Cultural themes in family stress and violence among Cambodian refugee women in the inner city

Cambodian refugee women frequently face the cumulative trauma of war experiences and cultural adaptation to the American inner-city environment. This qualitative study investigated cultural beliefs, coping strategies, and management of family stress among Cambodian refugee women living in the inner-city environment. Focused and open-ended interviews were conducted in the informants' homes using the Cambodian language. Stressful and violent events were managed by nonconfrontation and withdrawal. These two themes are hypothesized as the culturally identified means by which inner-city Cambodian refugee women control and harmonize situations of stress. Further study is needed to develop the theoretical base for developing culturally sensitive nursing intervention strategies with this high risk population. Key words: Cambodian refugee women, cultural themes, inner-city violence

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THE PAST TWO YEARS have witnessed increasing global refugee emergencies as well as deterioration in existing refugee and internal displacement situations.[1] This increasing escalation in refugee movements is preceded by years of conflict and constant danger for many population groups, including the Cambodians situated on the border of Thailand and Cambodia.[2] Among those refugees who have been resettled into the United States, conflict and danger have not necessarily disappeared. As of 1990, it is estimated that 147,000 Cambodians (Khmer) live in the United States, mostly in the large metropolitan areas of southern California and Massachusetts, where additionally they daily face the stress and violence of inner-city life.[3]

The Khmer in America bring with them the cumulative traumas of war, separation from and death of family and friends, cultural disruption, torture, the experience of Communist reeducation camps, escape to and life in border and refugee camps, and the cultural

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adjustment to the American society. In most cases, this adjustment has been to the inner-city environment. These refugees in America began arriving in 1980 as a part of the second wave of migration from Southeast Asia. Most were rural semiliterate or illiterate survivors of the Communist Khmer Rouge rural reeducation camps.[4]

Based upon the psychosocial stressor severity rating of the American Psychiatric Association classification for mental disorders [DSM-III], the Khmer refugee population has endured more than any other refugee group collectively.[5] The Khmer have been identified as the Southeast Asian population at highest risk for stress-related problems resulting from their prior experiences.[6-10] In one epidemiologic profile of 378 Cambodian refugees conducted in Santa Clara county, northern California, of all the Indochinese groups studied, the Khmer were found to be the least educated, most ill, and most depressed across all ages.[9] Common stress-related problems identified by other researchers include suicide, somatization, posttraumatic stress syndrome, and sudden unexpected death syndrome [SUNDS].[8,10-13] This literature on stress among Khmer refugees has focused mainly on past traumatic experience, rather than examining the current experience of adjustment and cultural adaptation within the inner-city environment. Likewise, nursing research and literature on refugees has tended to focus on adjustment issues, although not specifically within the milieu of the inner city.[14,15] Psychologic and therapeutic approaches have addressed prior traumatic experience and cultural differences rather than current cultural adaptation within the framework of the inner city. The experience of refugee women as a subset of refugee literature has paralleled these same issues.[16-19]

The research presented in this article is a postdoctoral follow-up study evolving from research on health care decision making among Khmer women.[20] The doctoral ethnographic study of 30 Khmer women refugees in southern California evolved from 5 years of participatory observation with the Khmer in America and prior research by the first author on traditional health practices in Khao I Dang refugee camp in Thailand. The cultural theme of equilibrium predominated as the basis for health-seeking behavior and was identified as the reference point from which culture-bound syndromes were defined. Among others, one key culture-bound syndrome identified was *koucharang*, described as "thinking too much."[21] The focus of the follow-up study was the exploration of perceptions of stress and violence, and management of koucharang among Khmer women and their families within the context of the inner-city environment.

PURPOSE OF THE STUDY

The purpose of this study was to examine cultural beliefs, taboos, coping strategies, and management of family stress and violence among Khmer refugee women within the context of the inner-city environment. It was assumed that the culture-bound syndrome koucharang would emerge as a part of the belief pattern, and that management strategies for this syndrome would be identified and described.

