temples or community centers helped them feel less stressed: "most of us are Buddhist so we rely heavily on the temples as our support system mentally and physically" (P17, age 55). Many participants expressed similar beliefs that having places to do activities or bond with one another were important for health and well-being. The act of socializing in other physical spaces was also conceptualized by many of the older adults as a form of exercise and physical activity.

Community spaces also allowed opportunities to share their thoughts, discuss, and unburden themselves with others. One participant who attends a community group remarked: "It helps to talk to others and connect with others to deal with the bad memories" (FG2, older adult). While seeking formal mental health treatment was generally felt to be stigmatized, some participants were open about talking with their peers to cope, indicating a level of acceptability in acknowledging sensitive issues with those who have had common experiences.

Theme 3: Historical Trauma

Historical trauma from experiencing was a prevalent topic for both youth and older adults. The majority of participants agreed that trauma has made their community sick and brought up trauma from the Khmer Rouge as a concern in the community, something they have personally experienced, or have witnessed in family members. Experiences during the war were conceptualized by many of the older generation as causing them stress and being an emotional burden that they struggle to cope with in the present day. One participant noted that:

> "Trauma makes me sick...it's hard to deal with. Because of war everyone has a wound in their heart, everyone tries to move on but the wound is still there." (FG2, older adult)

Some of the impacts of trauma are mental illnesses such as post-traumatic stress disorder (PTSD) and depression. Others described symptoms they experience, such as trouble sleeping and affected cognitive functioning. For example, participants mentioned that it has affected their memory negatively, made it difficult to process things, and caused feelings of being overwhelmed. As a result of experiencing trauma, participants theorized that other people in the Khmer community turn to negative coping mechanisms such as alcohol and gambling. Overeating and unhealthy eating was also cited as a coping mechanism, which one participant attributed as partially stemming from experiencing starvation during the war.

According to the interviewees, trauma has also impacted people's interaction with the healthcare system. One way it has done this is contributing to a distrustful medical system as a result of becoming more guarded about the intentions of others and their own safety after having bad experiences with doctors in the refugee camps or from other authority figures. One participant expressed that people in the community did not want to look vulnerable or have their personal matters used against them. Another expressed that the war:

> "killed trust in members of the community. Some people feel like if they attempt to look for help something bad will happen... if someone offers help they feel like that person might have ulterior motives." (P21, age 21)

Reluctance to seek healthcare as a result of historical trauma seemed to come from generalized distrust and qualms about entrusting others with their health, which was viewed as highly personal. Fears about potential repercussions and authority figures from past experiences echoed into refugees perception of healthcare. However, interactions with the healthcare services was also cited as a potential source for further trauma and stress, particularly with emergency care. People recounted feeling confusion and having their privacy invaded in their encounters with emergency services.

While most of the older generation participants admitted to being affected by trauma, seeking care for their symptoms were complicated by cultural conceptions of trauma and perceived shortcomings of healthcare services. A few interviewees pointed towards a lack of awareness around mental health concerns that arise from trauma experiences. Cambodian Americans may not perceive PTSD as a medicalized health condition that is possible to treat, or one that necessitates pursuing health services.

> "Khmer people can speak of their trauma very bluntly, but there is a lack of vocabulary that encapsulates those experiences as a disease because Khmer people traditionally associate sickness with physical pain, the impact of trauma is overlooked in their idea of wellness." (P17, age 55)
>
> "PTSD is prominent in the community. Even though we went through 3 years, 8 months and 23 days of the genocide, the impact is not repairable" (P17, age 55).

For those who do recognize the health impacts of trauma, they may experience roadblocks in receiving care by not having their symptoms recognized or receiving further treatment from the provider. A couple participants described how physicians missed some of symptoms they were experiencing because they were probably not aware of their background and did not know what to look for. Another explained that while they approached the doctor with concerns about their symptoms, they did not receive medication or further treatment.

Discussion

This study gave insight into the factors that contribute to the negative and positive healthcare experiences of Cambodians Americans in the Seattle area. While participants described barriers and challenges in more depth than facilitators, not all participants personally had negative experiences. Many spoke towards larger community issues or those of friends and family. For example, some factors such as language barriers were commonly cited among all all participants as an issue for accessing and receiving quality care. Younger participants who were born in the U.S., adults with higher English proficiency, or immigrants who had family available to support them did not necessarily experience as much difficulty navigating the healthcare system as others. However, larger systemic issues such as lack of Khmer interpreters to serve enough of the population were still acknowledged as factors that affect the overall Cambodian American community. Additionally, participants spoke to larger socio-cultural influences, such as stigma, which did impact their personal behaviors and experience.

Overall, the results of the analysis supported many of the findings and theories from the literature and conceptual model. Health systems and cultural barriers contribute to avoidance and underutilization of health services. Factors in healthcare seeking behavior were revealed to be partially motivated by socio-economic barriers such as cost of healthcare and low health literacy. Although these concerns are not unique to the Cambodian-American community, they were exacerbated by the immigration status and experience of trauma experienced by older participants. This study adds that the experience of historical trauma may not only be linked to poor health outcomes, but also acts as a mediating factor for healthcare utilization. Acculturation stress and historical trauma made navigating

and using healthcare services more stressful. Compounded with a lack of cultural competence in the providers that they encountered, some participants expressed distrust and lack of confidence in the health system to meet their health needs. There is a need beyond cultural-tailoring to avoid potential re-traumatization and address physical health through trauma-informed practices.

Some of the findings of this study has implications for the possibility of further exploration. Younger participants were highly involved in the healthcare of their parents and families in addition to talking about their own health. Exploring the relationship between first and second generation immigrants could help reveal more about the overall healthcare experience of Cambodian Americans as well as the unique issues that youth may be dealing with. While many youth mentioned intergenerational trauma as a concern, most did not go into detail about their personal experience of it or how they see it manifesting in their community. The impact of intergenerational trauma on youth's experience of healthcare warrants additional study and comparison to older adults' experience of historical trauma. Additionally, participants' reliance on social networks outside of the formal healthcare system for both advice and as a means of healing points towards the potential of developing community based methods for health education as a means for improving health access.

Limitations

One of the major limitations of the study was that recordings were not able to be taken during interviews. The analysis relied on notes taken from interview facilitators. Additionally, due to the limited capacity of the Khmer Health Board, more than one note taker was not available and often the interviewer and notetaker were the same person. This might have introduced bias as the facilitators must decide what responses are important or relevant enough to record. Additionally, only one person worked on the analysis and coding process. Therefore, inter-rater reliability could not be established, limiting the overall validity of the analysis.

The generalizability of the study is also limited by the sampling method and demographics of participants. The use of convenience sampling limits the applicability of responses to the wider Cambodian American community. The participants who were recruited were affiliated with organizations that Khmer Health Board members have a pre-existing relationship which may lead to an overrepresentation of some characteristics. For example, youth had higher educational attainment as they were recruited from the University of Washington while the focus group's involvement in the community group at Southwest Youth and Family Services indicated a willingness to engage in wellness activities that may not be as common to the rest of the population.

The convenience sampling also led to a skewed demographic. The majority of participants identified as female. This could potentially obscure any gender differences in themes and responses especially in regards to cultural beliefs and norms. Only 9 participants were from the middle age range of 38-56, about half that of the younger (19-37) and elderly (57-75) age groups. This can obscure different priorities, beliefs, and experiences of middle aged Cambodian Americans and the results may reflect a more extreme contrast between young and old generations, rather than a nuanced depiction of intergenerational relationships.

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