An Exploration of Alcohol Use in Karen Refugee Communities in the Context of Conflict-Related Displacement

A DISSERTATION

SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL

OF THE UNIVERSITY OF MINNESOTA

BY

Jennifer Simmelink McCleary

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

Dr. Elizabeth Lightfoot, Advisor

and

Dr. Elizabeth Wieling, Advisor

July, 2013

Acknowledgements

This dissertation would not have been possible without a host of people – family, friends, colleagues, professors, mentors, participants, and others who fueled this project with hours of mentorship, conversation, insight, laughter, food and encouragement.

First and foremost, this body of work would not exist without the participants who shared their stories and often their homes with me. I am grateful for the trust you put in me.

I owe a deep, deep *tablu doma* to Eh Taw Dwe, my cultural liaison in Minnesota. Eh Taw graciously shared his culture, his history, his language, his story and, most importantly, his infectious laughter with me and I will forever be grateful to him for his gentle teaching on all things Karen.

I am grateful to many teachers in Thailand: La Law Say, Dah, Pam and the rest of the DARE Network staff; Julia, Liberty, and Eh Ka Lu.

A huge thank you to Sister Stephanie Spandl and Day Wah at MORE School for participant recruitment support that turned into what I know will be a life-long partnership.

I consider myself extremely lucky to have entered the Ph.D. program in 2008 along with JaeRan, Ericka, Shweta, Sue, Seok Won and Kofi. Over the past five years we have shared laughter, tears, about a hundred Bombay Bistro celebratory dinners, statistics notes and writing support. I am so inspired by the way that each of you tirelessly pursues a deep intellectual and activist approach to social work scholarship and I know I will continue to grow from our friendships.

I am also grateful to my committee and their support during this journey. To my co-advisor, Liz Wieling, thank you for being not just a mentor but a friend. I am so grateful for your guidance and support and your example of how to be both a woman and a scholar. To my co-advisor, Liz Lightfoot, your support of this project extended to travelling with me to Thailand as I began my data collection there and I am so grateful to have shared that experience with you. Thank you for all of your support and mentorship through my entire program. To Dave Hollister, thank you for your gentle wisdom and guidance. To Patty Shannon, you have been a mentor to me since my first days in the Ph.D. program and I am so inspired by your vast experience and creative mind. To Liz Boyle, thank you for providing unique insight into the human rights aspect of this work.

Last, but clearly not least, I am deeply grateful for my family and their enduring support. Mom and Dad: since I was a little girl reading every book I could get my hands on you have supported my love of knowledge and learning and provided examples of what it means to passionately pursue engaged and meaningful careers. Thank you for really meaning it when you told me I could be whatever I wanted to be. Kari and your family: thank you for giving me much needed joyful breaks from academia to play – from wine-filled girls' nights to trampoline jumping sessions with Jake and Ella. Jason and your (growing!) family: I am so awed by your creativity and it inspires me daily. Kyle: during this journey you met me, swept me off my feet, married me, fed me, kept me daily entertained with your laughter and never, ever, once stopped believing completely in my ability to do this. I am so grateful for your love, your support, your joy and your intellect. I love you completely, confidently and joyfully.

Dedication

This dissertation is dedicated to my family whose love, laughter, joy, passion and creativity made me who I am today; and to my participants who graciously shared their lives with me.

Abstract

Refugees who are displaced due to political conflict often experience a range of traumatic events throughout displacement and resettlement including exposure to traumatic events such as imprisonment or gender-based violence, protracted periods of time in refugee camps or resettlement related stress. Refugees who are displaced across borders bring cultural beliefs and values with them, although often the structures that support culture such as family and community are disrupted due to displacement. All of these factors can influence patterns of alcohol consumption and the consequences of alcohol use. Traditionally, high levels of alcohol consumption in refugee communities have been explored using models of self-medication of trauma or acculturation (Ezard, 2011). There have been almost no studies conducted of refugee alcohol use that qualitatively explore refugees' perceptions and experiences of alcohol use from their own perspectives. This dissertation describes a qualitative that study drew from critical ethnographic and phenomenological methodologies to explore the experiences and perceptions of alcohol use in Karen refugee communities displaced by political conflict. I collected data through focus group and individual interviews (N=62) and participant-observation in two locations: refugee camps in Thailand and a resettlement community in St. Paul, Minnesota. Analyzing the data using domain analysis (Spradley, 1979), I found that both culture and displacement related traumatic experiences contributed to increased levels of problematic alcohol use and negative consequences of alcohol use after displacement. I also discovered that geographic location may have played an influencing role on patterns of alcohol use. Participants said that many cultural structures and patterns were disrupted during displacement and this disruption of culture led to

increased problems related to alcohol. Finally, Karen participants described people with problematic alcohol use as people who had stopped thinking about community and family and had begun to think only of themselves, which is counter to traditional Karen ways of thinking communally. These findings contain knowledge that will contribute to the development of culturally relevant treatment programs that consider the cultural, historical and political factors that contribute to alcohol use in Karen refugee communities as well as the ways in which communal cultural values impact both use of alcohol and quitting problematic alcohol use.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Chapter Overview

In this chapter I will introduce and describe my doctoral dissertation research study. This study employed a qualitative methodology to investigate the experiences and perceptions of alcohol use in the context of conflict-related displacement in Karen refugee communities in refugee camps in Thailand and in a resettlement community in St. Paul, Minnesota.[1] This chapter is meant to provide an overview and guide of the study. In it I will briefly describe the study itself, the problem under study and the research questions designed to explore the problem, in addition to providing a brief overview of the history, politics and culture of Karen people in Burma, Thailand, and Minnesota. Finally, I will conclude this chapter by providing an overview of the remaining chapters.

Brief Study Description

In this qualitative study I explored the experiences and perceptions of alcohol use in Karen refugee communities in two locations: refugee camps in Thailand and a resettlement community in St. Paul, Minnesota. The Karen are an ethnic minority group in Burma who have been fleeing conflict with the Burmese military government and human rights abuses perpetrated by the Burmese military government into refugee camps in Thailand since the 1980s. Karen refugees have been resettling in the United States in increasing numbers since 2005. I drew from critical ethnographic and phenomenological

[1] The use of first person language in this document is intentional and is consistent with qualitative research methodologies such as critical ethnography that require reflexivity on the part of the researcher.

methodologies to explore the ways in which Karen refugees experience and perceive alcohol use within the context of conflict-related displacement in refugee camps and resettlement. I contextualized this project in elements of critical and eco-systemic theories and drew from models and theories of substance use, human rights, and historical trauma to frame the conceptualization of the study and the analysis and discussion of the findings. The findings that emerged from this study indicate that both culture and the trauma of displacement had deep and important effects on the ways in which refugees experienced the reasons for and consequences of high levels of alcohol use.

Study Background

Alcohol has been identified as a significant problem in refugee camps along the Thai-Burma border, home to large communities of Karen people. According to the United Nations High Commissioner for Refugees (UNHCR), between 30% and 80% of refugee families from Burma living in camps along the Thai-Burma border are affected by drug and alcohol use and abuse (United Nations High Commissioner for Refugees [UNHCR], 2007). Consumption of alcohol in camps is associated with high levels of domestic and family violence and adolescents are using substances at increasing rates (Barrett, 2007; Ezard, Debakre, & Catillon, 2010, Macdonald, 2006).

Problems related to exposure to alcohol use can continue after resettlement. Refugees with histories of conflict-related trauma exposure as well as refugees who struggle with the difficulties of resettlement in a new culture are at increased risk of developing substance use disorders (Keyes, 2000). While there are no studies of prevalence rates of alcohol or drug use among resettled refugees from Burma in the

United States, anecdotal evidence from Karen cultural leaders and health care professionals who work with Karen communities in Minnesota, a state with a large and growing Karen community, indicates that alcohol use in the resettled Karen refugee community is a significant concern (personal communication, October 19, 2011). Prevalence studies conducted in Cambodian, Hmong, and other Southeast Asian refugee communities in the United States describe elevated rates of substance use, particularly in relationship to trauma exposure, Posttraumatic Stress Disorder (PTSD), depression, anxiety and other war-trauma related symptoms (D'Amico, Schell, Marshall, & Hambarsoomians, 2007; D'Avanzo, Frye, & Froman, 1994; Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; O'Hare, & Van Tran, 1998; Westermeyer, Lyfoung, & Neider, 1989; Westermeyer, 1993; Yee, & Nguyen, 1987).

While it is clear that alcohol use among refugee communities is a concern, there is a dearth of academic research on alcohol and other drug use among refugees in both refugee camp and third country resettlement settings. A few studies describe prevalence rates and patterns of drug and alcohol consumption (D'Amico et al., 2007; Westermeyer et al., 1989) or pilot tests of brief interventions for substance use disorders (Amodeo, 2004; Ezard, Debakre, & Catillon, 2010), yet there appears to be little in-depth understanding or exploration of the experience and perceptions of alcohol and drug consumption in refugee communities from the perspective of refugees themselves, particularly as it relates to displacement, trauma or culture. Furthermore, there has been almost no exploration of changes in alcohol consumption after conflict-related displacement or analysis of the factors that contribute to alcohol use during displacement,

including experiences related to exposure to trauma, cultural factors, and geographic context.

Research with resettled refugees has primarily focused on describing and diagnosing psychological responses to trauma in refugee populations and describing and analyzing the resettlement and acculturation experience, including the distress caused by resettlement. In refugee camp settings, public health and social work research has focused on epidemiologic analyses of health and mental health concerns such as infectious diseases, malnutrition, and psychosocial trauma symptoms. Consequently, the refugee experience both in camps and after resettlement has come to be defined by trauma exposure and its psychological consequences. This focus has obscured exploration of related issues such as alcohol use or domestic violence. Substance use research, prevention, and intervention techniques conducted with refugee communities are primarily based on a Western, biomedical understanding of the mechanisms of addiction and effective treatment and fail to consider refugees' unique cultural, political, and geographic contexts (Ezard, Debakre, & Catillon, 2010). Kleinman (1980), however, suggests that the most effective mental health treatment modalities are those that have developed from a culturally grounded understanding of the lived experience of illness and a full exploration of the causal factors, including culture.

The refugee experience is influenced by an infinite number of factors and is an individualized phenomenon. However, there are a few factors that contextualize the experience of conflict, flight, life in a refugee camp, and resettlement, including exposure to trauma and resulting emotional distress, culture and disruption of culture, and geographic contexts. Exposure to trauma is certainly a significant concern for refugees,

and by definition, most refugees have experienced some form of traumatic event. In 2011, the most recent year for which data is available, there were an estimated 10.5 million refugees worldwide and 27.5 million people who had been internally displaced (UNHCR, 2010). Defined in the 1951 Refugee Convention, a refugee is someone who, "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [sic] nationality, and is unable to, or owing to such fear, is unwilling to avail himself [sic] of the protection of that country" (United Nations General Assembly, 1951). Most refugees, by definition, have experienced one or more severe traumatic events in their country of origin prior to flight including rape, torture, beating, forced labor, imprisonment, or displacement from their homes (Hollifield et al., 2002). Even after reaching the relative safety of a refugee camp, refugees frequently face brutal physical conditions, may be unable to work, and may be at continued risk of rape, beating, torture, cross-border conflict, or other violence within the camps (Lischer, 2006).

Because of their exposure to traumatic events in their home countries and in refugee camps, refugees are at increased risk of developing psychological symptoms related to and including PTSD, depression, and anxiety, as well as trauma-related somatic symptoms such as headaches and joint pain (Johnson & Thompson, 2008). Some studies indicate that adult refugees may be ten times more likely to develop PTSD than the general population in Western resettlement countries (Fazel, Wheeler, & Danesh, 2005). In addition to diagnosable mental health disorders, refugees at health clinics frequently

report other trauma-related symptoms including sleeplessness, nightmares, headaches and stomach pain (Weinstein, Dansky, & Iacopino, 1996).

The varied psychological responses of refugees to conflict-related trauma are well documented (Hollifield, et al., 2002) and there is growing awareness of the need for culturally relevant definitions of and responses to refugee trauma exposure. While there is a well-documented link between trauma exposure and substance use in Western cultures (Jacobsen, Southwick, & Kosten, 2001) and an acknowledgement of increased post-conflict substance use in refugee communities (Ezard, 2011; Weaver & Roberts, 2010) as of yet there is very little scholarship that contextualizes refugee substance use from the perspectives of refugees themselves. While some literature about refugees' emotional responses to traumatic events mention increased risk of substance abuse (Keyes, 2000), there is a lack of research that specifically explores drug and alcohol use in refugee communities, particularly as it relates to culture, trauma exposure and trauma-related mental and emotional responses (Weaver & Roberts, 2010).

Refugees who flee conflict or oppression across borders frequently end up in refugee camps where they register with the United Nations and begin the wait for a solution to their displacement. Once across a border and registered with the UNHCR in a refugee camp, refugees face three options: 1) repatriation to their country of origin after the conflict or crisis has abated, 2) integration into the country of refuge, or 3) resettlement to a third country, generally a Western country such as Canada or the United States. Currently less than 1% of refugees worldwide are resettled in third countries every year and repatriation and integration are often difficult (UNHCR, 2010). For these reasons many refugees, including Karen refugees in Thailand, can languish in camps for

fifteen to twenty years in protracted refugee situations, further adding to the complexity of trauma experienced by refugees (UNHCR, 2010). The exposure to traumatic events experienced during conflict and flight can contribute to increased risk of alcohol and drug use in refugee communities in refugee camps and after resettlement (Keyes, 2000).

