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S. Megan Berthold

Sengly Kong

Jason Ostrander

Sacred Heart University, ostranderj@sacredheart.edu

Seiya Fukuda

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Socially Isolated Cambodians in the US: Recommendations for Health Promotion

**S. Megan Berthold
Sengly Kong
Jason Ostrander
Seiya Fukuda**

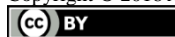
Abstract: *Community organizations in the United States are severely challenged to serve Cambodian refugees who experience health disparities associated with their traumatic experiences. Community leaders have identified a sub-set of community members of particular concern: those at either end of the age spectrum (elders and young people) who are socially isolated. As part of a larger community-based participatory research project, we conducted a focus group with seven Cambodian community leaders from six cities. The study sought to better understand the phenomenon of social isolation of Cambodian elders and young people in order to inform health promotion efforts. Cambodian leaders expressed keen concern for those community members who rarely seem to leave their homes or interact with the Cambodian community. Prominent themes identified by leaders related to isolation were: a generational pattern; benefits of extended family; health concerns; cultural influences and language; impact of stigma; fear and safety concerns; and lack of sufficient resources. In addition, leaders identified several possible solutions to address the phenomenon of social isolation in their communities. Health promotion efforts with this population should identify isolated individuals and enhance their social connectedness and support networks as part of a larger integrated effort.*

Keywords: *Cambodian; genocide; social isolation; community leaders; community-based health promotion*

Concerned about socially isolated elders and adolescents in their families, Cambodians in the United States have reached out to community leaders for help. The impact of exposure to trauma experienced in Cambodia, during migration and in refugee camps, and/or in the United States, along with other factors such as social determinants, may interact to contribute to the problem of social isolation among some Cambodian Americans (Wagner, Berthold, Buckley, Kuoch, & Scully, 2015).

The elders are survivors of the genocide in Cambodia, when an estimated 1.7 million Cambodians were killed during the 1975 to 1979 reign of the Khmer Rouge (approximately 21% of the total population; Kiernan, 2004). Article II of the United Nations' Convention on the Prevention and Punishment of the Crime of Genocide defines genocide as "any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such: (a) Killing members of the group; (b) Causing serious bodily or mental harm to members of the group; (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part; (d)

S. Megan Berthold, PhD, LCSW, is an Associate Professor, School of Social Work, University of Connecticut, Hartford, CT, 06103. Sengly Kong, PhD, is Project Coordinator, Khmer Health Advocates, West Hartford, CT, 06110. Jason Ostrander, PhD, MSW, is an Assistant Professor, Department of Social Work, Sacred Heart University, Fairfield, CT, 06825. Seiya Fukuda, MS, MSW, is a Research Associate, U.S. Department of Veterans Affairs, Bedford, MA, 01730.



Imposing measures intended to prevent births within the group; (e) Forcibly transferring children of the group to another group” (UN General Assembly, 1948, pp. 1-2).

An epidemiological study of a representative sample of Cambodian refugees (aged 35 to 75, $n=490$) living in Long Beach, California (the largest community of Cambodians in the United States) who survived the Cambodian genocide documented an average of 15 different types of major traumas from the Cambodian civil war and genocide experienced before their arrival in the United States (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Such traumas include: exposure to bombings and combat; slave labor; starvation; separation from family members and kidnapping; brain-washing; being terrorized, including living under a constant threat of death; witnessing atrocities; murder of family members and friends; and other forms of torture. Those with exposure to a greater number of types of trauma were more likely to have posttraumatic stress disorder (PTSD; Marshall et al., 2005).

Despite their significant exposure to multiple severe traumas and consistent with findings across refugee populations (Simich & Andermann, 2014; Wagner et al., 2015), Cambodian refugees in the United States exhibit enormous strengths and resilience (Grigg-Saito, Och, Liang, Toof, & Silka, 2008). Many have demonstrated creative and successful mechanisms of coping, strategies for survival, and adaptive abilities to respond to intergenerational conflict (Lewis, 2010). Some community initiatives support intergenerational bonding through engagement activities meant to develop and nurture senior-youth relationships (Yoshida, Henkin, & Lehrman, 2013).

Cambodian refugee elders have documented health and mental health disparities with higher rates of depression, PTSD, diabetes, hypertension, and cardiovascular disease than found in the general U.S. population (Kinzie et al., 2008; Marshall et al., 2005, 2016). Among Cambodian refugees (who arrived in the United States prior to 1995) and Cambodian immigrants (arriving 1995 and later) seeking medical care, those who were refugees reported poorer health-related quality of life, overall health, and health status across all physical health conditions measured (Sharif et al., 2018). Cambodians who came as refugees to the United States as young children or adolescents experienced high rates of PTSD and depression associated with their experiences during the Khmer Rouge regime, in refugee camps, and exposure to community violence in the United States (Sack et al., 1994). Racial discrimination in the United States is also associated with PTSD and depression in Cambodian adolescents (Sangalang & Gee, 2015).