RESEARCH QUESTIONS

Khmer refugees within the inner-city environment are on the horns of a dilemma.

On one hand, they have an ancient and rich cultural tradition informing them on beliefs and behaviors. On the other hand, the American inner-city cultural environment permeates their daily lives and demands attention and conformity. Conducting a study of Khmer refugee women within the inner city involved addressing both the traditional cultural beliefs and the adaptation of beliefs and behaviors to accommodate to the environment. Twelve research questions were addressed to the informants:

1. What behaviors are culturally recognized as indicating a stressful state?
2. What are the perceived causes of stress?
3. Which of the perceived causes of stress are perceived as the most potent causes?
4. What are the taboos imposed by the culture when a person is in a stressful state?
5. Which of these taboos are perceived as most important?
6. What coping strategies for stress does the culture dictate?
7. Which of these strategies are most important?
8. What should the family do to help the person who is stressed?
9. What should the women in the family do to help the person who is stressed?
10. What is the perceived effect of stress upon the family unit?
11. What are the cultural dictates for the management of violence in the family?
12. What are the cultural dictates for the prevention of stress?

DESIGN AND METHODOLOGY

The study was conducted in two regional sites, Long Beach, California, and Lowell, Massachusetts, from January through March 1991. The interview tool was pretested in both sites prior to the initiation of the study. Access to the Long Beach Cambodian population was a function of 5 years of prior experience both in the United States and in Thailand, which involved participatory observation and trust-building. Entrance into the Lowell Cambodian population was a function of 4 years of experience with refugee populations in camps on the Thailand border as well as established contacts within the Cambodian population of Lowell. Both investigators have educational backgrounds and extensive clinical and teaching experience in community health nursing.

Data were collected in the Khmer language using alternate translation. Focused and open-ended interviews were conducted in the inner-city homes of the informants. Such approach is the recommended strategy for cross-cultural studies attempting phenomenologic description.[22-24] Each investigator worked collaboratively and consistently with one on-site trained female Khmer translator/culture broker who came from a background and experience similar to the informants' and was known to the study population. Each informant was interviewed for a period ranging from 1 to 2 hours on one occasion. Initial contact with the informant was made in advance by the translator/culture broker who explained the purpose of the study, assured confidentiality, and arranged the appointment time. As a result, there was minimal difficulty with attrition in this study.

Initial exposure during the interview included adherence to cultural expectations including the removal of shoes, culturally correct sitting posture, and acceptance of ritual drinks as offered. The translator built cultural bridges by linking the investigator

with Khmer experiences, both in the refugee camps in Thailand and in the United States. In most cases, informed consent was obtained verbally and witnessed by the translator, as the majority of informants were functionally illiterate in both Khmer and English. The written consent form was available in both Khmer and in English.

Initial interview questions revolved around the family.[25,26] Subsequent interviewing addressed the research questions. The interview concluded with demographic questions and social interaction to deintensify the mood of the interview. Each informant was given a small culturally appropriate gift. Most interviews consisted of only the informant, investigator, and translator. However, as is realistic in community health nursing, other family members sometimes drew close, particularly the children, who would sit next to or on the lap of the investigator. Although such interaction theoretically could change the output of data, it was not discouraged as it appeared to enhance the emotional warmth and trust within the interviewing process.

No electronic recording devices were used during the interview process. On occasion the Khmer Rouge used electronic recording devices as means of verifying data or establishing confusion or guilt. Therefore, the investigators decided that such machines could potentially terrify the informants and could decrease the quality of data.

SAMPLE SELECTION

A community network sampling technique was employed to reach 120 Khmer refugee inner-city women. Sixty informants were interviewed in the Long Beach, California, cohort. These women were selected from 10th Street and the surrounding enclave area of Khmer residences within the city of Long Beach. Sixty informants, likewise, were selected in the Lowell, Massachusetts, inner-city Cambodian enclave.