In addition to exposure to traumatic events, culture influences the ways in which Karen people use alcohol. There is a host of evidence that cultural beliefs, values, and norms have significant influence on a person's reasons for using alcohol, beliefs about the properties of alcohol or even where a person chooses to drink alcohol (Partanen, 1991; Heath, 2000). Karen culture, like any culture, contains a set of beliefs, practices, and values that influence patterns of alcohol consumption. One of the traumas of conflict and displacement is the disruption of culture, cultural norms, and cultural practices (Braveheart, 1999), which may contribute to changes in patterns of and levels of alcohol use after displacement (Walters, Simioni, & Evans-Campbell, 2002). Cultural practices prior to displacement as well as the ways in which culture has been disrupted or changed by displacement may contribute to the ways in which refugees use alcohol during displacement.

Further, geographic location may play a role in influencing alcohol consumption during displacement and resettlement. Refugee camps often have substandard living conditions including overcrowding, lack of adequate nutrition and clean water, and insufficient health care (Lischer, 2006). Refugees can live in camps for many years, often without education or employment opportunities, leading to feelings of hopelessness, entrapment, and despair (Lischer, 2006). After resettlement, refugees must adapt to a new geographic context that includes a different climate, culture, and language. Research on

acculturation of refugees and immigrants indicates that they often struggle with adapting to new patterns of behavior, including patterns of consumption of alcohol (Beiser & Hou, 2006). Geographic location may contribute to the ways in which refugees use alcohol in the context of conflict-related displacement. Refugees often occupy multiple geographic locations during the course of displacement, leading to a need to explores the multiple and differing ways that each location influences experiences of alcohol use.

Problem Statement

Trauma exposure, cultural beliefs, cultural disruption, and geographic location all contribute to increasing refugees' risk of developing substance use disorders (Keyes, 2000). However, there is little research on refugees' perceptions of the factors that contribute to alcohol use in refugee communities including cultural, political, individual, family, and community-level factors (Ezard, 2012; Weaver & Roberts, 2010). Scholarship that addresses alcohol use in refugee communities has used Western constructs of addiction, obscuring refugees' culturally grounded views and experiences of alcohol (Weaver & Roberts, 2010). This qualitative research study drew from critical ethnography and phenomenology methodologies to explore the lived experiences, perceptions, and constructs of alcohol use of Karen refugees in a resettlement community in Minnesota and in refugee camps in Thailand. An intersection of ecosystemic theory, critical theory, and human rights frameworks was used to provide a broad conceptual grounding for the study, while specific models of psychological trauma and substance use guided methodological choices and procedural decisions, as well as provided a framework for discussion of the findings of the study. The research conducted in this study contributes to building social work knowledge about the effects of political conflict

related to displacement and to the development of more culturally relevant and effective alcohol use prevention and intervention techniques for Karen refugees across the spectrum of displacement and resettlement.

Research Questions

I developed one overarching research question, commonly referred to as a grand-tour question, with six related sub-questions to guide this study across two geographic locations:

1. How do Karen refugees in multiple sites of displacement perceive and experience alcohol use?
    a. How do Karen refugees perceive and experience the *reasons* for alcohol use in their communities?
    b. How do Karen refugees perceive and experience the *consequences* of alcohol use in their communities?
    c. What individual, family, and community level factors including cultural, political, geographical, situational, historical, and familial contribute to alcohol use?
    d. What do Karen refugees see as the relational impact of alcohol use at individual, family, and community levels?
    e. What do Karen refugees believe would be effective in stopping problematic alcohol use?
    f. What are the similarities, differences, and changes between locations of refuge (refugee camps) and resettlement (United States)?

Karen Populations in Burma, Thailand and Minnesota

To provide context for the study I will review the historical context of Karen displacement from Burma, Karen culture, Karen communities in refugee camps in Thailand, and Karen communities in Minnesota.

Historical Context of Karen Displacement

The Karen are an ethnic minority group in Burma who have been fighting for political autonomy or independence from the government since Burma's independence in 1948. The area that would become Burma was colonized by Britain beginning in the mid-1800s as part of the expansion of British India (Milbrandt, 2012). The Burmans were the dominant ethnic group in the area and a host of smaller self-governed ethnic territories were nearby.[2] As part of expansion of colonial rule, Britain incorporated these nearby ethnic territories into the empire including Karen, Karenni, Mon, Kachin, Arakan, Chin and Shan states (Partners Relief and Development & Free Burma Rangers, 2010). Colonization meant different things to different ethnic groups. For the majority Burmans, British rule meant the destruction of a Burman monarchy. Conversely, some ethnic minority groups felt liberated from oppressive Burman rule by the British and experienced a small measure of equality (Moonieinda, 2011).

In the 1940s there began an increasing push for an independent Burma, and Britain agreed to grant Burma independence in 1947 with the condition that the minority ethnic groups agreed to participate in the union (Milbrandt, 2012). During World War II

[2] I use the term "Burman" to refer to the majority ethnic group in the country. I use the term "Burmese" to refer to the people of Burma as a whole

and a brief period of occupation by the Japanese, as well as an armed independence movement, the Karen and other ethnic minority groups supported the British and participated in fighting against the Japanese Army and the Burmese Independence Army. This allegiance with the British led to promises of support for equality for ethnic minority groups after independence from the British. The Panglong Agreement of 1947 dictated that the Burmans and the minority ethnic groups participate in the federal union based on a "principle of equality," which guaranteed political autonomy for the ethnic minority states, although only three ethnic groups (the Chin, Kachin, and Shan) signed the agreement (Milbrandt, 2012).

Autonomy for ethnic minority states was not achieved and shortly after signing the agreement a new constitution went into effect that did not adequately meet ethnic minority demands (Sakhong, 2005). Many ethnic minority groups saw this as a violation of promises for equality made by the British (Moonieinda, 2011). Additionally, the central government was dominated by majority Burmans with very little representation of ethnic minority groups. Regardless of the failure of the constitution to provide equality for ethnic minority groups, Britain granted independence to Burma in 1948 (Milbrandt, 2012). After independence the Burman majority wanted to reinstate supremacy and instituted widespread massacres in Karen and other ethnic states (Moonieinda, 2011). This led to the beginning of the Karen armed revolution on January 31, 1949. Within months of independence, ethnic minority groups—the Karen being the first—established opposition groups to fight for autonomy from the central Burma government (Fink, 2005). The Karen formed the Karen National Union (KNU) as a political group with an armed wing, the Karen National Liberation Army (KNLA), in 1949. The KNLA, backed

by the KNU, as well as several other ethnic minority groups, have continued armed opposition to the Burmese government and sustained fighting for political autonomy since 1948. In addition to fighting for autonomy, the KNU has established a parallel government system in Karen state that provides extensive medical and education services to address the lack of services on the part of the government.

On March 2, 1962, General Ne Win of the Burma Army seized control of Burma through a military coup (Milbrandt, 2012). Protests broke out across Burma that were met with brutal and deadly suppression by General Ne Win's military. All Burmese, including ethnic Burmans and ethnic minorities, were targeted. During this time the Karen National Union and the Karen National Liberation Army were gaining influence, leading to increasing military campaigns in Karen State by General Ne Win. By the early 1970s General Ne Win had increased his assault on the Karen, planning to "cleanse the area of insurgents once and for all" (Zaw, 2008). In addition to widespread suppression of political opposition and calls for democracy throughout Burma, the Burma Army continued sustained attacks on minority ethnic opposition groups (Milbrandt, 2012).

In the 1970s the Burmese Army developed the Four Cuts policy, which was intended to weaken minority ethnic opposition groups (International Human Rights Clinic [IHRC], 2009). The Four Cuts were cutting off groups' access to food, funding, information, and supplies. Directly related to the Four Cuts, thousands of civilians have died and hundreds of thousands of people have been displaced (IHRC, 2009). While the Burmese government has denied the existence of the Four Cuts policy, there is evidence that the policy continues today (IHRC, 2009). As a result of these oppressive practices

and human rights violations, refugees have been pouring over the border into neighboring Thailand since the 1980s.

General Ne Win left the presidency in 1981 and stepped down from chairing the Burma Socialist Program Party in 1988. After years of brutal suppression and amid economic uncertainty, wide-spread protests broke out across the country on August 8, 1988, which came to be known as the 8888 Uprising (IHRC, 2009). Protesters demanded an election of a civilian government and more democratic governing processes. The Burma military responded with widespread killing (including killing of thousands of unarmed students and Buddhist monks), torture, and political imprisonment of protesters and opposition leaders (IHRC, 2009). During this time Aung San Suu Kyi, the daughter of one of the leaders in Burma's independence movement, emerged as a leader of the fight for democracy in Burma. She co-founded the National League for Democracy in 1988 and was placed under house arrest in 1989. She spent fifteen of the next twenty-one years under house arrest and was most recently released in 2010 (Milbrandt, 2012).

After the protests in 1988, a group of military general seized power of Burma and instituted martial law under a ruling military junta, the State Law and Order Restoration Council (SLORC) (US Department of State, 2012). After taking power, the SLORC attempted to suppress public demonstrations for democracy and killed an estimated 3,000 civilians (US Department of State, 2012). At the same time, the SLORC responded to increased ethnic minority opposition through widespread attacks on groups in the eastern part of Burma, including on the Karen. Starting in early 1990, several ethnic groups signed ceasefire agreements with the military regime, although many of these agreements have failed and fighting has continued (ALTSEAN Burma, 2004).

Martial law under the SLORC continued in Burma until national parliamentary elections in 1990. The National League for Democracy party, led by Aung San Suu Kyi, won an overwhelming victory in these elections, with almost 60% of the vote (US Department of State, 2012). In response, the SLORC stepped up imprisonment of political activists (US Department of State, 2012). For the next several years, through the mid-2000s, the SLORC attempted to draft a national constitution, although the process has been accused of being extremely restrictive and failing to incorporate opposition involvement to incorporating opposition involvement (US Department of State, 2012). In 1997 the ruling junta changed their name from the SLORC to the State Peace and Development Council (SPDC), but their tactics and continued oppression of ethnic minority groups remained the same.

In 2008 the SPDC held a referendum on the draft constitution, although they were accused of repression of free debate and intimidation throughout the voting process. In 2008 the SPDC declared that the new constitution had received 92% approval (US Department of State, 2012). The international community has been harshly critical of Burma's clear repression and silencing of democracy and political opposition and numerous human rights abuses perpetrated by the military government in all its incarnations have been documented, including torture, mass killing, political imprisonment and suppression of free speech (US Department of State, 2012).

On November 7, 2010, Burma held parliamentary elections that effectively ended SPDC rule, but the election was described as extremely unfair by the international community (US Department of State, 2012). Members of the military regime won more than 75% of seats in the parliament and while the government does include civilians for

the first time in years, almost all key positions are occupied by former SPDC leaders (US Department of State, 2012).

Throughout this history the SLORC and later the SPDC have continued oppression, armed attacks, and widespread human rights abuses in ethnic minority territories in the eastern part of Burma, including against the Karen. Human rights abuses against the Karen include extrajudicial killing, rape, torture, forced labor, forced removal from land, use of child soldiers, restriction of freedoms, and widespread use of landmines (Amnesty International, 2011). The Thai-Burma Border Consortium estimates that more than 969 villages have been destroyed by the Burma military and more than 580,000 villagers have been displaced since conflict began forty years ago (TBBC, 2012).

In January, 2012, the Burma government signed a ceasefire agreement with the Karen National Union. Democratic Voice of Burma has reported that while fighting has decreased in Karen State, many Karen people distrust the agreement, seeing it as an effort to improve international diplomatic relationships rather than to protect ethnic minority groups. In addition, there have been several reports of continued attacks by Burma military in Karen State after the ceasefire (IHRC, 2012).

According to a report by Milbrandt (2012) documenting the case for labeling Burma's treatment of Karen people genocide, one of the most wide-spread and significant human rights violations by the Burma Army has been widespread, systematic, and deliberate displacement of Karen people from their homes and villages. This removal is achieved through armed attacks on villages, burning villages to the ground, shooting villagers, raping women, kidnapping children for child soldiering, stealing livestock and food stores and littering fields with landmines to prevent the return of villagers.

Milbrandt (2012) identifies these tactics as deliberately "calculated to bring about physical destruction of the Karen people in whole or in part" (p. 44).