Now in their mid-thirties to forties, some Cambodian survivors who came to the United States as children or adolescents have become parents themselves. Research with families of U.S. military veterans, Holocaust survivors, and Cambodian mothers in the United States with PTSD have found support for the intergenerational effects of trauma (Bowers & Yehuda, 2016; Dekel & Goldblatt, 2008; Field, Muong, & Sochanvimean, 2013). Specifically, role-reversing parenting (i.e., when a parent seeks to get their own emotional needs met by their child) mediated the intergenerational transmission of anxiety symptoms from Cambodian mothers who had survived the genocide and were seeking treatment for PTSD in the United States (Field et al., 2013).

The American Academy of Social Work and Social Welfare and AARP have identified social isolation as one of the Grand Challenges that must be addressed (Lubben, Gironda, Sabbath, Kong, & Johnson, 2015). Reports of poorly functioning, traumatized, and depressed Cambodian adolescents, young adults, and elders who isolate themselves in their homes are deeply concerning for a number of communities (Berthold et al., 2018; M. Scully, personal communication, May 18, 2016). Cambodian American leaders have struggled with how to understand and address the isolation of their elders and youth. Some of these isolated individuals have died by suicide. The Centers for Disease Control and Prevention (2013) has called for increased training in refugee communities to expand awareness of suicide and increase the identification of those at high risk.

Social isolation is a prevalent and potentially modifiable risk factor that affects the health and mortality of elders (Cornwell & Waite, 2009; Cudjoe et al., 2018; Holt-Lunstad, 2018; Lubben, 2018; Miyawaki, 2015; Steptoe, Shankar, Demakakos, & Wardle, 2013). Socially isolated elders experience mental health issues such as depression (Dorfman et al., 1995) and suicidal ideation (Vanderhorst & McLaren, 2005). Their social isolation can be exacerbated not only by personal factors but also by a variety of structural factors, such as living in a high-crime neighborhood (Portacolone, Perissinotto, Yeh, & Greysen, 2018).

There is a growing body of research on adolescent internet usage, although few studies have focused on internet usage as a socially isolating factor among Cambodian American youth. For more than a decade, surveys of U.S. households have reported adolescents spending greater amounts of time on the internet and socially isolating themselves from their families and peers (Gross, 2004). Turow (1999) reported that 60% of families in the United States expressed concern that their children were going to become socially isolated because of their internet usage. No statistically significant relationship was found between social isolation and well-being (i.e., loneliness, social anxiety, depression) in one study with a White, middle-to-upper class population (Gross, 2004). Many contemporary youths have unprecedented access to the internet and are “growing up wired” (Spies Shapiro & Margolin, 2014, p. 1), using social networking sites (SNS) as a primary means of establishing social connections and relating with peers (Ellison & Boyd, 2013). Systematic reviews document mixed findings regarding the association between the use of the internet and SNS and adolescent well-being and mental health (Seabrook, Kern, & Rickard, 2016). Some studies report that the social connectedness promoted by the use of SNS may protect youth from mental health problems (Ellison & Boyd, 2013), while others find that problems with communication and managing expectations contribute to increased experiences of isolation (Baek, Bae, & Jang, 2013; Best, Manktelow, & Taylor, 2014). Positive influences of SNS on adolescent well-being may include more chances to associate with and enhance relationships with peers, including with those who may generally be less accessible, and more opportunity to self-disclose (Spies Shapiro, & Margolin, 2014). These same authors identified potential risks associated with the use of SNS, however, such as receiving negative feedback and pressure to self-disclose, as well as experiencing harmful social comparisons. In a U.S. nationally-representative sample aged 19-32, young adults with higher social media use reported feeling more socially isolated than those who used social media less (Primack et al., 2017). The characteristics of social media use by young adults rather than the amount of time spent using social media may be what has the most impact

on their mental health. Problematic social media use of an addictive nature was found to be independently and strongly associated with greater depressive symptoms in young adults in a U.S. nationally-representative sample (Shensa et al., 2017).

Humans are social beings and most belong to complex and intricate webs of social networks that allow for support, engagement and interpersonal contact. Social supports have been shown to have positive health benefits (Hurtado-de-Mendoza, Gonzales, Serrano, & Kaltman, 2014) and social attachments appear to be potentially beneficial in managing adversity and trauma (Bryant, 2016). Several theoretical frameworks including Social Ecological Theory (Bronfenbrenner, 1979), Conservation of Resources Theory (COR; Hobfoll, 2001), Network Individual Resource (NIR) model (Johnson et al., 2010), and the Network Episode Model (NEM; Pescosolido, 2006) all posit that networks are instrumental to stress responses and to coping with stressors. Social Ecological Theory is often cited in social work literature (Rotabi, 2007) and serves as a holistic theoretical approach to help understand the interconnectedness between Cambodian refugees and their socio-political environments. Bronfenbrenner (1979) separates the different levels of the environment into five nested subsystems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem. This framework helps social workers to better understand Cambodian refugees' experiences, such as language difficulties, unemployment, family dynamics, community violence, and poor health outcomes (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larsen, 2010). Various deleterious effects are experienced by adults who have been exposed to childhood trauma in the absence of effective social supports (Norman, Hawkey, Ball, Berntson, & Cacioppo, 2013). Without social networks to create and establish social supports, social isolation may result (Cacioppo & Hawkey, 2003). Social disconnectedness is also associated with damaging neuroendocrine effects (Cacioppo, Cacioppo, Capitanio, & Cole, 2015). Social isolation, similar to more traditional clinical risk factors, has been found to predict mortality in a nationally representative U.S. sample (Pantell et al., 2013). When considering the impact of social isolation, it is important to recognize the potential effect of cultural context. Compared to the more individually-based culture predominant in the United States, Cambodian refugees come from a group-based culture. As such, it is possible that the impact of social isolation may be intensified for Cambodians.