ANALYSIS

Demographic characteristics of the sample were analyzed descriptively. The research questions were analyzed for frequency and rank order of response. Content was analyzed using triangulation of data from responses and from observation. Data patterns were used in the identification of cultural themes. Narrative data as well as responses to focused questioning were included.

LIMITATIONS OF THE STUDY

One limitation of the study included limited Khmer language fluency on the part of the first author and lack of Khmer language fluency on the part of the second author. Both translators were highly fluent in both English and Khmer. A second limitation was possible bias in response by translation error or deletion by face-saving efforts on the part of informants. This limitation was assumed to be controlled to some extent through the development of trusting relationships with the translators, through orientation of the translators to the interviewing process, and through adherence by the investigators to culturally correct behavior prior to and during the interviewing process.

ETHNOGRAPHIC BACKGROUND FRAMING THE STUDY

In a densely populated region of the world, Cambodia remains an underpopu-

lated agrarian society. Population growth rate has been slow, estimated at 2.2% per year with a crude death rate of 47.8/1,000. The United Nations estimated life expectancy is 44.2 years for men and 43.3 years for women with high mortality during the childbearing years. Prior to the holocaust, most of the population lived in small hamlets of 100 to 300 persons governed by an elected headman.[27]

Cambodia came to the attention of the Western world when its fertile rice fields were cratered by B-52 saturation bombings. Cambodia plunged into starvation, massacre, and civil war under Pol Pot's communist Khmer Rouge reign of terror. One third to one half of the country's population died within the 4 year period of 1975 to 1979. There was almost complete destruction of the educated class, particularly doctors, nurses, and teachers. This massacre was followed by mass refugee migration of rural peasants to the Thailand border when the Khmer Rouge were defeated by the invading Vietnamese troops in 1979.[28-31]

Prior to the holocaust period, very little anthropologic work was done among the Khmer. One well-recognized prerevolutionary work done in rural Cambodia was that of Ebihara.[25] In her ethnographic field work, she describes Cambodian culture as insular and tradition-bound, filtered through the philosophy of Buddhism, which espoused maintenance of harmony. Open confrontation was uncommon. Behavioral characteristics highly valued were generosity, avoidance of competitive behavior, humility, joviality, and gentleness toward the natural world and toward children. The temple (wat) was the moral, social, and educational center of the society. In order to "make merit" (ie, accumulate blessings for future incarnations) food was brought to the temple, monks were honored, and mercy was shown to those with problems.[25]

Cambodian culture values relationships over organization and accomplishment. About prerevolutionary Cambodia, Whitaker writes, "One of the striking aspects of Cambodian society is the high degree of homogeneity found among its majority group, the ethnic Khmer."[27(p1)] Characteristics corrected in children included selfishness, display of anger, and a competitive spirit.[25] In a study of Khmer public school children in San Francisco, Bit[32] found that academic achievement among the children was enhanced when they were placed in cooperative rather than competitive activities.

The traditional ethnomedical system was pluralistic in the attribution of causation of illness. Naturalistic causes of illness were identified as imbalances resulting in loss of body harmony. "Hot" and "cold" forces and "bad winds" within the body were treated with oppositional foods and treatments. Personalistic causes of illness resulted from incorrect actions, which aroused the anger of the "neak ta," the guardian spirits. Blended with this animism were other spiritual explanations of illness evolving from Buddhism, defining life as characterized by suffering and advocating "merit-making" activities to avoid suffering in future incarnations. A complex system of healing and shamanism addressed the etiology and treatment of illness. These belief systems have persisted and permeate the world view of Khmer refugees.[33-37]

In the context of this stable societal system came a devastating war and the imposition of a social regime that attempted to obliterate the culture of Cambodia. The re-

sulting disruption has severely stressed the fabric and fiber of the culture. Superimposed upon this disruption has been the introduction of inner-city American culture into the lives of a southeast Asian agrarian people whose world view and behavioral expectations sharply contrast to urban life. As one refugee resettled in Long Beach, California, commented "What am I doing here? I am a rice farmer and no one needs a rice farmer in Long Beach."