The Karen National Liberation Army and the Democratic Karen Buddhist Army

The conflict between the Karen people and the Burmese military is made more complex by the existence of two different Karen armed groups: the Karen National Liberation Army (KNLA), which is the armed faction of the KNU and the Democratic Karen Buddhist Army (DKBA), which is an armed group that split off from the KNLA in 1996. The KNU and the KNLA were formed in 1949 and have multiple aims within Karen State and for Karen people, leading to a complex relationship with the Burmese government. As a result of the Four Cuts policies Karen State has a significant lack of resources, including medical and education services, food, and other material goods. Consequently, the KNU has had to resort to participation in the black market to procure food and other supplies. Money made from participation in the black market has been funneled back into supporting the KNU and the KNLA, but has also resulted in frequent accusations of corruption aimed at KNU and KNLA leaders. In addition, the leadership of the KNLA and KNU was primarily Christian while the front line units were almost all Buddhist. As a result of perceived religious discrimination as well as corruption a group of Buddhists mutinied from the KNLA and formed the DKBA. The DKBA then aligned with the SPDC and turned against the KNLA. It is important to note that many people believe the DKBA was coerced into aligning with the SPDC against the KNLA out of very real fear for their lives. For next 16 years there have been allegations of significant abuses by both the KNLA and the DKBA against each other. The KNLA has accused the DKBA of partnering with the SPDC to massacre Karen refugees in camps in Thailand

and the DKBA has accused the KNLA of significant human rights abuses against Buddhist Karen. In recent years (2010 and 2011) there have been significant movements toward peace and cooperation between the DKBA and the KNLA culminating in a joint ceasefire agreement between the DKBA, the KNLA/KNU and the Burmese government in 2012 (Nyar, 2012). This ceasefire is tenuous at best as reports of violations by the Burmese government have been documented by the Karen Human Rights Group (KHRG, 2012).

Karen Culture, Language, and Religion

Burma has an estimated population of 52 million people (Human Rights Watch, 2005). Ethnic minorities make up at least 35% of the population, with the other 65% made up of Burmans (Human Rights Watch, 2005). The Karen are the largest ethnic minority group. Although Karen people live in rural and urban areas throughout Burma, the majority of Karen people live in Karen State (*Kawthoolei* in Sgaw Karen language) in the eastern part of Burma, along the border with Thailand. This area is mountainous and heavily forested. Most Karen in Karen State are subsistence farmers, living in small villages and growing mostly rice. There are two main Karen languages—Sgaw and Pwo—and multiple dialects. Sgaw Karen are the largest sub-group of Karen (Moonieinda, 2012). There is also a large population of Thai-Karen people living in Thailand along the Thai-Burma border (Moonieinda, 2012). Karen people are predominantly animist, Christian, and Buddhist, with the majority (85%) being Buddhist (Human Rights Watch, 2005).

Karen people typically value community and shared cultural identity over individual opinion or needs (CDC, 2010). Because of this, family and family identity is

central to Karen culture. Both immediate and extended families are vitally important to Karen social life and much time is spent nurturing social bonds within families and communities. Food is a significant part of Karen culture and eating together is a way to create and support social bonds (Moonieinda, 2012).

Education is also extremely important in Karen culture. In fact, many Karen communities set up schools in the jungles for children after forced removal from villages, continuing to educate their children during the months of flight across the border to refugee camps in Thailand (Moonieinda, 2012).

Religion is important in Karen communities and Karen are primarily animist, Buddhist, and Christian (Moonieinda, 2012). Traditionally, Karen have been animist, with a belief in spirits that inhabit trees, rivers, mountains, and houses. Even Karen who are now Buddhist or Christian may continue some animist practices (Moonieinda, 2012). Today, most Karen are Buddhist and an estimated 15% are Christian. Christian Baptist missionaries began converting Karen people in the mid-1850s and today, the majority of Karen Christians are Baptist (Moonieinda, 2012).

Alcohol is an integral part of Karen culture and is a significant part of most cultural ceremonies such as marriages, funerals, parties, and social gatherings (Moonieinda, 2012). Alcohol is traditionally consumed as an appetizer before meals and is often used for health reasons, such as to treat a cold or headache. Most Karen people, especially in Burma and in refugee camps in Thailand, drink a home-brewed beer or whiskey made from rice (Moonieinda, 2012). In the refugee camps people who make rice-based alcohol at home often use their rice rations to do so. Men are the primary consumers of alcohol, although older women do occasionally drink together as well.

Most drinking is done in social groups rather than alone. Men will often gather together and sit in a circle with one bottle of alcohol and one cup. They will then pass the cup and bottle around the circle, drinking until the bottle is finished or until the participants pass out (Moonieinda, 2012).

Status is important in Karen culture and leaders are given a high level of respect (Centers for Disease Control [CDC], 2010). Many Karen place a high value on being quiet and reserved and being direct is often considered rude (CDC, 2010). Decisions are often made by consensus in Karen communities and disagreement or confrontation is often avoided. In particular, many Karen believe that anger is disrespectful and should be avoided (CDC, 2010). Many Karen follow gender roles in which men work in the fields and women care for children and do household tasks. Karen culture is matrilineal and while men are often considered the head of the household, women's opinions are often highly respected and honored (CDC, 2010). Karen people have typically had large and extended families with multiple generations living together in one household. Karen people often highly value family, respect for elders and duty to parents (CDC, 2010).

Karen Refugees in Thailand

The Burmese refugee situation in Thailand is one of the most protracted in the world. Refugees have been fleeing across the border from Burma in large numbers since 1980 (UNHCR, 2009). There are nine government-run refugee camps along the eastern border of Thailand and Burma and about 79% of refugees living in these camps are Karen (TBBC, 2012). Figure 2 below depicts a map of the location of the camps in Thailand. These camps officially host more than 150,000 refugees, although actual numbers of refugees are estimated at approximately 250,000 (TBBC, 2012).

Additionally, there are currently about 400,000 people internally displaced in Burma and many thousands more living as undocumented migrants in Thailand (TBBC, 2012). Refugee camps in Thailand are closed camps, meaning that residents cannot leave the camps. Refugees found outside of camps face arrest, detention, and deportation to Burma. Refugees receive basic shelter, food, health care, and schooling in the camps, but the lack of freedom and the length of time refugees have been living in camps leads to psychological and social strain (UNHCR, 2009). Refugees in camps often face harsh conditions; issues such as domestic violence, rape, and substance use are common (UNHCR, 2009).

Thailand is not a signatory to the 1951 United Nations Convention for the Protection of Refugees, meaning the Thai government oversees admission to the camps and maintains a stronger jurisdiction over refugees, asylees, and migrants in Thailand than other refugee host countries. Thailand has a mixed record on protection of refugees from Burma and the current volatile political situation in Thailand has pushed refugee concerns to a lower priority status (UNHCR, 2009). With the political developments of 2011 and 2012 in Burma and the signing of cease-fire agreements with some ethnic groups the Thai government has begun to consider repatriation for Karen and other Burma refugees (UNHCR, 2013b).

Karen Refugees in the United States

Karen refugees were first resettled in the United States in Minnesota in 1994. However, until 2005 their numbers were quite small (ORR, 2012). Beginning in 2005 resettlement of Karen refugees from Thailand began in earnest and by early 2013 more than 75,000 refugees from Burma had been resettled in the United States, including

10,000 in 2011 (UNHCR, 2013c). Minnesota has received more than 4,000 refugees from Burma since 2005, most of whom are Karen (ORR, 2012). Many more Burma refugees have moved to Minnesota after resettling in other states (Power et al., 2010).

In Minnesota, more than 90% of the Karen community lives in one area in St. Paul (Power et al., 2010). There is a small but growing Karen community in Worthington, a small farming community in southwest Minnesota. Worthington is also home to a large meat-packing industry which has become a significant provider of jobs for Karen and other refugees (Power et al., 2010).

A comprehensive medical chart review of 322 Karen patients at a health clinic in St. Paul revealed a significant amount of information about the resettlement and health needs of newly arriving Karen refugees (Power et al., 2010). Power and colleagues found that language barriers were a significant issue for newly arriving Karen refugees to accessing health care as well as finding employment or stable housing. Because of the relative newness of this particular refugee group there continue to be a lack of interpreters for health and social service visits (Power et al., 2010). The study authors also found that 19% of the population reported alcohol consumption, although they also noted this number was most likely lower than normal because of underreporting (Power et al., 2010).

Definition of Terms

Prior to describing the procedures of this study I will define the use of the terms refugees and alcohol use and explain the use of 'Burma' rather than Myanmar as the country name.

Refugee

In this study I defined refugees using the United Nations definition of a refugee cited above. Participants in this study who were interviewed in Minnesota were all refugees who have been registered as such with the United Nations and have resettled in the United States with refugee status. Participants in Thailand who participated in semi-structured formal interviews were all refugees registered with the United Nations. Participant-observation and other informal conversations took place both with registered refugees and with Karen migrants who were in Thailand but were not registered with the UNHCR or living in refugee camps. Migration from Burma into Thailand is common along the porous Thai-Burma border and many migrants cross the border both with and without documentation to escape conflict and to find employment. In addition, some refugees who spent time in refugee camps have since left the camps and settled in Thailand as guest workers, particularly with NGOs along the border (Thai Burma Border Consortium [TBBC], 2011).

Alcohol Use

This study focused primarily on alcohol use rather than both alcohol and drug use. Drug use, especially methamphetamine use, is a growing concern along the Thai-Burma border and in the refugee camps (UNHCR, 2007). However, few participants spoke about drug use and overwhelmingly reported that alcohol use was their main concern. While I had intended to focus on both drug and alcohol use when conceptualizing this study, it quickly became clear that alcohol use was the focal point for all of the study participants and thus became the focal point for this study.

Throughout this research I employed a broad definition of alcohol use and problematic alcohol use. Rather than using the American Psychological Association's Diagnostic and Statistical Manual definition that describes levels of use, abuse, and dependence, I allowed participants to define problematic levels of use. In this study I purposefully avoided pre-defining addiction, problematic substance use, or levels of alcohol consumption and instead used participants' voices to describe appropriate and inappropriate levels of alcohol use and resulting behaviors.

Use of Burma as Country Name

The population for this study is Karen people, an ethnic group from Burma. In 1989 the ruling ethnic majority group, the Burmans, changed the name of the country from Burma to Myanmar. Burma was an English modification of the name of the country given during the British colonial era and the ruling military regime called the name change a return to a Burman identity. Other English place-names where changed, as well. Minority ethnic groups viewed the name change as an act of ethnic cleansing and a top-down "Myanmarification" of the country in which the ruling military regime enforced a single linguistic and cultural identity that denied the identity of ethnic minorities (Delang, 2000). Currently, within a larger political context including at the United Nations, Burma is formally called Myanmar. However, because the name Myanmar is perceived as part of a broad attempt to strip minority ethnic groups of their ethnic identity, language, and heritage, most Karen people prefer to use Burma as their country name. Even further, most Karen people refer to their homeland as Karen State or *Kawthoolei*, the geographic area in Burma in which most Karen people live.

Karen people living in Thailand also referred to Karen State or Burma as "inside." For example, in describing what life is like in Burma someone might say "We used to do that inside, but not here," with "inside" indicating within the borders of Karen State in Burma. In this study I used the language of the study participants, referring to Burma, Karen State, *Kawthoolei*, and "inside" where appropriate. I chose to use the language of the study participants, particularly when referring to Burma, out of respect for the participants in this study and recognition of the historical oppression that the use of Myanmar implies.

Outline of Remaining Chapters

The remaining chapters contain a detailed examination of all aspects of the study. In Chapter 2 I present an extensive review of the background literature that frames this study, including a review of literature about the trauma of displacement, the correlation between substance use and trauma exposure, and the influence of culture on alcohol use. I also review and describe the multiple theoretical frameworks, models, and paradigms that guided this study. In Chapter 3 I present the methodologies and procedural steps that I followed in conducting the study. I include a review of trustworthiness in qualitative research and steps I took to ensure the trustworthiness of the data. In Chapter 4 I present the categories and themes that resulted from the data analysis. In Chapter 5 I discuss the findings in light of current knowledge about alcohol use in Karen refugee communities. Finally, in Chapter 6 I conclude with a discussion of the implications of this study for social work knowledge, policy, and practice, provide an explanation of limitations of this study, and suggest avenues for future research.

Chapter 2: Literature and Theoretical Frameworks

Chapter Overview

In this chapter I will review the literature that serves as the context and background for this study and describe the theoretical frameworks that guided the research. First I will review the growing body of literature that describes and analyzes the experience of conflict-related displacement and refugee status with a particular emphasis on the historical evolution of the understanding and definition of the trauma of displacement. Second, I describe the well-documented correlation between psychological trauma and substance use in Western-born populations and the relative influences of this research on addressing substance use in refugee communities. Third, I describe and review literature about the intersection of culture and alcohol with a particular emphasis on reviewing current culturally grounded understandings of the causes, consequences, and experiences of alcohol use in Southeast Asian cultures. Fourth, I review the small body of literature that describes the intersection of trauma and substance use in displaced populations, pointing out the gaps in the literature that were addressed by this study. Finally, I review the theoretical frameworks employed in this study, including the overarching paradigms of social construction, critical, eco-systemic, and human rights theories, relevant substance use models and theories, including social learning theory and self-medication models and trauma and displacement models, including models of historical trauma.

Literature Review

Refugee Displacement, Trauma, and Mental Health

Non-governmental organizations such as Amnesty International and Human Rights Watch as well as the United Nations have documented a wide range of oppression, torture, trauma and human rights violations that have occurred as a result of dozens of civil wars, ethnic conflicts and oppressive regimes around the world (Amnesty International, 2011; Human Rights Watch, 2011). These violations include, but are not limited to, rape, beating, imprisonment, forced labor, forced dislocation, oppression of free speech, torture, and genocide (Amnesty International, 2011; Human Rights Watch, 2011). Most refugees and internally displaced people have experienced some form of physical or psychological trauma at several points during conflict, displacement, and resettlement (UNHCR, 2010). Judith Herman (1992) describes psychological trauma as occurring at three major points during displacement and resettlement: 1) refugees often experience physical or psychological trauma during active conflict or oppression in their home country, 2) refugees often experience physical or emotional trauma during confinement in refugee camps due to continued cross-border fighting, disruption of culture and community, isolation, lack of access to adequate food and water, and hopelessness about the future, and 3) refugees often experience psychological and emotional trauma related to the difficulties of resettlement and acculturation in a third country.