Social isolation has both subjective and objective components (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Subjective social isolation (self-report of loneliness and isolation) has been independently linked to mortality (Luo, Hawkey, Waite, & Cacioppo, 2012) and depression (Vanhalst, Goossens, Luyckx, Scholte, & Engels, 2013). Objective social isolation is seen in those who are socially disconnected from others, as measured by living alone, having a small social network, being unmarried, lack of regular participation in social activities, and limited contact with family and friends (Holt-Lunstad et al., 2015). Southeast Asian elders living in Philadelphia were found to be socially disconnected and at risk for depression (Kim et al., 2015). In this sample, those Cambodians who were younger at the time that they immigrated had less depression than those who were older at immigration. Social disconnectedness and co-occurring health conditions were found at high rates in a sample of Cambodians in Connecticut (Berthold

et al., 2018). Lack of community and religious engagement were associated with their poor health outcomes.

The living situation of Cambodians in the United States is often quite different from their traditional life in Cambodia (Smith-Hefner, 1999). In stark contrast to their experiences of residing in relatively small close-knit communities in Cambodia prior to the Khmer Rouge regime, life in the United States is often difficult and isolating for Cambodian elders (Wagner et al., 2015). Their communities in the United States are more dispersed, making it a challenge to access their social networks and socialize with friends without using a car or bus. Elders are frequently dependent for transportation on their adult children who have busy lives and may not live with them. Persistent isolation faced by these elders may exacerbate the adverse mental and physical health outcomes experienced from their exposure to trauma and torture in their home country, exposure to toxic stress (i.e., joblessness, poverty, gang violence) in the United States, and intergenerational role conflicts between traditional and acculturated values (Dinh, Weinstein, Kim, & Ho, 2008; Smith-Hefner, 1999).

To date, health promotion efforts in Cambodian American communities have been limited, in part due to lack of resources (Kuoch, Scully, Tan, Rajan, & Wagner, 2014; Sharif et al., 2018). Existing efforts have largely been targeted at the chronic health of elders, including group treatment and health education programs for diabetes (Berkson, Tor, Mollica, Lavelle, & Cosenza, 2014; Wagner et al., 2015), integrated interdisciplinary models that attend to the whole person (Grigg-Saito et al., 2010; Wagner et al., 2015), and preventive health measures (Grigg-Saito et al., 2008; Nguyen, Tanjasiri, Kagawa-Singer, Tran, & Foo, 2008). The use of traditional, complementary, and alternative medicine, including spiritual practices, is common in Cambodia for treating chronic conditions (Peltzer, Pengpid, Puckpinyo, Yi, & Anh, 2016) and was integrated with Western healthcare in Cambodian refugee and displaced persons' camps in Thailand (French, 1994). While Cambodian Americans continue to use complementary and alternative medicine in the United States, its use is often not integrated with Western health and mental health care, with some notable exceptions such as the practices of the Metta Health Center in Lowell, Massachusetts (Grigg-Saito et al., 2010).

Limited research has focused on factors associated with health behaviors and health outcomes in resettled Cambodians (Nelson-Peterman, Toof, Liang, & Grigg-Saito, 2015) and understanding psychosocial factors related to exercise (Coronado, Sos, Talbot, Do, & Taylor, 2011). Little attention has been given to deepening the understanding of social isolation among members of the Cambodian American community or to specifically targeting isolated individuals in health promotion efforts.

This article reports findings from the final phase of a community-based participatory research (CBPR) study conducted collaboratively between Cambodian leaders from six states in the United States, university researchers, and Khmer Health Advocates (a Cambodian non-profit organization). The purpose of the larger study was to build Cambodian community capacity to design and conduct research related to the health of the estimated 327,719 members of the Cambodian community in the United States (U.S. Census Bureau, 2016). A community survey was conducted in the initial phase of this study

and concerns about socially isolated community members were reported by all study sites. We share the findings of a focus group of leaders from the six Cambodian communities that sought, in part, to better understand the phenomenon of social isolation of Cambodian elders and young people in order to inform health promotion efforts.

Methods

Design and Participants. A single focus group was conducted to gain perspectives from community leaders regarding social isolation and other challenges and strengths of their communities. Seven Cambodian community leaders from the six study sites (two from Connecticut) participated. This included 6 females and 1 male, aged 45 to 66, who were in leadership positions (i.e., directors or senior staff members) at Cambodian non-profits in six cities or states in the United States: Long Beach, California; the State of Connecticut; Lowell, Massachusetts; Minneapolis, Minnesota; Portland, Oregon; and Philadelphia, Pennsylvania. The leaders were highly educated (possessing at least some college to masters' degrees), bilingual in English and Khmer, and from the middle-class. All but one of the focus group participants were ethnically Cambodian genocide survivors who came to the United States as refugees. The remaining participant was White and had worked in Cambodian communities in the United States for approximately three decades. The leaders had extensive experience working with Cambodian refugees and served small-to-large Cambodian communities in the east, mid-west and west of the United States where approximately one-third of all Cambodians in the United States resided.