FINDINGS OF THE STUDY

Demographically, the total sample (N=120) showed minimal variation from the profile of the east and west coast cohorts. Household size was large by American standards. Educational level and annual family income were generally low, with the Long Beach cohort having slightly higher income. Fifty-seven percent of the informants in the Lowell cohort had single head of household status as compared to 28% of the Long Beach cohort. In addition, the Lowell cohort was more likely to have dependent children under the age of 18 years. The Long Beach cohort was slightly older than the Lowell cohort, with 40.24 years being the mean age of the total sample. The mean period of residency in the United States was 6.83 years. In summary, the Lowell cohort was slightly poorer, younger, less educated, less frequently married, and had more young dependents. (See Table 1.)

Culturally recognized stressful behaviors

Informants were asked to identify and rank order the behaviors of a Khmer person who was thought to be having the culture-

Table 1. Demographic profile of informants

Variable	Total sample (N=120) mean	Lowell cohort (N=60) mean	Long Beach cohort (N=60) mean
Household size	4.59	5.07	4.83
Number of dependent children	2.42	2.95	1.89
Years of school in Cambodia	1.26	0.88	1.63
Years of school in US	0.90	0.93	0.87
Period of US residency in years	6.83	6.32	7.33
Annual income	$12,823	$11,333	$12,999
Age of informant in years	40.24	38.42	42.07

Table 2. Culturally recognized stressful behaviors

Behavior	Total sample (N=120)	Lowell cohort (N=60)	Long Beach cohort (N=60)
Complaint of headaches	89 (74%)	53 (88%)	36 (60%)
Somatic chest complaints	66 (55%)	36 (60%)	31 (52%)
Excess sleep pattern	55 (46%)	25 (42%)	30 (50%)
Withdrawal	47 (39%)	20 (33%)	27 (45%)

bound syndrome koucharang or thinking too much. Both cohorts identified complaints of headaches as the most prevalent behavior indicative of koucharang. Somatic complaints of chest pain, palpitations, and shortness of breath were the second most frequently reported behavior, followed by excess sleeping and withdrawal. (See Table 2.) One informant described her battle with koucharang as follows, "I think too much until I think I am crazy."

Perceived causes of stress

Informants were then asked to identify and rank order the causes of thinking too much. Haunting memories of the Khmer Rouge regime were the most potent cause of stress identified by 93% (n=56) of the Long Beach cohort. One woman stated, "All my children died during the Pol Pot time. I think too much about death." Seventy-seven percent (n=46) of the Lowell cohort identified financial difficulties as the main cause of thinking too much. As previously noted, the Lowell cohort was poorer and had more dependent children than the Long Beach cohort. Women in the Lowell cohort stated that in Cambodia one person's labor could provide for the whole family, while in Lowell everyone had to work to barely support the family. Other stressors perceived as causing thinking too much included family conflict, difficulties with English language acquisition, and coping with the American culture. Oblique indicators of violence within the family system were revealed in the following statements. One mother said, "I used to hit the children a lot when I was thinking too much, but not now."

Cultural taboos

Taboos surrounding koucharang were elicited from the informants and rank ordered as to the importance of the taboo. The strongest and most important taboo identified by 79% (n=96) of the sample was the prohibition on the use of alcohol when thinking too much. The Lowell cohort identified avoidance of street drugs as the second most important taboo (82%, n=49) whereas 30% (n=18) of the Long Beach cohort identified avoidance of sad thoughts as the second most important taboo.

Cultural coping strategies

Informants at both sites were consistent in the identification of an avoidance strategy for coping with koucharang. The strategy of avoiding sad thoughts and of being alone was the top ranked response (56%, n=67). However, comments emerged during the interviews that indicated other ways of coping. For instance, suicide was obliquely yet frequently mentioned as an alternative. One woman said, "When I can't think of any solution, I think to commit suicide. Then I would have no problems. Many Khmer women think to do this."