Current definitions of trauma include a wide range of experiences including both first-had exposure to traumatic events and historical or intergenerational transmission of trauma through multiple generations. However, this was not always the case when

describing the trauma of refugees. Historically, ideas about trauma experience, trauma response, and refugees were much more narrow and contextualized by Western understandings and definitions of trauma and corresponding psychosocial responses. War-related mental and emotional distress is well-documented historically both in popular literature such as Vonnegut's (1969) *Slaughterhouse Five* and in colloquial terms like "shell-shock," popularized after World War I (Trimble, 1985). Building on a growing understanding of the specific psychological symptoms caused by exposure to traumatic experiences especially by United States veterans of the Vietnam War, the third edition of the American Psychological Association's Diagnostic and Statistical Manual (APA, 1980) published in 1980 identified Posttraumatic Stress Disorder (PTSD) as the diagnosis for these symptoms. Posttraumatic Stress Disorder is a constellation of symptoms describing psychological and emotional reactions to traumatic events. To be diagnosed with PTSD a person must experience or witness a traumatic event that involves the threat of injury or death. Symptoms of PTSD develop after the event and are clustered in three categories: reliving the event through flashbacks, nightmares, or intrusive memories of the event; avoidance symptoms including feeling numb or detached, avoiding people and places that are reminders of the event; and arousal symptoms which include difficulty concentrating, startling easily, or feeling irritable (APA, 1994). Since the 1980s, as more refugees from more countries have resettled in the United States and as PTSD has gained prominence in psychosocial research, further studies have been conducted to assess PTSD and other war-related mental health disorders in resettled refugees.

In the late 1970s and early 1980s Southeast Asian refugees from Laos, Cambodia and Vietnam began resettling in the United States in large numbers (Mollica, Wyshak, & Lavelle, 1987). These refugees had experienced a range of conflict-related traumas including sexual violence, imprisonment, forced labor, torture, beating, and witnessing the death of family members (Mollica et al., 1987). As more refugees resettled in the United States, social work, psychology and psychiatry professionals and researchers began to recognize their pressing mental health needs and began exploring the mental health symptoms of refugees who had experienced war trauma and torture. Mollica and colleagues' (1987) work and a report by Kinzie et al. (1984) represent some of the first explorations of the mental health sequelae of war trauma in resettled refugees.

Drawing on a clinical sample of 13 Cambodian concentration camp survivors in the United States, Kinzie (1984) reported severe and debilitating PTSD symptoms including withdrawal from friends and family, intrusive memories, nightmares, and trouble sleeping. In a clinical sample of 52 Southeast Asian refugees, Mollica et al. (1987) found that all had experienced multiple severe traumatic events and that those with PTSD had experienced twice as many traumatic events as those without PTSD. Fifty percent of the sample had a diagnosis of PTSD.

These studies, motivated by the historical convergence of the development of PTSD and the rapid resettlement of Southeast Asian refugees, set the stage for a host of subsequent research studies that described resettling refugees' mental and emotional states through the lens of a Western set of diagnoses including PTSD, depression, and anxiety (Jaranson et al., 2004; Moisander & Edston, 2003; Shrestha et al., 1998). This narrow definition of the experience of displacement placed traditional first-hand

experience of physical and emotional trauma experiences such as rape, imprisonment, torture, and witnessing the death of family members at the center of the definition of trauma. It consequently omitted from the definition of trauma intergenerational transmission of trauma experiences, the trauma of living in a refugee camp and the trauma experienced during resettlement and acculturation in a third country. Subsequently PTSD, depression, and anxiety became the diagnoses that would define the research, understanding, and treatment of refugees for many years afterward, often obscuring other types of responses to displacement, including behavioral responses such as alcohol use and domestic violence or resilient responses and limiting the scope of the definition of traumatic experiences.

One of the most significant examples of the ways in which PTSD can be questioned in the literature is the evidence of extremely wide and conflicting rates of PTSD among refugees. Hollifield et al. (2002) analyzed 183 articles describing prevalence rates of PTSD, depression, and anxiety in resettled refugee communities and found that the studies reported a range of PTSD rates between 4% and 86%. In a review of twenty surveys covering 6,743 adult refugees from seven countries Fazel et al. (2005) found a similar range of prevalence rates. Both Fazel et al. (2005) and Hollifield et al. (2002) posit that the wide range of reported PTSD prevalence rates in the literature could be the result of sampling and assessment methods. In particular, Hollifield (2002) writes that data about refugees' war-related mental health symptoms is difficult to interpret due to a lack of culturally relevant, standardized or validated assessment tools.

There are a multitude of factors that could contribute to this problematic range of PTSD prevalence rates including cultural and experiential differences between the

ethnic groups under study, a lack of understanding of protective factors for PTSD and a lack of culturally valid descriptions and understandings of the experience of trauma and displacement. For example, in an epidemiological study of 1,134 Somali and Oromo refugees in Minneapolis results showed torture prevalence rates of 25% for Somalis and 69% for Oromos, resulting in different rates of PTSD due in part to the differing rates of torture in each ethnic group (Jaranson, et al., 2004). Most important in describing and understanding this problematic range of PTSD rates is the lack of reliable measurement tools that have been validated in refugee ethnic groups for assessing mental and emotional distress. This lack of measurement tools is directly related to the lack of understanding among scholars of the culturally grounded constructs of emotion, mental health, and trauma experience in refugee communities. Without an in-depth understanding of the ways in which different ethnic groups understand and perceive emotional and psychological responses to the trauma of displacement, prevalence rates measured with tools validated in Western communities become less useful.

In recent years, in part as a response to conflicting rates of PTSD in the literature, scholars have begun to question the relevance of the PTSD diagnosis as it has been applied to refugee communities (Bracken, Giller & Summerfield, 1995). Biomedical discourse about problems imported to non-Western locales can obscure non-biological explanations for psychological symptoms such as poverty, discrimination, or role conflict. Medical anthropologists (Breslau, 2004; Kleinman, 1980) have questioned the validity of diagnoses like PTSD in non-Western settings. Bracken et al. (1995) assert that the diagnosis of PTSD has an implicit assumption of individuality that might not be universal. Additionally, assuming the universality of diagnoses like PTSD emphasizes

similarities in responses to war trauma while obscuring culturally specific responses. These arguments imply that the development of assessments and interventions based on assumed universal constructs of PTSD could be ineffective.

This questioning of the applicability of PTSD to refugee communities has led to a range of research on other factors relating to the mental and emotional consequences of displacement, including expanding the definition of traumatic events to include historical and intergenerational transmission of trauma, the trauma of living in a refugee camp and the trauma of acculturation and resettlement, in essence a definition that is better described as the "trauma of displacement." It has also led to an expansion of the understanding of refugees' responses to these various traumas to include somatic experiences, culturally bound syndromes, resilience, and relational and behavior responses.

This new way of conceptualizing trauma experiences and trauma response has led to a new way of conceptualizing displacement itself. In most research about refugees, study populations are geographically discrete, meaning refugees are either studied in camps or after resettlement. This has contributed to a tendency to conceptualize refugees' experiences as geographically discrete, as well. Definitions of and thinking about displacement should be broad enough to contain multiple locations and should consider refugees' experiences as being important during conflict, during time in refugee camps as well as during and after resettlement. Having a concept of displacement that contains multiple locations allows for a more encompassing understanding of the range of traumas and responses contained in the refugee experience.

The trauma of displacement includes physical and emotional trauma such as violence and witnessing the death of family members. It also includes historical or intergenerational trauma, loss of culture, effects of living in protracted refugee camp settings and acculturation and resettlement stress.

Like other refugees, Karen refugees, the focal population of this study, have experienced high levels of trauma prior to and during displacement. In 2002 public health scholars conducted a mortality survey with 244 newly arriving refugee families in one refugee camp in Thailand (Cecchi, Elder, Schafer, Drouhin, & Legros, 2003). The families in the study reported high mortality due to violence from military actions. Families also reported attacks on their villages and fear of persecution (37%), forced labor (34%), and forced relocation (22%) as reasons for leaving Burma. Families also reported that their houses had been set on fire by Burmese military and that entire villages had been burned to the ground. These experiences of trauma are consistent with reports of first-hand exposure to physical and psychological trauma during conflict from a host of other refugee groups (Amnesty International, 2011; Human Rights Watch, 2011).

Expanded definitions of the trauma experience for refugees now include historical or intergenerational transmission of trauma. Historical trauma (Braveheart, 1999; Braveheart, 2003; Evans-Campbell, 2008; Whitbeck, Adams, Hoyt, & Chen, 2004) is defined as cumulative psychological and emotional distress resulting from mass and wide-spread trauma such as genocide that has been transmitted across multiple generations. Within the framework of historical trauma, an individual does not have to have personally experienced traumatic events to suffer emotional wounding. This is

particularly the case when trauma is widespread and experienced on a community level for multiple years. Refugees, especially Karen refugees, have experienced multiple generations of trauma and the psychological wounds resulting from this trauma have been passed down through generations (Fuertes, 2004).

Current definitions of trauma experienced by refugees include the loss of culture due to displacement across borders. A host of studies have indicated loss of culture as a significant factor impacting emotional, psychological, and relational well-being after conflict-related displacement (Davis, Kennedy, & Austin, 2000; Hodes, 2000; Sideris, 2003; Steel, Silove, Bird, McGorry, & Mohan, 1999; Tempany, 2009). These studies describe loss of culture as including both the loss of homeland as well as the loss of community and community structures that support culture, language, and identity. Loss of culture can happen during conflict when oppressive regimes destroy the culture of an ethnic group through oppression of language, dress, and cultural practices. Loss of culture happens when communities and families are torn apart and displaced to refugee camps where they may have little opportunity to participate in cultural actions such as religious ceremonies or marriage and funeral rites. Finally, loss of culture happens when refugees resettle to third countries and must acculturate in order to survive, which can contribute to further loss of culture. Loss of culture is often simply listed as one of many traumas a refugee experiences and the effects of culture loss are rarely explored in depth in the academic literature. However, scholars do point out that this loss of culture significantly impacts emotional well-being after displacement. There is a significant need for more understanding of the ways that cultural loss or disruption impact emotional and psychological well-being during and after displacement.

Studies of refugees in refugee camp settings indicate high levels of war-related mental and emotional distress, indicating that site-specific variables may affect the development of PTSD. In a study of 495 Karenni refugees in three camps along the Thai-Burma border, Cardozo, Talley, Burton, & Crawford (2004) found high levels of depression, anxiety, and PTSD. Cardozo also found that refugees who lacked sufficient access to food (a common problem in refugee camps), had experienced a higher number of traumatic events, or had previous mental illnesses were more likely to have poorer war-related mental health outcomes. De Jong et al. (2001) explored PTSD in four settings and found that poor refugee camp conditions like lack of access to food and clean water was significantly related to higher levels of PTSD in refugee camps in Gaza and Algeria. In contrast, Shrestha et al. (1998) found that low rates of PTSD (14%) among tortured Bhutanese refugees in Nepal were attributed to situational factors including relatively good living conditions within the refugee camps and that entire villages and families had been displaced together, leading to more social support.

Explorations of refugee trauma and trauma response historically have been contained to PTSD diagnoses after resettlement. However, as conceptualizations of displacement, trauma, and trauma response expanded, so did the understanding of refugees' emotional and psychosocial responses to resettlement and acculturation. A significant body of literature exists that describes the traumas that occur during the resettlement process. After resettlement refugees encounter a host of stressors, including difficulties learning a new language, adjusting to a new culture, finding stable employment, finding adequate and stable housing, dealing with role loss, dealing with generational gaps created by youth who acculturate faster than adults, accessing the

health care system, and dealing with separation from family members left behind in refugee camps and countries of origin (Beiser & Hou, 2006). These difficulties have been identified as additional traumas that can cause emotional distress (Herman, 1992). Several studies have indicated that pre-migration trauma coupled with resettlement stress contributes to elevated levels of emotional distress including PTSD in resettled refugees (Beiser & Hou, 2006; Lindencrona, Ekblad & Hauff, 2008; Silove, 1999). It is important to understand and conceptualize resettlement stress as an additional form of trauma for refugees because it is so often compounded by pre-migration trauma and the trauma of living in refugee camps. Multiple forms and experiences of trauma can lead to difficulty with resettling and acculturation, prolonging the amount of time it takes for refugees to feel successfully integrated into their new countries and cultures.

Expanded understanding of the types of trauma experienced by refugees has led to an expanded and more comprehensive understanding of the range of responses to the trauma of displacement. Historically, the refugee experience of trauma has been defined by the singular diagnosis of PTSD. More recently, understanding has grown to include not only PTSD, depression, anxiety, but also culture-bound syndromes, somatic symptoms, behavior and resilience, and relational responses such as substance use.