Procedures. Participants engaged in a 90-minute conference-call focus group discussing their community's key health concerns. The focus group was conducted in spoken English and facilitated by the PI, Co-Investigator, and a graduate research assistant. Semi-structured questions were asked of participants relating to their understanding of the health of the Cambodian American community and concern about homebound members of the community. Questions included, in part: "As a leader, how do you see the health of your community?"; "What do you perceive to be the most common health problems of Cambodian American adults in your community?"; [after social isolation and homebound community members was raised by focus group members] "How much do you view members of your community being homebound as a problem? People who are isolated, who don't leave their homes much - is that a big problem in your community?"; and "What are your perceptions about how important community health workers are or aren't to the health of your community?". The focus group was audiotaped and transcribed verbatim, yielding twenty single-spaced pages of transcript. An informed written consent process was used, and the University Partner's IRB provided oversight of this study.

Data Analysis. The transcript was entered into NVivo for coding and data analysis. Holistic coding was employed to identify underlying themes by "lumping" the narrative according to stories or broad topics (Saldana, 2013). The PI, Co-Investigator, and a graduate research assistant coded the focus group transcript separately and met to discuss their coding decisions. This process continued until coding consensus was achieved. At the conclusion of each debriefing, memos were created to help document the team's decision-making during the various phases of the research project and how these changes impacted the study. These steps increased the rigor of the study by helping to control for the

researchers' biases and positionality (Padgett, 2008). Once all the transcripts were holistically coded, the research team thematically analyzed the codes and condensed them into 13 broad constructs (Padgett, 2008; Saldana, 2013). This article reports on an in-depth analysis of the social isolation-related themes.

Results

Cambodian leaders expressed keen concern for those community members who rarely seem to leave their homes or interact with the Cambodian community. Prominent themes identified by leaders related to isolation were: a generational pattern; benefits of extended family; health concerns; cultural influences and language; the impact of stigma; fear and safety concerns; and lack of sufficient resources (see Table 1). In addition, leaders identified several possible partial solutions to address the phenomenon of social isolation in their communities.

Table 1. <i>Social Isolation Themes</i>
1. Generational pattern
2. Benefits of extended family
3. Health concerns
4. Cultural influences and language
5. Impact of stigma
6. Fear and safety concerns
7. Lack of sufficient resources
8. Possible partial solutions

Generational pattern of isolation. Community leaders saw social isolation as a particular problem for two groups in the community: elders (variously defined as older than 50 and over aged 60 or 65 by others) and the younger generation (teenagers and young adults). Leaders identified elders as particularly at risk of isolation if they were unemployed, lacked transportation, and were depressed. With respect to isolated youth, one leader remarked, "We hear about young people. Usually they're males and they're in their 20's, who never come out of their room." Other leaders indicated that this was the case in their communities as well, and that the problem extended to teenagers.

Benefits of extended family. Among the key benefits of extended family discussed were the practical benefits of intergenerational aid provided by those in the younger generation to their elders. This aid included assisting elders to socialize outside of their home, encouraging them to be more physically active, and driving elders to their health appointments (occasionally interpreting for them at their appointments). One leader described intergenerational Cambodian living arrangements, "We're scattered, and a lot of parents live with their adult children that take good care of them already. So they provide transportation, have their own medical insurance for the parents." Elder grandparents may also provide valuable assistance for the younger generation. For example, they may provide care to grandchildren that in turn reduces their own social isolation.

Health concerns. A number of health concerns were seen as linked to isolation, either as a perceived cause of isolation and/or believed to result in isolation over time. Youth and elders alike were known to be depressed and isolating themselves in their bedrooms or

homes. Leaders shared similar stories about the youth isolating themselves in their bedrooms. One leader explained that youth,

age between 18, 19, 20, 22, some of them lock themselves in their room. What I learned, some of them, their parents didn't want them to get out, so what they do, they lock themselves in their room and then they have Internet, and they would spend hours and hours at night on Internet or playing games, and they become a challenge for their parents to get them out, because they just lock themselves in. They become isolated and when their parents become concerned, sometimes it's too late to get them out.

Leaders expressed concern about suicide being a problem among younger Cambodians who were extremely socially isolated. One leader shared an example of a youth suicide and reflected that suicide in the younger generation was a problem in his community,

Just Saturday, I went to the temple. This woman said her grandson just hanged himself or killed himself, he's 21 years old. There must be something going on that we don't know about in this age group. So that is depressing and it's . . . an issue of concern for the family and for us as a community. So they [are] kind of hidden, but it's also an issue for us to look into.

One leader highlighted that some elders were isolated “because they still live in the past,” affected by symptoms of PTSD such as traumatic memories of their experiences during the genocide. Those secluded in their homes were known to get less than adequate physical exercise that was believed to lead to worse physical health. Several of the leaders asserted that less activity led to more smoking for some. Closely related to their concerns about social isolation, the health of elders was seen as at risk for being compromised when they depended on others, such as children or other extended family members, for transportation to the doctor or for other daily necessities. A leader from the northeast stated that,

children grow up, have family of their own and move out, and they come to visit their parents once or twice a week at the most. If parents feel like they can drive or they can go out on their own, they can get out and socialize among their peers, especially in the summer, but in the winter it's hard for them to get out. So they are homebound and they are more depressed and they don't do much physical activity, which puts more stress on their health as well, on their physical health.