Management of stress within the family

When asked to describe how the family should help the person with koucharang, the avoidance strategy was again clearly defined. The first ordered response was to encourage avoidance of the problem by using encouraging words and discouraging the person from entertaining sad thoughts (54% of responses). The second ordered response also paralleled the above-described cultural coping strategy. It was to ensure that the person with koucharang was not left alone (18% of responses). The question on management of stress within the family elicited many comments, which were frequently delivered with laughter. The authors have noted this behavior among the Khmer in the refugee camp sites as well as in the United States. In her book *Spirit of Survival*, Gail Sheeney describes the experiences of her adopted Khmer daughter, Mohm, who was orphaned and forced into slave labor in a re-education camp under the Khmer Rouge. Mohm describes her ability to cope as "always something to laugh."[38]

The woman's role in the management of stress within the family

Informants were asked about the role of the woman in mediating stress in order to identify differences in perception of the role of the family in general versus the role of the woman in particular. The response to this question was practically nil among the Lowell cohort. Further probing revealed frustration with perceived lack of ability to help other family members. Comments such as "What's the use?" or "No one can help" were common among this cohort. Among the Long Beach cohort, 73% of the responses identified the avoidance strategy of using encouraging words and discouraging sad thoughts. The second ranked response (26% of responses) was, as described above, to ensure that the stressed person was not left alone. The Long Beach cohort of women mainly discussed their role in family stress management in relation to their husbands. One woman commented, "My husband thinks too much. He thinks to kill himself. I tell him to forget his sad thoughts." A distinct role in stress management separate from the family at large was not identified.

The effect on the family unit

Informants were asked to recall the last time a family member was thinking too much. Then this question was probed to identify the behavior of the individual, the effect on the family, and what events had happened immediately before the person experienced thinking too much. Among the Long Beach cohort, the most frequent response regarding the behavior of the stressed person was withdrawal (68%, n=41). Lowell informants also named with-

drawal most frequently (55%, n=33). When asked to describe the effect on the family, 50% (n=30) of the Long Beach cohort and 63% (n=38) of the Lowell cohort stated that the family chose to forget about the behavior and not to think about it. Thirty percent (n=18) of the Long Beach informants and 37% (n=22) of the Lowell informants stated that the behavior made the family feel sad and depressed. The question was further probed to asked about the effects on children in the family. Twenty-eight percent (n=17) of the Long Beach respondents and 32% (n=19) of the Lowell respondents said that the children were not affected at all because they were too young to understand. In contrast, one informant commented, "The children get so upset. I feel sad for the children and I try to make them laugh and tell them to forget about it." Another said, "The children know but the best thing is to make them happy. I don't want them to think too much also."

Lowell informants named lack of money as the most important precipitating event prior to experiencing koucharang (78%, n=47). Fifty-five percent (n=33) of the Long Beach cohort and 57% (n=34) of the Lowell cohort identified flashbacks and nightmares as the immediate precipitating event prior to the emergence of koucharang in a family member. One flashback experience was described as follows, "The children make too much noise. My husband doesn't like sudden noise. He gets numbness when he hears a sudden noise."

Management of family violence

Informants were asked what they would do if a family member suffering from koucharang became physically or emotionally violent. Eighty-two percent (n=49) of the Long Beach cohort and 63% (n=38) of the Lowell cohort stated that they would talk softly to the person. The second most frequent response among the Long Beach cohort was to do nothing. Twenty-five informants (42%) commented that they would never call the police and that they would keep the problem within the family. Four informants stated they would not call the police because they cannot speak English. However, 50% (n=30) of the Lowell cohort said they would call the police if necessary. Fortunately, both communities have developed survival skills programs to teach illiterate and non-English speaking persons how to access emergency services.

The issue of spousal abuse was not directly inquired about nor was it directly discussed by informants. However, there were oblique indicators that it is not uncommon. One informant said, "Most Khmer men, they hit their wives but the women don't know who can help."