Historically, culture-bound symptoms of emotional distress such as "thinking too much" or joint pain as a manifestation of stress have often been overlooked by the Western professional mental health community because they do not fit within conventional classification and diagnostic systems. Recently, though, scholars have begun to explore and describe a range of culturally specific ways of describing and experiencing refugees' trauma-related stress (Haque, 2010; Sulaiman-Hill & Thompson,

2012). Several examples of culture-bound syndromes include somatic symptoms such as headaches and stomachaches with unknown causes experienced by Burmese refugees (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011), "thinking too much" as a way to describe stress experienced by Afghan refugees (Sulaiman-Hill & Thompson, 2012), and sudden unexplained death during sleep in Hmong men (Xiong, Finn, & Young, 2013). These studies clearly indicate that refugees experience mental and emotional distress in ways that move beyond traditional diagnoses of PTSD. Studies that limit their definition of emotional responses to trauma to PTSD, depression, and anxiety may be overlooking cultural explanations and experiences of distress.

In recent years scholarship about refugees has begun to explore factors related to resilience in the face of significant trauma (Agaibi & Wilson, 2005). These studies have significantly added to current understanding and conceptualization of trauma response, further contributing to a move away from a narrow definition of trauma response to a broad understanding that encompasses multiple ways of responding to trauma. Explorations of resilience are predicated on the idea that refugees do not always respond to trauma with negative emotional and psychological sequelae. Instead, many refugees live through multiple traumas and go on to live healthy and successful lives during displacement and after resettlement. Several studies have examined the protective factors that contribute to resilience post-trauma and have identified strong family support, physical health, religion and the availability of community support and access to culturally relevant services and activities after displacement as contributing to resilience (Arnetz, Rofa, Arnetz, Ventimiglia, & Jamil, 2013; Hutchinson & Dorsett, 2012; Soussoua, Craig, Ogrenc, & Schnakd, 2008).

Psychological Trauma and Substance Use

Beginning in the late 1970s with research with Vietnam veterans, scholars have documented a strong relationship between exposure to traumatic events and substance use and the co-morbidity of PTSD and substance abuse or dependence (Keane, Caddell, & Martin, 1983). To date, research on the co-morbidity of PTSD and substance use has focused primarily on veterans; however, recent studies with civilian samples indicate similar strong correlations (Stewart, 1996).

PTSD is frequently comorbid with other mental health disorders (Jacobsen, Southwick, Kosten, 2001). In clinical samples of men with PTSD substance abuse or dependence is the most common co-occuring disorder (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In a review of research on PTSD and substance abuse in women, Najavits, Weiss and Shaw (1997) found that women with substance use disorders have high rates of dual diagnosis with PTSD (between 30% and 59%). The authors also found that men with substance use disorders had rates of dual diagnosis two to three times lower than women.

In studies in the late 1970s and early 1980s researchers found extremely high rates of PTSD and substance use comorbidity. Kessler et al. (1995) found that as many as 75% of Vietnam War veterans with PTSD also had substance use disorders. More recent studies in civilian populations show similarly high rates of comorbidity. In a random sample of 1,007 adults, Breslau, Davis, Adreski, & Peterson (1991) found that 21.5% of respondents with PTSD had co-occurring substance use disorders compared to 10.6% of the respondents without PTSD. Among substance users in the general population, Cottler, Compton, Mager, Spitznagel, & Janca (1992) found that 8.3% had co-occurring PTSD.

Similarly, in a clinical sample of 91 participants attending an out-patient substance abuse treatment program, Bonin, Norton, Asmundson, Dicurzio, & Pidlubney (2000) found that 52.8% had either PTSD (37.4%) or possible PTSD (15.4%) as measured by the Beck Anxiety Inventory.

In addition to comorbidity, persons with both PTSD and substance use disorders appear to suffer more severe PTSD symptoms, particularly avoidance and arousal symptoms. In a study that compared 28 women with comorbid PTSD and substance use disorders with 28 women with PTSD only, Saladin, Brady, Dansky, Kilpatrick (1995) found that respondents with both PTSD and substance use disorders had significantly more avoidance and arousal symptoms and had experienced more traumatic events than the group with PTSD only.

The relationship between PTSD and substance use is extremely complex and determining causal order is difficult—two primary correlations have been suggested in the literature. In the first, substance use precedes the development of PTSD. Some persons with substance use disorders frequently place themselves in dangerous situations as a result of using or securing illicit substances, thereby increasing their risk of physical or psychological harm (Cottler et al., 1992). In addition, chronic substance use is thought to increase vulnerability to developing PTSD after experiencing a traumatic event (Brady, Dansky, Sonne, & Saladin, 1998).

In the second correlation, studies suggest that PTSD precedes substance use, abuse, or dependence. The most prominent theory of PTSD as a preceding risk factor for the development of substance use disorders is Khantzian's (1985) theory of self-medication. Studies indicate that substance use develops after experiencing traumatic

events as a way to reduce or mediate PTSD symptoms (Bremner, Southwick, Darnell, & Charney, 1996). Bremner and colleagues found that a sample of 61 Vietnam War veterans with PTSD had high rates of marijuana, heroin, and alcohol use to alleviate hyperarousal symptoms. In a study using data from the National Epidemiologic Survey on Alcohol and Related Conditions (n=34,653), Leeies, Pagura, Sareen, and Bolton (2010) found that 20% of respondents with PTSD used drugs or alcohol to self-medicate PTSD symptoms.

There is conflicting evidence in the literature about whether simply being exposed to trauma without developing PTSD increases risk of later developing substance use disorders. Similarly, there is some evidence that exposure to trauma without PTSD increases alcohol use independent of the development of substance use disorders (Green, Grace & Gleser, 1985). Green et al. (1985) found that simply experiencing a traumatic event without onset of PTSD could contribute to elevated levels of alcohol use. Conversely, Breslau, Davis, and Schultz, (2003) found that experiencing a traumatic event alone without PTSD did not increase risk of substance use disorders, including alcohol.

Research indicates multiple factors may contribute to co-morbidity of PTSD and substance use disorders including pre-trauma factors like prior substance use disorders or family substance use, and type or number of traumatic experiences (Green et al., 1985; Hein, Cohen, & Campbell, 2005; Najavits, Weiss, & Shaw, 1997). In a study conducted with survivors of a deadly fire in California, Green at al. (1985) found that persons exposed to more grotesque scenes of death and those more closely involved with rescue efforts were more likely than other respondents to develop alcohol use disorders two

years after the fire. Both Hein et al. (2005) and Najavits et al. (1997) suggest that women are highly susceptible to comorbid PTSD and substance use because of their increased likelihood to experience sexual violence. The concept of "polytrauma" or experiencing multiple traumas is relevant for refugee communities (Hollifield et al., 2002, Miller & Rasco, 2004). Refugees have frequently experienced multiple traumas over the course of months or years, which puts them at increased risk for PTSD and the development of substance use disorders.

Culture and Alcohol Use

Before reviewing the body of literature that explores drug and alcohol use in displaced populations, I will describe and review literature that places alcohol use in a cultural context. This context is essential to understanding the current state of knowledge of substance use in refugee communities because of the influence culture can have on patterns of alcohol use. The few studies that explore alcohol use in displaced refugee communities do not address cultural factors related to alcohol consumption. Instead, these studies focus on assessing prevalence of alcohol consumption using Western measures of alcohol use. Because cultural beliefs about what constitutes problematic alcohol use can influence perceptions and definitions of drunkenness, substance abuse, or addiction, cultural understanding of alcohol use is essential to assessing prevalence rates. Studies that use a measure of alcohol abuse or addiction that has not been validated in the particular ethnic group under study and does not consider cultural factors risk reporting erroneous rates of prevalence or patterns of consumption.

The literature about culture and substance use is vast and encompasses substance use in a wide range of cultural contexts within the United States as well as a

comprehensive anthropological analysis and epidemiological prevalence rates of substance use in myriad countries and cultural groups. For the purposes of this study and to maintain a realistic scope, I will focus on cultural analyses of drug and alcohol use in Southeast Asian countries including Thailand and Burma and in Southeast Asian immigrant communities in the United States. There is almost no established academic literature about substance use in Karen communities in Burma, Thailand. or the United States. Therefore, I will review the literature on Southeast Asian communities in general. Clearly, Southeast Asians are a diverse group with a range of cultures, ethnicities, and languages and multiple countries within Southeast Asia will be discussed to identify the range of cultural influences on drinking behavior.

Culture—including a group's values, norms, and behaviors—plays a significant role in influencing motivations for alcohol use and patterns of alcohol use. Cultural norms, beliefs, practices, and behaviors have significant influence over the ways in which groups use alcohol and over beliefs about what constitutes problematic alcohol use. In more communal cultures, such as the Karen, alcohol consumption often happens in groups and social networks can significantly impact patterns of consumption (Partanen, 1991; Heath, 2000).

Alcohol and culture in Southeast Asia. The World Health Organization (WHO) recognizes that across the globe, harmful alcohol use is a significant health burden resulting in death, disease, injury and violence (WHO, 2011). According to the WHO (2011) the harmful use of alcohol results in 2.5 million deaths worldwide each year. The WHO keeps statistics on drinking patterns in the 193 member countries. In 2011 the WHO reported that 1.6% of men and .05% of women in Myanmar had an alcohol use

disorder in a given 12-month period (WHO, 2011). In the same report, 18.7% of men and 3.3% of women were identified as heavy episodic drinkers, meaning they had consumed at least 60 grams or more of pure alcohol in one sitting weekly. In the same study, the WHO reported that in Thailand 10.2% of men and .99% of women had an alcohol use disorder in a given 12-month period (WHO, 2011). While these figures are important for understanding and comparing global patterns of alcohol consumption and alcohol misuse, they are problematic because of the ways in which the WHO measures alcohol use disorders. Alcohol use disorders are measured by the WHO using the Tenth Revision of the International Classification of Diseases and Health Problems, which defines alcohol dependence as a group of physiological, behavioral, and cognitive symptoms in which the user places a higher priority on using alcohol than previously valued activities (WHO, 2011). This definition of alcohol dependence may obscure cultural definitions of problematic use that would lead to more accurate representations of use in a given cultural context. For example, some cultural groups, including the Karen, place a higher priority on the relational consequences of alcohol consumption as a determinant of problematic alcohol use rather than physiological consequences. Additionally, in some ethnic groups alcohol use and drunkenness is a significant part of cultural and social activities such as weddings, funerals, or social gatherings. Asking a respondent to compare priorities around alcohol use without considering the cultural role of alcohol in the particular ethnic group may lead to inaccurate depictions of priorities.

In many Southeast Asian cultures, including ethnic minority groups in northern Thailand and in Burma, alcohol is a significant part of culture (Thamarangsi, 2006). Like Karen people, many Thai people drink alcohol as an appetizer before a meal and alcohol

and other indigenous drugs such as opium and marijuana are used during weddings, funerals, and social gatherings as well as during meals. Alcohol in small, rural communities in Thailand is often used as a way to nourish social bonds and to relax together after long days of work in agricultural fields (Thamarangsi, 2006). Because of the importance of using alcohol and drinking to enhance friendships and social networks, there can be perceived pressure to consume alcohol when in large groups (Thamarangsi, 2006). In addition to cultural influences, the political economy of Thailand and other Southeast Asian countries has influenced the production, sale and consumption patterns of alcohol (Thamarangsi, 2006). For example, because Chinese migrants in the 1300s in Thailand were the first authorized sellers of alcohol, some scholars believe that Chinese drinking patterns still influence Thai drinking patterns, especially as Chinese migrants increased in the 1700s (Thamarangsi, 2006).

Alcohol and culture in Asian communities in the United States. In this next section I will describe some of the literature that explores patterns of alcohol use in Asian immigrant communities in the United States. It is important to note here that the Asian immigrant population in the United States is quite heterogeneous and is comprised of a wide range of ethnic groups including Japanese, Thai, and Indian immigrants, Lao, Vietnamese, and Karen refugees, and second- or third-generation descendants of immigrants and refugees, among others. Each of these groups has a unique cultural, ethnic, and political background and they often cannot be compared or grouped together easily. However, the majority of literature about Asian Americans and Asian immigrants does exactly that. In this review of the literature I will primarily describe studies of Southeast Asian immigrants and refugees.

There are two ways in which scholars approach studying culture and alcohol use among immigrant ethnic groups in the US. First, some scholars focus on identifying the ways in which immigrants adapt to US patterns of alcohol use (Hahm, Lahiff, & Guterman, 2004; Hendershot, 2008; Rogler, Cortes, & Malgady, 1991). This acculturation paradigm is concerning because it uses white Americans as the referent group, assuming that white Americans constitute "Americanness." This presumption obscures the diversity of American cultural practices. A second concern is the assumption that acculturation by immigrant groups involves a shedding of or turning away from birth culture. Studies that use the acculturation paradigm risk overlooking the continued influence of birth culture on patterns of alcohol use after immigration.

Second, some scholars focus on the ways in which patterns of drinking in countries of origin affect alcohol consumption after immigration (Cook, Mulia, & Karriker-Jaffe, 2012). In a study of the influence of country of origin drinking culture on Southeast Asian immigrants' drinking patterns in the US, Cook, Mulia, & Karriker-Jaffee (2012) found that prevalence of heavy drinking in countries of origin significantly increases drinking after immigration. This finding is particularly significant for ethnic group—including Karen and Thai—because of the high prevalence of alcohol consumption in their countries of origin and countries of refuge.