The inability to get out of the home to buy fresh vegetables was seen as contributing to elders eating larger quantities of salty fish paste and processed foods, which in turn was believed to lead to increased problems with high blood pressure, a condition the leaders knew was prevalent among genocide survivors in their communities.

Of keen concern to the leaders was that many in their communities relied on going to the emergency room for routine health problems, in part due to their isolation and difficulty getting to regular doctor visits. As one leader remarked,

... we have new programs, it's called ER diversion, because why, because they use a lot of ER or use emergency visit ... for health care, for doctor visit.... they wait until they have problem, and they don't have a primary care doctor. They just go

to ER...when they are sick, they just take themselves or take their children to the ER and use that as their [laughs] their primary care doctor. So now we have a plan called ER diversion, try to convert that system back to a primary care visit.

Cultural influences and language. The dynamics between parents, adolescents, and elders were described as having a strong cultural dimension, which appeared to interact with the problem of social isolation. Some members of the older generation have limited or no English fluency and the younger ones frequently have limited fluency in Khmer. Language barriers between the generations may also contribute to the communication challenges experienced. As one leader put it,

But the teenager, they also face that problem, why? Because I heard somebody brought up about that they hide themselves in their room playing games, and they don't understand how to explain, how to communicate with the parents, how to explain their feelings.

The communication barrier between parents who lived through the genocide and their children who did not may make it difficult to understand each other's experiences and needs. This is particularly challenging when it can be impossible to fully or accurately express the experience of genocide in words in any language. Another leader commented that the barrier to communication related to the poor mental health of the parents.

I see isolation mostly with the elderly, 55 and up, and the younger ones, the first generation that were born in Cambodia then they came here. . . . [The children] cannot talk or express feelings to the parents. Parents [are] depressed, so the children go their own way.

The leaders were concerned that depressed and otherwise poorly functioning parents may be compromised in their ability to supervise their children.

Leaders also noted the influence of culture among Cambodian elders who report their health as good or bad. The leaders explained that a negative complaint (i.e., that their health is not good) means (culturally) they are blaming their children for not taking good enough care of them. In keeping with Cambodian culture, even under circumstances when they are isolated and their children and/or other family members are not providing them with sufficient assistance (including transportation to get them out of the home), elders are not supposed to complain. One participant commented,

Also another thing is that look at the Cambodian culture. So we supposed not to complain. Because nobody takes care of you besides yourself. The parent cannot say, not good, because otherwise, they say that the children not good to take care of you.

Another participant acknowledged that context (including whether they are asked when they are alone or in the presence of others) might influence the response of elders to being asked about their health.

My mom for example, my mom cannot [laughs], if somebody ask her, she probably look around first, if her children [laughs]. If she say that she is not good, so it mean she blames her children, too.

Impact of stigma. Stigma was another theme identified by the leaders that contributed to the isolation of elders in the home. The loss of employment was one identified source of stigma. The experience of loss of social status and stigma associated with loss of employment by Cambodian elders is a phenomenon shared by older adults in the general population as well. The Cambodian leaders explained that Cambodians in the United States value being able to buy a house and car, and they do not want to be seen as unemployed or receiving unemployment benefits or other government assistance. One leader remarked that

The parents are, what we learn is that people who are losing their jobs, if they are 50 years old to 60 years old, they don't want to get out because they lose the job. They sometimes did not feel comfortable and the most people whom have a problem, the most of the seniors.

It became apparent from the leaders that people felt others looked at them differently if they were not employed. A fairly common question asked when meeting others in the community is, “Where do you work?” This question would be difficult and stigmatizing to answer for those unemployed, contributing to their preference to stay home to avoid such questioning. Older Cambodian men might find being unemployed particularly troubling, as culturally they are used to being the ones to financially support their families.

Fear and safety concerns. Fear and concern for safety was another key factor identified as contributing to elders staying at home and parents keeping their children inside in the evenings. There were regional differences, however, with several of the communities being particularly noted for higher rates of community violence, including Cambodian and non-Cambodian gang violence. One of the leaders linked the low rates of high school completion and college attendance, and the high unemployment of youth, with involvement in crime, a problem the leader's agency was insufficiently resourced to address.

...it's very, very limited to hire people, especially in [NAME OF CITY]. About five hundred plus [CAMBODIAN] youth in [THE CITY], and 46% graduated from high school, only about 10% go to college. So you can see the issue. If ten shootings in [THIS CITY], probably six, seven of them are by Cambodian youth.

Leaders made a link between fear and safety concerns among their community members and the phenomenon of social isolation.

Lack of sufficient resources. Cambodian leaders saw community health workers—or other staff members conducting outreach—as invaluable because they could check on homebound community members, assist them in leaving their homes, and connect them with activities. None, however, had the resources to afford robust outreach programs. Most were working with small or bare-bones staff and could not meet the need in the community.

I think we do need some kind of outreach, but also have to be the combination of socialization, sport activity, especially in wintertime. And also probably, just to bring the seniors as well as the youth and adults out of the home. So it mean[s] that the role of social services is very important here, because [MY ORGANIZATION] is the only [CAMBODIAN] social / human services in [THE STATE].