Cultural dictates to prevent stress

Informants were asked to describe the best way to prevent a person from thinking too much. The idea of preventing stress seemed to surprise the informants, a finding that, interestingly, did not emerge in the pretesting. Eighty-five percent (n=51) of the Lowell cohort stated that there was no way to prevent thinking too much. Twenty-three percent (n=14) added, however, that it was important to keep busy and forget sad thoughts. Among the Long Beach cohort, the most prevalent response was to keep busy and forget intrusive thoughts (45%, n=27). Twenty percent (n=12) refused to accept the idea that prevention was possible. One informant stated,

It's impossible to stop to think too much. When I sit quiet, millions of thoughts come. When I get busy, I forget but when I stop it all comes back. Nothing can help. No one can help. I can't even help myself. (The informant laughed as she made these statements.)

None of the informants described a truly preventive approach, but a way to keep "thinking too much" under control was described as follows:

I have thought about this many times. I don't really have an answer except to keep it inside. When a person lets feelings out, it doesn't get any better. It is best to encourage to keep inside, not to complain or cry. Just forget it.

Use of mood altering drugs to control stress

Informants were asked to describe personal and family patterns of drug and alcohol use. A high proportion of the Long Beach cohort denied alcohol use (82%, n=49) as compared to the Lowell cohort (43%, n=26). Forty-two percent (n=25) of the Lowell cohort admitted to the use of alcohol for stress and pain control. Personal or family drinking problems were basically denied among the total sample with little regional difference (93%, n=112). Use of prescription drugs, primarily sleeping pills to reduce stress and to block emotional pain during the daytime, was heavy among the Long Beach cohort, (58%, n=35) while only 20% (n=12) of the Lowell cohort used sleeping pills in this way. None of the informants admitted to the use of street drugs. Use of street drugs by other members of the family was admitted to by 15% (n=9) of the Lowell cohort and completely denied by the Long Beach cohort.

DISCUSSION OF THE FINDINGS

"The cardinal principle in qualitative analysis is that causal and theoretical statements be clearly emergent from and grounded in field observation. The theory emerges from the data; it is not imposed on the data."[39] The data patterns in this study were developed into a matrix of cause, effect on the family unit, and management of stress and violence. Under the management portion of the matrix, cultural belief and reported behavior were identified. Incongruent behaviors were linked to the belief or behavior with which they were inconsistent. (See the box.)

When flashbacks and nightmares resurrected terrifying memories, the Khmer person was identified as suffering from the culture-bound syndrome koucharang (thinking too much). In response, the family withdrew from the problem while reporting that they managed this problem in the family by providing encouraging and supportive presence. While alcohol and street drug use were identified as cultural taboos for the person who was thinking too much, alcohol and sleeping pills were used to mediate the problem. Although many informants did not perceive that koucharang was preventable, among those who did hold such a belief, masking or withdrawal activities were identified as the means of prevention. Once thinking too much was manifested, the cultural coping mechanism advocated was withdrawal from the problem through avoidance of sad thoughts and avoidance of solitary behavior. In this context of withdrawal as a coping strategy, suicide ideology was expressed by a number of informants.

Koucharang (Thinking Too Much): Matrix of Linkages

Primary cause

War memories

Effect on family unit

Afflicted person	*Precipitating event*	*Family response*
• Withdrawal from family	• Flashback/nightmare	• Withdraw from problem

Management

Cultural taboos	*Cultural prevention beliefs*	*Cultural coping beliefs*	*Behavior: Nonviolent stress*	*Behavior: Outburst of violence*
• Alcohol use • Street drug use	• Not preventable • Keep busy • Forget intrusive thoughts	• Avoid sad thoughts • Avoid being alone	• Encouragement • Don't leave person alone	• Encouragement • Don't leave person alone

Incongruent behaviors

• Use of alcohol and sleeping pills to control stress	• Suicide ideology	• Wife abuse

In managing koucharang, informants advocated proactive behavior of encouragement and not leaving the afflicted person alone, yet the most frequent family response when the problem last occurred was withdrawal from the problem. Thus, there appeared to be an incongruence between how informants stated the problem should be handled and how it was reported as handled in actuality. Informants were also queried about recommended management of violent behavior in the family. The most frequent response was a nonconfrontative and withdrawal response, to "talk softly" and to "do nothing."