Many studies of drinking patterns among Southeast Asians in the United States indicate that sociodemographic characteristics such as educational attainment and economic status greatly influence drinking patterns and risk of alcohol-related problems (Makimoto, 1998). People with lower education levels and incomes tend to have higher levels of alcohol consumption and alcohol-related problems. This is especially significant

for refugees and recent immigrants who may struggle to obtain both education and secure jobs (Makimoto, 1998). Overall, research on alcohol consumption, especially among Southeast Asian immigrant youth indicates that they are less likely than their Caucasian counterparts to consume alcohol (Makimoto, 1998). However, scholars do indicate that certain sub-groups such as youth who drop out of or struggle in high school or immigrants who struggle to resettle or acculturate are more likely to have alcohol use problems than their Caucasian counterparts (Makimoto, 1998). Again, this is particularly troubling for refugees because of the documented barriers to acculturation and resettlement.

Price, Risk, Wong and Klingle, (2002) describe a set of cultural protective factors that may limit alcohol use in recently arrived Southeast Asian immigrants and refugees including religious prohibitions of alcohol consumption and strong family bonds. Other scholars indicate that with acculturation Southeast Asians may lose some of these protective factors and adopt Western patterns of alcohol and drug use, leading to higher levels of substance use problems in Southeast Asians who have been in the US for several years (Amodeo, Robb, Peou & Tran, 2008; O'Hare & Tran, 1998).

Substance Use in Displaced Populations

Although substance use is mentioned as a comorbid mental health issue in studies of war-trauma and refugees (Keyes, 2000), there is little research focusing specifically on alcohol or drug use as it relates to trauma in refugee communities (Weaver & Roberts, 2010). Until recently, minorities and people of color were underrepresented in substance abuse research (Caetano, Clark, & Tam, 1998) and more recent research that does address substance use in communities of color has focused primarily on Hispanic, Latino, and

African-American communities with underrepresentation of immigrants or refugees (D'Amico, Schell, Marshall, & Hambarsoomians, 2007). The literature that is available about drug and alcohol use in refugee communities falls primarily into two categories: epidemiological studies that assess prevalence and scope of substance abuse in displaced communities and explorations of factors that contribute to increased alcohol and drug use during and after displacement. In this section I will review the available literature that estimates prevalence of drug or alcohol use in resettled refugee communities, the literature that estimates prevalence of drug or alcohol use in refugee camps or areas of conflict, literature that evaluates culturally adapted substance use disorder treatment programs, and literature that explores factors that influence alcohol and drug use in displaced communities.

A small number of studies have explored prevalence and patterns of drug and alcohol use in communities of refugees or asylum seekers who have resettled in Western countries (D'Amico, Schell, Marshall, & Hambarsoomians, 2007; D'Avanzo, Frye, & Froman, 1994; Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; O'Hare, & Van Tran, 1998; Westermeyer, Lyfoung, & Neider, 1989; Westermeyer, 1993; Yee, & Nguyen, 1987). There appears to be a range of reported prevalence rates, which is likely related to the range of assessment tools used by the studies. While some studies recognize that drug and alcohol use is stigmatized, particularly in Southeast Asian ethnic communities (D'Avanzo et al, 1994; Westermeyer, 1993), few studies acknowledge that reluctance to report drug or alcohol use may contribute to low prevalence rates. Additionally, the majority of the research on substance use in refugee communities has

been conducted with Southeast Asian refugees and other refugee communities are significantly underrepresented.

In a community sample of 120 Cambodian refugee women in Massachusetts (n=60) and California (n=60) D'Avanzo, Frye, and Froman (1994) found that about 45% of the East Coast sample used alcohol for nervousness, stress, headaches, insomnia, and pain. While the authors did not assess PTSD, evidence from Mollica et al. (1987) indicate that these symptoms could be indicative of PTSD.

Conversely, in a non-clinical sample of 490 Cambodian refugees D'Amico et al. (2007) found that while their sample had experienced a high number or traumatic events and had high levels of PTSD and depressive symptoms, very few participants reported alcohol consumption and there was little evidence of problem drinking. Four percent of the total sample met criteria for problem drinking using the Alcohol Use Disorders Identification Test (AUDIT). Participants with more pre-migration traumatic events and were more likely to have consumed any alcohol in the past 30 days.

There are some important limitations to these studies described above. First, these studies all use measures of substance abuse that have been validated in Western populations but have not been validated in the ethnic groups under study. Additionally, the studies reviewed above all use different definitions and concepts of substance abuse and problematic substance use making it difficult to compare rates of use. This use of non-validated measurement tools and the wide range of definitions of problematic substance use employed fail to consider refugees' and displaced people's own definitions and conceptualizations of substance use and related problems.

Research on substance use in displaced populations also explores factors that contribute to elevated levels of use. These factors most often include conflict and displacement-related trauma and resettlement and acculturation stress. Refugees often stay in camps for years. Conditions in camps can be difficult and refugees can face issues such as lack of food or clean water, lack of ability to work, uncertainty about their ability to repatriate or resettle, separation from family, as well as continued traumas like sexual violence, torture, beating, and continued fighting from protracted civil wars. All of these issues potentially contribute to elevated risk for drug and alcohol misuse.

Kozaric-Kovacic, Ljubin, & Grappe (2000) and colleagues evaluated 368 displaced persons in a refugee camp in Croatia and found that men were more likely than women to have PTSD as well as alcohol dependence. In their sample, 69.6% of men with PTSD had alcohol dependence and 11.7% of women with PTSD had alcohol dependence. Interestingly, pre-war alcohol use problems were not significantly related to current alcohol dependence in men, suggesting that war trauma played a role in the development of alcohol problems comorbid with PTSD. Kozaric-Kovacic et al. (2000) also found that respondents with comorbid PTSD and alcohol use disorders had higher numbers of traumatic events than those with only PTSD or with only alcohol problems.

Outside of refugee camps but within conflict areas drug and alcohol use is problematic (Strathdee et al., 2006). In an article that evaluates drug use in Africa, Odejide (2006) writes that problems like war, poverty, and political instability foster drug trafficking and use. In Sub-Saharan Africa drugs used are marijuana/cannabis, alcohol, amphetamines and *khat*. Odejide describes the social and cultural history of alcohol in Africa, emphasizing its role in commerce, social customs, and social cohesion.

Odenwald (2007) has extensively studied *khat* use among Somalis both in and out of camps. *Khat* is a plant that grows primarily in northeastern Africa and is used in Somalia, Ethiopia, Yemen, and Kenya. It has stimulating properties and is most frequently chewed, but is also consumed in paste form or in tea. Traditionally, *khat* has been used by men at weddings and other ceremonies. More recently, there is evidence that the use of *khat* in these countries has become less formalized and socially regulated and more informal, excessive, and chronic among some groups. In a survey of over 8,000 Somali ex-combatants (some of whom are child soldiers or were forced into combat) Odenwald, Hinkel, & Schauer (2007) found a significant number with concurrent PTSD and dependence on *khat*. The respondents estimated that 69.5% of their fellow combatants used *khat* regularly and 29% of respondents indicated they used *khat* to forget intrusive memories of traumatic events from the war.

Strathdee et al. (2006) cite similar factors contributing to increased drug and alcohol use during complex humanitarian emergencies. Substance use is exacerbated by psychosocial distress and trauma as well as increased availability of substances due to economic instability and increased trafficking when legal and governmental systems break down.

The studies described above all have a common limitation in that they focus rather narrowly on traumatic experiences during pre-flight and flight and the stress of resettlement and acculturation as the primary factors that contribute to elevated levels of substance use during and after displacement. Several of the studies described above mention political, social, and cultural factors that may contribute to patterns of substance use, but these are rarely explored in any depth.

There are very few studies of the efficacy of drug or alcohol treatment programs specifically for refugees. Alcohol use is increasingly being recognized as a serious public health issue in refugee camps (Barrett, 2007; Macdonald, 2006). The UNHCR in partnership with the World Health Organization (UNHCR, 2008) has a rapid assessment tool to analyze substance use needs, but few evidence-based studies that explore treatment efficacy exist.

Amodeo et al. (2004) describes a substance abuse treatment program for Cambodian refugees in Boston, Massachusetts that culturally adapted individual psychotherapy to include aspects of Buddhism and acupuncture. Amodeo and colleagues report that the treatment had some success, but that stigmatization of substance abuse in the Cambodian community led to few referrals to the program.

Ezard, Debakre, and Catillon (2010) describe a pilot study that used AUDIT to assess alcohol use disorders in a Burmese refugee camp in Thailand and provided brief interventions for those with high risk alcohol use. Of 1,256 men screened, 36% appeared to screen positive for high-risk alcohol use and 4% scored high enough to be considered alcohol dependent. The authors were testing the feasibility of providing screening and brief intervention services in a refugee camp setting and, consequently, did not assess outcomes of the intervention.

Clearly refugees who have been exposed to severe and multiple traumas in the course of war, living in a refugee camp, and resettlement are at increased risk of developing PTSD and other trauma-related mental health issues. Refugees are also at increased risk of developing substance use disorders co-morbidly with PTSD. Alcohol use in particular appears to be a significant issue in refugee camps and is complicated by

often deplorable camp conditions. There is a significant gap in the literature about refugee survivors of war and torture that specifically addresses drug and alcohol use. Existing literature measures prevalence and evaluates treatment programs, which is essential to understanding and addressing these issues. However, a major missing piece is research that evaluates from a culturally relevant perspective the connection between trauma, culture, war, and substance use or misuse within refugee communities. For example, much of the literature on PTSD and substance use with Western populations indicates that women are more likely than men to have comorbid PTSD and substance use disorders. However, given cultural prescriptions that limit women's intake of alcohol in some refugee ethnic groups, more understanding is needed of the ways in which gender and culture interact with substance use. Exploratory research is needed to ground understanding of substance use from a cultural perspective and to begin to map a culturally and politically relevant model of substance use in refugee communities as it relates to trauma, resettlement, living in a camp, and culture.

Theoretical Frameworks

In the following section I will describe the theoretical frameworks that were used to guide this study in three complementary ways. First, the overarching paradigms and theoretical frameworks guided the conceptualization of the study, the construction of the research questions, and my thinking about the political and practice implications for this study. Second, the theories and models specific to psychological trauma and substance use guided the development of interview guides and my thinking about the implications of the study. Finally, a human rights framework grounded the study in a human rights discourse.

Overarching Paradigms

My initial interest in and motivation for this study arose out of my personal assumptions, values, beliefs, and orientations about the world in general and research and knowledge in particular. These assumptions and beliefs are consistent with an affirmative postmodern paradigmatic orientation (Rosenau, 1992). In particular, this study is grounded in three beliefs: 1) a belief in the importance in deconstructing grand narratives; 2) a belief in multiple truths rather than one single Truth and the importance of valuing and privileging previously marginalized truths; and 3) that knowledge is co-constructed by social groups through discourse.

Affirmative postmodernism has an activist element in which the power inherent in grand narratives and objective truths is questioned and critically examined. For this study I wanted to question previously established narratives of alcohol use in displaced communities that prioritize trauma as a primary contributing factor to the exclusion of culture, social relationships, and politics. Affirmative postmodernism posits that there are multiple truths rather than one single, objective Truth. However, rather than a skeptical postmodern stance that then dismisses any provable truths, affirmative postmodernism recognizes the inherent role of culture and social structures in constructing knowledge and truth. In this study in particular I strove to understand previously marginalized truths for the individuals and communities who participated in the study. These assumptions guided my choice of using social constructionism as the foundational epistemological framework guiding this study. I also drew from eco-systemic and critical feminist theoretical frameworks. In the following section I will discuss the overarching theories

that guided this study including social construction, critical and feminist, eco-systemic, and human rights.

Theories of social construction grew out of postmodernism in the field of social psychology and became prominent in the social sciences in the mid-1960s with Berger and Luckmann's (1966) *The Social Construction of Reality*. In their writing Berger and Luckmann (1966) posit that all knowledge is socially constructed through relationships and interactions with members of a community or social group. In communication with each other, humans negotiate what is thought, known, understood, valued, and perceived about human behavior, ideas, and knowledge.

This research started from the assumption that the phenomenon or experience of alcohol and drug use—the beliefs, ideas, thoughts, patterns of use, effects, and knowledge about alcohol and drug use—are socially constructed (Berger and Luckmann, 1966). The perceived social reality of drug and alcohol use is a co-constructed phenomenon. In the West, drug and alcohol use, particularly problematic use (addiction) has been constructed as an individual, bio-psycho-social problem that is generally treated medically or through behavior and cognitive modification. I developed this study from the assumption that Karen refugees have a perceived social reality grounded in the experience and culture of being a Karen person and/or a refugee. I began with the hypothesis that Karen refugees think about, experience, and, therefore, treat alcohol and drug use from within their own cultural, political, and experiential lens. The social interactions involved with experiencing life in Burma, civil war, flight, life in a camp, and resettlement maintain the phenomenon of drug and alcohol use.

This study is also grounded in critical theory. Critical race and feminist theorists including Michel Foucault, Herbert Marcuse, Edward Said, Kimberle Williams Crenshaw and bell hooks have had a significant role in disciplines such as sociology and anthropology. In this study I drew from Fook (2002) and Pease and Fook (1999). Critical theory is, at its root, an examination and critique of social structures and, particularly essential to this study, a critique of power dynamics and systems that maintain oppression of women, people of color, and displaced communities. Social and feminist theorists use theory to shed light on oppressive systems by exploring and tearing open status quo structures.