Possible partial solutions. In the face of such challenges related to social isolation in their communities, leaders identified possible strategies and partial solutions. One leader spoke about having vans and staff members for driving elders to temples to socialize and get religious/spiritual support, and to take them to health appointments:

. . . the most people whom have a problem, the most of the seniors. But we have five vans provide transportation to them every week. So that resolve[s] some issue[s] with the people who live in [NAME OF CITY]. However, people living in another area, especially in [ANOTHER CITY] area, it's about 90 miles from us. Those people don't have [any] place to go.

Other leaders noted how they wished they had such resources in their communities, but they lacked sufficient funding. In addition, all leaders agreed that another critical resource was community health workers (CHWs) who are bilingual in Khmer and English.

Yeah, very, very important to have a community health worker, because translator come when needed, but a community worker be there to advocate and to also bridge the cultural gap . . . that's what we need, because the community health workers have built a relationship with the community on an on-going basis, and also have built a relationship with the provider on an on-going basis.

In relation to the problem of adolescents isolating themselves in their rooms, one leader had recommended to some parents to disconnect the internet and try to take their adolescent out and spend more time with the adolescent.

Discussion

Cambodian community leaders in this study identified two very socially isolated groups within their communities: elders and young people (teens and young adults). Although the Cambodian leaders represented six separate Cambodian communities across the United States, most were experiencing similar challenges with these isolated groups. All but one of the leaders were themselves ethnically Cambodian genocide survivors who came to the United States as refugees in the 1980s and had lived and worked in their Cambodian community in the United States ever since. These community leaders provided contextual insights into some of the factors that may be contributing to social isolation. The Cambodian leaders themselves had experienced many of the same or similar circumstances and losses that elders in their community faced. These shared experiences may have made them particularly attuned to the losses of the elders and to the challenges parents faced with teenagers isolating themselves.

A shift in family culture, particularly given the younger generations' more engaged participation in a new culture in the United States, and limited communication between family members due to language barriers, appeared to be pervasive factors affecting the Cambodian communities. Cambodian leaders explained that older generations possess limited English fluency and younger generations lack fluency in their native Cambodian language of Khmer. Although intergenerational aid is often a significant benefit of an extended family (e.g., teens or young adults providing elders with transportation to medical appointments, the temple, and to visit friends; and with young people learning about their

culture and heritage), many Cambodian Americans are severely limited in their verbal interactions across generations due to language barriers.

Further amplifying the social isolation of elders and adolescents are their fears and safety concerns within their own neighborhoods and communities. Many elders report a fear of leaving their homes and parents keep their children at home because of community violence—specifically, Cambodian and non-Cambodian gang violence—which has been associated with adverse mental health outcomes (Green, Gilbertson, & Grimsley, 2002).

The barriers discussed above were perceived by the community leaders in this study and also supported in the literature (D’Anna et al., 2017; Wagner et al., 2015) as contributing to increased health concerns for these two isolated populations, impeding them from engaging in adequate physical exercise, purchasing healthy fresh fruits and vegetables, and accessing preventative health services. These circumstances make reducing negative health outcomes and implementing health promotion activities more challenging.

It may seem surprising to some social workers that grief and loss were not mentioned by the community leaders as a theme in the focus group related to social isolation, given the history of genocide that they and their community members experienced. Grief and loss are universal in the Cambodian community, however, culturally it is not common for people to talk about this as a theme. The majority of Cambodians are Buddhists who focus on acceptance and maintaining a relationship with those who have died through traditional ceremonies that occur in community. There continues to be a give-and-take between the dead and the living as the living pray for guidance and blessing and the spirits of the dead offer comfort and protection. Social isolation is therefore seen as a serious problem because those who are isolated have not only diminished contact with the living but also with the dead.

Given the association of social isolation with poor outcomes, including increased mortality and adverse mental health outcomes (Cudjoe et al., 2018; Holt-Lunstad et al., 2015; Lubben, 2018; Pantell et al., 2013; Steptoe, Shankar, Demakakos, & Wardle, 2013; Vanderhorst & McLaren, 2005), health promotion efforts should be directed to socially isolated elders and young Cambodian Americans. Their communities, however, have severe resource constraints (Kuoch, Scully, Tan, Rajan, & Wagner, 2014). Cambodian community-based organizations in the United States have been pushed to the brink of financial collapse during this economically challenging time (T. Kuoch and M. Scully, personal communication, May 10, 2018). Since this study concluded, one of the participating community-based agencies has closed. New and creative partnerships need to be developed to improve health outcomes for Cambodian American elders and young people. Social workers should partner with Cambodian community-based agencies and community healthcare systems to aid in reducing unnecessary emergency room visits and provide necessary language services. One of the vital resources helping to bridge barriers to health promotion efforts is the excellent work being conducted by Cambodian CHWs. Unfortunately, most are working as volunteers and are not able to engage with all the Cambodian Americans who need their support. Cambodian CHWs are bilingual and possess the required skills to provide federally mandated Title VI translation services for

social workers and other health personnel, which would reduce the unethical reliance on family members and nonprofessional interpreters (Berthold & Fischman, 2014). The CHWs have the skill set (language, cultural and ethnic expertise, and advocacy) and trust of the community to help increase long-term health outcomes and improve access to publicly funded community care (Lu, D'Angelo, Kuoich, & Scully, 2018; Zahn, Matos, Findley, & Hicks, 2012).