Cultural theme: Nonconfrontation in response to stress and violence

The cultural theme of *nonconfrontation* was identified. The phrase "talk softly" was frequently used by informants to describe response to stress and violence. This expression coupled with the expression "talk sweetly" has been observed by both investigators to be used frequently by Cambodian women. This approach contrasts sharply with the directness of American culture and traditional Western modalities of approaching issues of stress. For the professional nurse oriented in the Western world view, this response to stress may be perceived as

maladaptive, whereas such behavior is affirmed and rewarded within the Cambodian culture. In addition, the inner-city environment where many Cambodian refugees live poses additional stresses and risks to this newly immigrated population. Not fully aware of the cultural rules, expectations, and cues of this environment, the Khmer women fall back on the Cambodian cultural rules of nonconfrontation that worked in their traditional society. Such behavior makes these refugees susceptible to victimization within the urban inner-city environment.[40]

Cultural theme: Withdrawal in response to stress

The second cultural theme that was identified was *withdrawal* in response to stress. This theme of withdrawal was threaded throughout the interviews. Family withdrawal occurred when koucharang was manifested, preventive and coping strategies evolved from the theme of withdrawal, and taboos during koucharang centered around withdrawal from use of alcohol and drugs. However, within this context there were marked incongruencies, especially the violation of the taboo against alcohol use when thinking too much. Another incongruency was the advocated behaviors of encouragement and not leaving the person with koucharang alone, while the actual reported behavior was withdrawal of the family from the problem. All societies establish rules and expected behaviors for managing identified problems while tolerating wide ranges of deviance from the expected norms. What is surprising in this study is not that there is deviant behavior from expected norms but rather that the informants were so open in discussing this deviance, particularly the use of alcohol to deal with koucharang.

IMPLICATIONS FOR NURSING PRACTICE AND RESEARCH

Research

This study was a descriptive qualitative study of Cambodian refugee inner-city women using a community networking sampling approach. It was not designed to generalize to the Cambodian population at large but rather to be a baseline phenomenologic study. It described beliefs and behaviors identifying cultural themes as a theoretical base for further study and for designing nursing intervention with this high risk population. The cultural themes of *nonconfrontation* and *withdrawal* were identified.

One purpose of phenomenologic study is the generation of hypotheses for further research. The hypothesis that emerged from the findings of this study is as follows: Nonconfrontation and withdrawal in response to stress and violence are an extension of the cultural theme of equilibrium in that they are culturally identified means by which Cambodian women control and harmonize situations of stress and violence. Additional research is needed to test this hypothesis. Additional research is also needed to identify environmental stressors perceived by Khmer women within the inner-city environment and to identify coping strategies in relation to these externally imposed stressors.

Nursing practice

In relation to nursing practice, this study can serve as a beginning point from which cultural strengths can be identified, cultur-

ally sensitive nursing intervention strategies can be designed, and areas of risks can be targeted. For instance, the practice as described of using alcohol and sleeping pills as a means of withdrawal from thinking too much has profound implications for the stability and adjustment of the Cambodian refugee family. The oblique manner in which references to suicide ideology and wife abuse were presented could be overlooked by the professional nurse with a Western world view who is more accustomed to direct communication. The underlying depression that may accompany these references may be masked by culturally dictated behaviors of "talking softly" and "talking sweetly."

Cambodian refugee women living in the inner-city environment are at risk for multiple stressors based upon their history of oppression as well as their current living conditions. At the conclusion of an interview, one Cambodian woman stated, "I feel like a rock is on my chest. I'm just waiting to die." Culturally sensitive nursing intervention is critical in assisting these refugee women to cope with the traumatic memories exacerbated by the stresses of the inner-city environment.

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