Critical social work theorists used these ideas to develop critiques of theories of behavior in the 1960s and 1970s (Payne, 2005). Radical theories in social work were grounded in Marxist critiques of social group oppression and worker and women's solidarity movements (Payne, 2005). Radical and structural social work theory emerged in the 1960s in Britain (Bailey & Brake, 1975), the United States (Galper, 1980) and Australia (Fook, 2002). Radical social work theory critiqued the profession's focus on individualized practice methods that implied an individual or behavioral locus of problems such as poverty, hunger, and inequality (Fook, 2002). Structural social work (Moreau, 1979; Mullaly, 1993) emphasized structural and systemic causes of issues like poverty and inequality, incorporating macro-level ideas about systemic oppression into social work practice methods. Feminist social work scholars incorporated a gender analysis to radical social work theory (Dominelli & McLeod, 1989). Pease and Fook (1999) argue that feminist social work scholars were able to articulate a connection

between personal and political contexts and to develop links between theory and practice that were missing from radical social work theories.

Fook (2002) describes four elements of a critical approach to social work theory, knowledge building, and practice:

> A commitment to a structural analysis of social and personally-experienced problems . . .; a commitment to emancipatory forms of analysis and action . . .; a stance of social critique (including an acknowledgement and critique of the social control functions of the social work profession and the social welfare system; and a commitment to social change. (p. 5)

Fook (2002) describes an approach to social work that identifies and critiques the construction of social realities, in particular the power dynamics and social control inherent in traditional social work practice. Radical and critical social work is emancipatory in its critique of dominant discourses through dialogue between "social worker" and "client" and through self-reflection.

Ecosystemic theory also provided a guiding framework for this study. Eco-systemic theory was adapted from the biological sciences by social work and human development fields in the 1970s (Payne, 2005). Bronfenbrenner (1979) used theories of systems and ecology to develop a model for thinking about human beings in interaction with their environments, their family systems, their communities systems, and other significant systems within which individuals function. Ecosystemic theory places individuals within a vibrant system of connections with other people, their physical environment and social institutions or networks. Attention is paid to reciprocity between people and their environments and social systems. These relationships have a significant

influence on human development and behavior. Eco-systemic perspectives differ from psychopathological models that emphasize individual, personal, and demographic characteristics in understanding behavior or sociological models that emphasize the influence of external systems on behavior.

Bronfenbrenner (1979) developed four systems to categorize and describe the ecosystem within which people live and function and to: the microsystem, the mesosystem, the exosystem the macrosystem, and the chronosystem. The microsystem refers to the groups or systems that most directly impact the individual and the relationships contained within these systems. These systems usually include family, neighborhood, school, work, religious institutions, or clubs. Mesosystems refer to the interactions between different microsystems. A mesosystem might be made up of the interactions between school and work environments, family and school environments, or religious and employment systems. For example, a person who is experiencing difficulty in his or her family system due to divorce may have trouble functioning within his or her employment system by being late to work or being unable to keep stable employment. Exosystems refer to the indirect effects of the systems of which an individual does not have a direct role. For example, continued conflict in a refugee's home country may impact his or her ability to concentrate in English classes in the country of resettlement. Macrosystems refer to the general cultural, political, economic, and social systems within which individuals live. Finally, chronosystems refer to patterns of environmental interactions over time and the influence of past systems over current systems. For example, in refugee communities a lengthy history of political conflict may impact ability to function within school or employment systems.

Ecosystemic theory has two core tenets. First, individual development, behavior, health, and well-being are influenced by an individual's fit with each system, meaning his or her ability to function well within each of these levels of systems. Second, individual development, behavior, health, and well-being are influenced by the transactional relationships between these systems. Essentially, individuals cannot be understood without understanding the ways in which they function within these interconnected systems.

Particularly important to this study is the way in which ecosystemic theory has been used to understand the impacts of changing environments. Refugees experience significant changes to their environments including displacement from their country of origin, living in a refugee camp, and resettlement to a third country. Each of these environmental changes comes with attendant changes in a range of systems including changes in family structure, neighborhood and community structures, school systems, employment systems, and larger macrosystems.

This study is grounded in a human rights context which informed the motivation, design, and dissemination of findings. This study emerges out of my commitment to human rights in general and my belief that healing from human rights violations takes place at both an individual and community level. I believe that mental and emotional healing is an essential part of the peace and rebuilding process after conflict. If the psychological and emotional wounds of conflict are not addressed Karen people will withdraw in anger and frustration which limits potential for addressing human rights violations. Additionally, I believe that mental health and wellbeing is a vital human right and should be valued equally with political and civil rights.

Within social work the concept of social justice has been much more prevalent than human rights thinking (Reichert, 2003; Wronka, 2008). However, scholars such as Elisabeth Reichert (2003), Joseph Wronka (2008), and Jim Ife (2001) have recently begun to reframe social work as a human rights profession (Ife, 2001). Reichert (2003) writes that:

> Human rights encompass a more comprehensive and defined set of guidelines for social work practice than social justice. Human rights focus on what must be given to a client, which elevates the discussion into one not simply of recognizing the needs of a client but also of effectively satisfying those needs. (p. 13)

Reichert (2003) and others argue that a human rights framework allows social workers to participate in global conversations about individual and community level rights. Participation in this conversation moves away from discussing "needs" and focuses more on "rights" and what it takes to secure rights. Conversely, seemingly "individual" issues like mental health and substance use have been left out of human rights conversations that tend to focus on civil and political rights (Wronka, 2008). Using a human rights framework for this study places refugees' right to health and mental well-being within the international conversation about securing human rights.

Human rights have an ancient history, but modern human rights developed after World War II with the development of the United Nations (Weissbrodt, Aolain, Fitzpatrick, & Newman, 2001). The United Nations charter and the Universal Declaration of Human Rights enshrine fundamental, universal and indivisible human rights and offer a normative framework for protecting those rights (Weissbrodt, Aolain, Fitzpatrick, & Newman, 2001). These rights include civil and political rights such as the right to

freedom from torture and the right to free expression as well as economic, social, and cultural rights, including the right to adequate housing and the right to health (Weissbrodt, Aolain, Fitzpatrick, & Newman, 2001). As human rights frameworks have gained traction in disciplines like social work and public health, they have offered a framework for conceptualizing and responding to health issues (Gruskin, Plafker, & Smith-Estelle, 2001).

Human rights law obliges governments to respect, protect, and fulfill human rights (Weissbrodt, Aolain, Fitzpatrick, & Newman, 2001). Public health and social work scholars describe a dynamic relationship between health and human rights wherein violations of human rights significantly impact health and mental well-being (Gruskin, Plafker, & Smith-Estelle, 2001). In their study on youth and substance use Gruskin, Plafker and Smith-Estelle (2001) posit that substance use and addiction to substances can be framed as impacting human rights in that substance use further marginalizes substance users. Particularly in countries where understanding of substance use is limited and treatment options are minimal, substance use further negatively impacts the ability to fulfill human rights.

These overarching theories—social construction, critical, ecosystemic, and human rights guided the conceptualization of this study, methodological choices, development of the research questions and provided a guiding framework for the synthesis of the findings into implications for social work knowledge, policy, and practice. This study was grounded in a critical evaluation of dominant, Western discourses of substance use and displacement. This study employed an ecosystemic theoretical framework because it evaluates individual, family and community level perspectives of substance use, rather

than focusing primarily on individual experiences with displacement and substance use. Finally, a human rights framework was employed to enable the study to be located in a human rights discourse.

Substance Use Theories and Models

The development of the research questions, interview guides and the implications of findings in this study were all influenced by substance use models. The correlation between psychological trauma and substance use is documented above and there are two significant models of substance use that are pertinent to this study: social learning model and self-medication model. Both are described in turn below.

Social learning model of substance use. Social learning theory is most often used when studying adolescent substance use, but is relevant to this study because of the correlations with social construction and phenomenological theories. Social learning theory was developed by Robert Burgess and Ronald Akers in 1966 and was further developed by Akers in 1973 with the publication of "Deviant Behavior: A Social Learning Approach." Social learning theory posits that there is a reciprocal relationship between cognitive, behavioral, and environmental determinants of behavior (Bandura, 1977). People, especially youth, learn deviant behavior through interaction with and observation of others who are engaged in said behavior. Deviant behavior is additionally reinforced by punishment and reward.

Social learning theory is evident in recent social network analyses of substance use and addiction, especially among adolescents (Fujimoto & Valente, 2012). For this particular study I used social learning theory to help conceptualize ideas about the effects

of community and family relationships on substance use. Social learning theory was particularly relevant when analyzing and interpreting data from this study.

Self-medication models of substance use. Self-medication as a hypothesis for why people use drugs and alcohol developed in the mid-1970s from clinical observations by psychiatrists Khantzian, Mack, and Schatzberg (1974). This model posits that alcohol and drug addiction function to mitigate or alleviate distressful psychological symptoms including depression, anxiety, and trauma symptoms (Khantzian, 1997). Individuals use particular substances to manage specific types of distress and maintain emotional stability. Duncan (1974) included positive and negative reinforcement as an element in his model of self-medication. Experiencing relief from psychological symptoms as well as experiencing "high" or euphoric feelings through drug or alcohol use positively reinforces that use, leading to addiction, leading to repetitive use and eventually addiction.

The self-medication hypothesis has been suggested as a reason for alcohol use in several refugee communities (D'Avanzo & Frye, 1992; Ezard, 2011; Keyes, 2000). In this study the self-medication hypothesis served as a guide for developing interview guides that explored the relationship between trauma experience, conflict experience, and displacement as a contributing factor for alcohol use as well as provided a guide for discussion and application of the findings from this study.

Trauma and Displacement Models

Participants in this study have overwhelmingly experienced trauma and psychological distress while living in Burma, during periods of active conflict, during flight from Burma to Thailand, in refugee camps in Thailand, and during resettlement in

the United States. This study uses Maria Yellow Horse Braveheart's theory of historical trauma to provide a context for understanding the ways in which refugees experience trauma and how it may interact with substance use.

Historical trauma. Maria Yellow Horse Braveheart and other scholars developed the concept of historical trauma or the intergenerational transmission of trauma in the late 1980s as a way to describe the cumulative effects of trauma experienced by an entire community over multiple generations (Braveheart, 1999; Braveheart, 2003; Evans-Campbell, 2008; Whitbeck, Adams, Hoyt, & Chen, 2004). Growing out of research on Native American psychological and behavioral responses to massive traumatic events such as displacement from land, massacres like Wounded Knee and forced disruption of families, Braveheart identifies historical trauma as a constellation of psychological and emotional trauma responses. These responses include depression, substance abuse, somatic symptoms, guilt, anxiety, and chronic bereavement (Braveheart, 1999). Braveheart (1999) relates these symptoms to similar responses identified in Jewish survivors of the Holocaust and refugee survivors of political conflict. There are two key aspects of Braveheart's theory. First, trauma is described as happening both to individuals as well as to entire communities. Historical trauma can be viewed as a response to the limited diagnosis of PTSD among individuals and is particularly relevant when entire communities have experienced traumatic events across extended periods of time.

Second, psychological trauma responses can be transmitted across generations. According to Braveheart (1999) individuals do not have to experience trauma directly to be affected by those traumatic events. Descendants of trauma survivors often identify strongly with ancestral history of trauma, especially if the trauma was experienced by an

entire community or ethnic group. Van der Kolk (1987) describes the possibility of a biological inheritance of neurophysiological responses to trauma across generations.

Braveheart (2003) identifies substance abuse as a significant response to historical trauma in Native American communities. Echoing self-medication theory, she posits that substance use and abuse are frequently a way to numb the psychological and emotional pain associated with historical trauma. High levels of substance use, particularly alcohol use in Native American communities, are viewed by Braveheart (2003) as a manifestation of the pain associated with the historical and continued oppression of Native Americans. Continued substance use into parenthood contributes to a cycle of transmission of addiction as a way to deal with emotional pain and continues the transmission of trauma responses through multiple generations (Braveheart, 2003).

The theory of historical trauma fits well with Karen refugees and provided a guiding framework for the data analysis phase of this study. Karen people have been living with ongoing conflict since the late 1940s. Multiple generations of families have experienced trauma and entire communities have experienced individual, family, and community-level violations. Karen people have been fleeing across the Thai-Burma border into refugee camps since the 1980s and harsh conditions in refugee camps have been well-documented. While children born in refugee camps may not have directly experienced conflict-related trauma they are often parented by people with psychological and emotional trauma symptoms and live with daily reminders of the trauma their elders have experienced. In addition, new generations of Karen young people both in camps and in Karen State in Burma contend with poverty caused in part by the conflict, continuing the transmission of trauma.

Chapter 3: Methodology and Procedures

Chapter Overview

In this study I employed ethnographic and phenomenological qualitative research methodologies to guide the exploration of perceptions and experiences of alcohol use in Karen refugee communities across multiple sites of conflict-related displacement. In this chapter I will restate the study's guiding research questions, the rationale for the methodological traditions and procedures chosen to conduct the study, my role as the researcher, issues related to trustworthiness of the data, ethical considerations and relative limitations of the methodological procedures.