Implications for Social Work Practice

Social workers play a critical role in providing quality services to refugees both in direct care positions and within interdisciplinary teams and should partner with CHWs to become trusted members of this community. The National Association of Social Workers' (NASW's) (2016) *Standards for Social Work Practice in Health Care Settings* recommends that assessments are customized for vulnerable populations, such as refugees. Social workers must ensure that all facets of the refugee's life are taken into consideration when conducting an assessment and fully appreciate the interconnectedness and depth of the refugee's life journeys. This includes past experiences of trauma in their country of origin, during migration, and when resettling. Further, social workers must understand and appreciate the link between trauma exposure and health risks for refugees, and culturally appropriate systems of care (Ostrander, Melville, & Berthold, 2017). CHWs play an important role in ensuring that health care is culturally appropriate for Cambodian Americans.

Social workers should advocate to legislators for a significant investment of resources to support CHWs, which would ensure that the right to access health care for some of the most vulnerable and marginalized Americans is realized, that the health care they receive is culturally appropriate, and that they receive preventive care services (Nguyen et al., 2008; Renfrew et al., 2013; Taylor et al., 2013). Employing CHWs would also ensure that health providers are in compliance with Title VI (Berthold & Fischman, 2014; Wagner et al., 2013). Compared to the cost of medications and other treatment, the cost of funding CHWs would be modest. One study found a cost-savings and reduction in potentially dangerous medication errors when Cambodian CHWs partnered with pharmacists using telemedicine to deliver medication therapy management (Center for Technology and Aging, 2011).

Cambodian community organizations can also utilize bilingual CHWs to create, organize, and run online groups to support elders and young Cambodians struggling with limited transportation, fears about community violence, and social isolation. Cambodians have been early adopters of technology since they first came into the United States. They relied on videotapes for entertainment and information as soon as videotapes became available on a commercial level in the early 1980s. Over the ensuing years, Cambodian Americans have been among the first to use the Internet for communications with family across the United States and in Cambodia. Skyping and the use of Facebook-Messenger is common in Cambodian communities in the United States and technology serves as a link between the young and the old (T. Kuoich, personal communication, May 10, 2018). Employing an online peer support model, Cambodian elders and adolescents could develop quality peer relationships, enlarge their social networks, and decrease a sense of loneliness

and social isolation. One study of online peer support groups with children aged 7 to 11 from predominantly White, middle to upper-class populations across Canada suffering from asthma and their parents reported growth in supportive relationships with family and friends, increased self-confidence, and decreased loneliness and social isolation (Stewart, Letourneau, Masuda, Anderson, & McGhan, 2013).

Through the use of strategic and critical partnerships, CHWs, social workers, and their interdisciplinary colleagues could implement necessary trainings for health providers and non-profit agencies who work with Cambodian communities. Such trainings could focus on raising awareness and enhancing services for Cambodian Americans in the short term and increasing advocacy for health promotion resources in the long term. Following the example of organizations in communities with high concentrations of Cambodians such as Lowell and Lynn Massachusetts, Cambodian elders' physical, mental, and social needs may be met through participation in social day care or adult day health centers (Dubus, 2017). One possible model that could be considered is the development of a social enterprise for-profit arm of a community-based organization that has potential to generate additional revenue while combating social isolation in community members.

Rather than focusing efforts solely on the consequences of social isolation for individuals, promoting health requires addressing the root causes, such as structural factors contributing to the problem of social isolation. Metzl and Hansen (2014) define structural competence as "the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases...also represent decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures" (p. 128). Social workers must not overlook how an individual Cambodian's lived experiences are shaped and constrained by structural factors that impact Cambodian refugees every day, such as insurance companies dictating how long and what type of services they will cover, the effect that racism has on cortisol levels, the impact of community violence, the lack of culturally appropriate services and goods, and insufficient public transportation for daily living activities.

Limitations

The non-probability purposive sampling employed in this study was a key limitation. The leaders in the focus group represented six large Cambodian communities in the United States. Thus, our findings may not be representative of the opinions or experiences of other Cambodian community leaders or reflective of the situation of other Cambodian communities in the United States, including regions where there are no Cambodian agencies. Further, the participants may have opened up more or given different descriptions if the focus group had been conducted in Khmer. In addition, the findings came from only one focus group and were not meant to be generalized. The focus group explored multiple topics, therefore, we did not have time to probe further about social isolation. It is important to note that adolescents may not view themselves as socially isolated because they have access to vast social networks through the use of the internet. This study did not examine the nature of these networks or the type of support received by these adolescents via social media and the impact on adolescent well-being.

The fact that the focus group occurred as a conference call could be seen as a limitation, in that it did not allow for face-to-face non-verbal communication. If the participants had been strangers, the remote nature of the focus group may have also complicated the development of trust and open discussion. In our case, all participants were well known to each other, having met in person previously on multiple occasions to work on various research and community projects. Holding the focus group over the telephone allowed us to include leaders from around the United States, inviting a range of community experiences to be shared and accounted for.

Implications for Social Work Research

Future research that examines the problem of social isolation with additional focus groups and key informant interviews involving more community leaders, as well as elders and youth would be valuable. One pressing concern expressed by the focus group participants was of adolescents isolating themselves in their bedrooms and spending significant time on the Internet and playing video games. The leaders perceived that this was negatively affecting the adolescents' well-being. Given the relative lack of study of this phenomenon in Cambodian youth and the mixed findings in the literature regarding internet usage and well-being (Baek et al., 2013; Best et al., 2014; Ellison & Boyd, 2013; Seabrook et al., 2016), further study is needed to understand the prevalence and impact of isolating behavior by Cambodian American teens. Social workers should partner with Cambodian community agencies to better study this phenomenon and to understand the adolescents' perspectives and experiences. Research regarding the risk factors for suicide in Cambodian American community members, particularly in the young people, and on effective suicide prevention strategies is also a pressing need. In addition, outcomes research on interventions aimed at reducing the prevalence of social isolation in vulnerable Cambodian elders and adolescents and its negative effects should be undertaken.

Several of the observations and insights expressed by community leaders in this study based on their experiences living in and serving their communities for many years are not well-documented in the literature and would warrant further study. For example, the literature has identified the impact of sociocultural factors and smoking in Cambodian Americans (e.g., smoking to cope with stress, combat hunger during the Khmer Rouge genocide period, and as part of Buddhist religious ceremonies (Friis et al., 2012)) but no literature was found documenting that less activity leads to smoking by some Cambodian Americans. In addition, previous research has found that lower acculturation and education as well as a history of severe and prolonged food deprivation/insecurity during the Khmer Rouge regime is associated with greater consumption of high-sodium Asian sauces, lower consumption of vegetables and fruits, and other less healthy food behavior in Cambodian refugee women in Lowell, Massachusetts (Peterman, Silka, Bermudez, Wilde, & Rogers, 2011; Peterman et al., 2010). Further study is needed to determine if the inability to get out of the home noted by leaders in our study is related to eating behavior and health among isolated Cambodian Americans.

Research with non-Cambodian mothers has found a strong association between postpartum depression and impaired parenting (Muzik et al., 2017) and negative effects on child development (Brummelte & Galea, 2016). In a study of active child protective service

cases in Cambodian families in Los Angeles, maternal depression and/or PTSD was associated with poor parenting outcomes and neglect (Chang, Rhee, & Berthold, 2008). Further study is needed to examine whether there is a relationship between Cambodian American parents' mental health problems and poor functioning and their ability to supervise their adolescent children, a concern expressed by our study participants that they perceived to contribute to the adolescents isolating themselves in their rooms.

Further research is also needed regarding the leaders' expressed concerns about the factors leading some Cambodian youth to become criminally involved and the leaders' perception that social isolation in their community members is associated with fear and safety concerns. Findings from such research may contribute to the prevention of community violence and provide insights into strategies to reduce social isolation among vulnerable individuals. Researchers and clinicians have long known that long-term social isolation can lead to damaging psychological effects in humans. Recent research with mice has found that a brain chemical that causes stress, fear, hypersensitivity to threats, and aggression is overproduced in the context of chronic social isolation and that blocking the chemical can remove these negative effects of isolation (Zelikowsky et al., 2018). Possible therapeutic applications of these findings may yield benefits for socially isolated humans in years to come. Regardless of possible clinical and pharmacological advances in the future, efforts to target the structural factors that contribute to creating social isolation are fundamentally needed (Ostrander et al., 2017).

Conclusions

Cambodian leaders have explicitly identified social isolation as a major concern that must be addressed for cultural reasons and to reduce the risk of behavior-dependent chronic disease, such as Type II diabetes. Anecdotal reports of suicide attempts of isolated Cambodian youth in the United States are also particularly troubling to Cambodian CHWs and leaders. Health promotion efforts in this population should directly work to identify isolated individuals and enhance their social connectedness and support networks as part of a larger integrated effort. Programs should consider working closely with public schools if possible, in order to share resources and information to better prevent, identify, and address youth social isolation.

Further, the social isolation of Cambodians in the United States is a chronic community problem that requires a community solution (Ostrander et al., 2017). The problem of social isolation is related to cultural and language isolation (i.e., lack of a common language between the generations). Community-based organizations (CBOs) and Cambodian community members tend to be financially resource-poor. Adequate funding is necessary to develop needed programming and infrastructure, and to undertake and evaluate long-term interventions that address broader structural factors and social determinants associated with the chronic health conditions and isolation that are prevalent in this community.

Despite their financial limitations, Cambodian communities and CBOs have other relevant cultural resources and expertise. Many Cambodian communities have CHWs with interpreting skills, cultural understanding, and knowledge of the traumas experienced by

members that are necessary for effective interventions. Community-based organizations can also mobilize key stakeholders in the community such as Buddhist monks, elders, and youth organizations to educate its members about important issues like social isolation and work collaboratively to generate solutions. Working together, Cambodian communities have great potential for successfully combating social isolation.

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Author note: Address correspondence to: S. Megan Berthold, PhD, School of Social Work, University of Connecticut, 38 Prospect St., Hartford, CT 06103. Megan.Berthold@uconn.edu