Research Questions

I developed one overarching grand tour research question and six related sub-questions to guide this study across two geographic locations:

1. How do Karen refugees in multiple sites of displacement perceive and experience alcohol use?
    a. How do Karen refugees perceive and experience the *reasons* for alcohol use in their communities?
    b. How do Karen refugees perceive and experience the *consequences* of alcohol use in their communities?
    c. What individual and community level factors—including cultural, political, geographical, situational, historical, and familial—contribute to alcohol use?

d. What do Karen refugees see as the relational impact of alcohol use at individual, family, and community levels?
e. What do Karen refugees believe would be effective in stopping problematic alcohol use?
f. What are the similarities, differences, and changes in alcohol use between locations of refuge (refugee camps) and resettlement (United States)?

Research Design

This study is grounded in philosophical, ontological, and epistemological assumptions specific to a post-modern qualitative research agenda supported by ethnographic and phenomenological schools of thought. There are several key ontological and epistemological characteristics of qualitative research that define it, including: research takes place in a naturalistic setting, the researcher is the key instrument, research designs are often emergent, data analysis is often, but not always, inductive, and research is interpretive (Creswell, 2007).

In qualitative research the researcher is the instrument (Creswell, 2007). Rather than using a tested and validated measurement instrument the researcher herself gathers data, interprets data, and makes meaning of data. Rather than starting the study with a tightly controlled and detailed research plan, qualitative research designs start with a general plan that may shift as the researcher enters the field. Shifts in design allow the researcher to follow the natural contour of ideas and perceptions of participants themselves and to leave room for following a train of inquiry that may not have been clear at the outset of the study.

Qualitative research is reflexive (Denzin & Lincoln, 2000). Qualitative researchers are concerned with meaning-making and with understanding that meanings are multiple and varied. Study participants have cultures, values, ideas, relationships and experiences that shape their interpretation and meaning-making of experience, as do researchers. As the instrument, qualitative researchers recognize the ways in which their multiple identities of race, class, gender, ability, education, or citizenship intersect with the identities of their participants (Madison, 2005).

The choice of qualitative methodologies in general and ethnography and phenomenology in particular was well-suited to investigate the study described here. Much of the previous scholarship on drug and alcohol use in refugee communities consists of public health oriented prevalence studies that describe rates of consumption or patterns of use using surveys or measurement tools that have usually not been adapted and validated for use in non-Western populations (Ezard, 2011). Intervention research has been similarly conducted using quantitative trials that assess the efficacy of Western-designed treatment modalities (Ezard, 2011). A qualitative exploration of the perceptions and experiences of alcohol use in refugee communities allowed for an in-depth exploration of the meaning and value of alcohol to refugees themselves. This in-depth knowledge adds to and enhances what is known about drug and alcohol use in refugee communities and allows for a deeper and more contextualized understanding of the reasons for use and factors that contribute to use as well as of the perceived individual, family, and community-level effects of alcohol use. While the application of Western biomedical concepts of addiction, prevention and treatment may be useful in understanding the epidemiology and prevalence of substance use, interventions will be

more effective with a deeper understanding of the ways in which Karen refugees themselves perceive and understand their own substance use (Kleinman, 1980).

Ethnography and phenomenology were appropriate qualitative methodologies to use with this study for several reasons. Ethnography allowed for an examination of the culturally-bounded meaning and interpretation of alcohol use within the Karen community. Ethnography required placing a cultural lens in the forefront of both the research design and the data analysis. Ethnography also provided specific methods described below that allowed for in-depth exploration of community-level perceptions and experiences of alcohol use in addition to individual perceptions and experiences.

Phenomenology was an appropriate selection because of the philosophical underpinnings of the methodology. Phenomenology also allowed for participants' voices, words, and experiences to become the center of the study and allowed for privileging voices that have traditionally been silenced. Ethnography and phenomenology fit well by complementing each other and offered unique contributions to the cultural exploration of the specific phenomenon under investigation in this study.

Ethnography

Ethnographic fieldwork methods were developed in anthropology with fieldwork by scholars including Margaret Mead, Bronislaw Malinowski, and Fraz Boas. Ethnography is typically described as the exploration of the shared culture of a group of people. Historically, ethnographers have studied non-Western ethnically- or linguistically-monolithic groups, but more recently ethnographies have evolved to explore groups defined by shared identity, geography, experience, or even groups connected through internet or social media (Patton, 2002).

Clifford Geertz (1973) defines ethnography as a search for the meaning of culture. To discover this meaning ethnographers traditionally spend significant amounts of time conducting fieldwork, which consists of participant-observation, interviews, informal conversations, and immersion in the culture under study (LeCompte & Schensul, 1999). Ethnographers typically partner with key informants or cultural liaisons who are members of the group under study and act as a bridge between the researcher and study participants.

Ethnography takes as its data observations of behavior, experiences of participation in events, relationships, and daily life of a group and participants' descriptions of the meaning of behavior as data (LeCompte & Schensul, 1999). Ethnography explores and interprets the resulting data through the lens of culture, paying particular attention to the ways in which culture is constructed by groups of people (LeCompte & Schensul, 1999). Typically in ethnographic studies there are multiple types of data including transcriptions of interviews, notes from observations, and conversations and memos written after participant-observation experiences. There are a wide variety of ways to analyze ethnographic data. In this study all ethnographic data was coded and themes and categories were developed from the codes. Spradley's (1979) domain analysis was used in this study because it provides a framework for analyzing multiple types of data. The procedures for data analysis are described later in this chapter.

In this study I employed aspects of critical ethnography (Conquergood, 1991; Madison, 2005). Madison writes that critical ethnography "begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain" (2005, p. 5). Critical ethnography is guided by a critical examination of the

dominant representations of research participants. In much of the scholarship concerning refugees they are depicted as traumatized, mentally unhealthy, and passive recipients of diagnoses, assessments, and treatment. Critical ethnographic methods allowed for a deeper, more critical examination of the real voices and lives of refugees in their total complexity. For this study I used critical ethnography in order to move beyond the surface representation of alcohol use as simply a response to trauma and used refugees' own voices and explanations to construct concepts of alcohol use rather than Western methods of assessment or treatment procedures to contextualize refugee experiences.

Research of any sort must contend with a politics of representation and researching and telling the story of others is always complex and contentious (Madison, 2005). Madison (2005) contends that how people are represented informs how they are treated. This is certainly the case with refugees in camps and in resettlement locations. Because refugees are overwhelmingly represented as broken and traumatized people, they are often treated as broken and traumatized people. While it is certainly true that refugees have experienced multiple traumas and are often desperately in need mental health services, this is not the whole story. With this particular study it would have been too easy to follow in the footsteps of traditional scholarship by portraying Karen refugees as traumatized and alcohol use as a form of self-medication of trauma symptoms. While this scenario is certainly described by many of the refugees in this study, I believe there is more to this story and that refugees must be represented as they see themselves, with all the complexity—positive and negative—that their lives encompass. While the focus of this study was to explore alcohol use, by using critical ethnographic methods I allowed

for the whole story to arise and addressed some of the ethical dilemmas that occur when conducting research in marginalized communities.

Madison (2005) proposes three key aspects of critical ethnography that are at the core of this study. First, critical ethnographers must recognize injustice within the contexts of research and research participants' lives and make contributions toward freedom and justice. The researcher conducting critical ethnography "contributes to emancipatory knowledge and discourses of social justice" (Madison, 2005, p. 5). Second, the researcher must examine, confront, and critique their own positionality in relationship to the study participants. By doing so, researchers must confront their own power, privilege, and biases and recognize the ways in which studying and examining are also acts of domination. Third, critical ethnographers must remain in dialogue with the Other of the study. By this, Madison means that critical ethnographic research opens up an active, transactional relationship between the researcher and the participants of the study in order to dislodge passive representations and maintain a dynamic whole. This relationship between researcher and the Other is meant to be open, deep, dynamic, and ongoing.

In this study, critical ethnography provided the framework around which the methods and procedures were developed. Critical ethnography shaped the development of the research questions as well as guided the development of ethical procedures. By requiring submersion in a continued exploration and critique of my positionality in relationship to this study and to its participants and continued dialogue with the Karen community, a critical ethnographic methodology allowed me to analyze my data with an eye towards the political and human rights contexts out of which this study arose.

Phenomenology

Phenomenology, as developed out of Edmund Husserl's philosophical studies, is the exploration of the lived experience and personal meaning or perception of an experience of a phenomenon (Creswell, 2007). Phenomenological studies attempt to distill the essence or singular meaning for individuals who are experiencing a particular phenomenon such as grief, alcohol use, or being a refugee, and the ways in which individuals and groups turn those experiences into consciousness and shared meaning (van Manen, 1990 Moustakas, 1994). Phenomenology has a strong grounding in the philosophy of Edmund Husserl and Martin Heidegger.

In recent years various types and strains of phenomenology and phenomenological methods for research have evolved and grown to the point that a student of phenomenology can choose from a range of methods (Giorgi, 1985; Moustakas, 1994; Polkinghorne, 1989; van Manen, 1990). Rather than adhering strictly to one phenomenological tradition, for this study I chose to utilize two hallmarks of phenomenological tradition. First, I used phenomenology's emphasis on privileging and emphasizing the voice of the participant in interpreting experience. Second, I utilized the technique of *epoche*, or bracketing, to isolate, examine, and set aside my own values, beliefs, and perceptions in order to let the participants' voices emerge throughout the study.

Phenomenology is predicated on the understanding that there is an essence or essences of shared experiences and that those essences can be understood from rich, thick description. In this study I used participants' voices to describe the phenomenon of alcohol use after conflict-related displacement. Themes of shared meaning emerged

primarily through the participants' own explanations or interpretations of their experiences.

Moustakas (1994) describes *epoche* or bracketing as a process in which the researcher sets aside her own experiences, values, and beliefs in order to approach, with fresh, unbiased perspective, the phenomenon under investigation. Moustakas recognizes that pure *epoche* is impossible but identifies the practice of continued bracketing as essential to phenomenological research. In this study I used two approaches to bracketing. First, I spent considerable time examining and identifying my experiences, perceptions, beliefs, values, and thoughts about alcohol, refugee status, and displacement prior to beginning the study. Part of this examination involved identifying and labeling my own identities as a white, female, American-born researcher and how those identities and their attendant powers and privileges might intersect with the identities of my participants. Some of these thoughts are included later in this chapter. Second, I continually practiced bracketing throughout the data collection, analysis, and writing processes by keeping detailed field notes and journals of my experiences and thoughts in addition to my observations. Some of these journals involved identifying and setting aside my own personal perceptions that might be getting in the way of allowing participants' voices to emerge.

Role of the Researcher

Bracketing in phenomenology (van Manen, 1990) and the core tenets of critical ethnography both require a thorough elucidation of the role and identity of the researcher. This study arose out of my experiences in addiction work as well as my experiences in refugee rights work. I am a trained social worker and have worked as a chemical

dependency counselor with opiate-addicted adults. I chose the field of chemical dependency treatment after witnessing members of my family struggle with addiction. Like many in the addiction field, I was drawn to this work because I know well both the horrors of addiction and the beauty and hope of recovery.

In 2003 I began volunteering with a civil liberties organization working with Muslim and Arab immigrant and refugee communities to address legislative and individual backlash resulting from 9/11. In this position I developed close personal and professional relationships with East African and South Asian refugees.

At first, this work seemed worlds away from my work as a chemical dependency counselor. As I grew closer to my refugee colleagues we began to talk about the connections between substance use, trauma, displacement, resettlement, and culture in their communities. I also began to understand from my refugee friends and colleagues that mainstream, Western models of substance use treatment were ineffective because they didn't address the cultural and political context of their substance use. It soon became apparent that research was needed to develop evidence-based substance use treatment models for refugees that included their cultural, political, and experiential contexts. Because of my personal and professional experiences with alcohol and drug use and treatment and refugee rights work, I came to this study with a set of values, beliefs, and ideologies that required examination both before and during this study.

At the same time, I had to recognize and wrestle with my identity as an outsider to the Karen communities who participated in this study. I am a white woman with an advanced degree and these identities of gender, power, and privilege intersected with the gender, political, and ethnic identities of the study participants. This continued self-

evaluation required me to continually examine and identify my motives, my biases, and my assumptions. As a white researcher working with communities of color there are inherent power differences. Communities of color and refugee communities in particular have often served as the locus of research for dominant majority researchers. One experience at the beginning of data collection for this study exemplifies the ways in which research can be oppressive. During a meeting with the director of a Karen social service agency prior to the recruitment phase of the study, I spent time explaining the purpose of the study and the ways in which I wanted to partner with this particular organization to recruit participants. During the meeting the Karen agency director told me that he had grown tired of Western researchers calling his agency to ask for study participants. He was afraid that his community did not know enough about the process of Western research and would be taken advantage of. In particular he was concerned about helping his community to understand informed consent, research procedures, and to develop methods to evaluate whether research would be of direct benefit to the community prior to agreeing to participate.

After this conversation I had to question if my research would be of direct benefit to the community. I also had to address the transparency of my research procedures and adjust them to ensure participants clearly understood the study and what their participation would entail. To further address these issues I agreed to work with this agency to develop a set of community guidelines on evaluating and participating in future research directed by Western academics. Going through this process helped me make my own research more ethical and opened up a dialogue between myself and members of the

Karen community. I believe my willingness to participate in this dialogue led to this agency's eventual agreement to participate in this study.

A second process that helped me identify and confront my biases and relationships with the Karen community was to keep detailed field journals and about my experiences as a researcher and debrief these experiences through multiple lengthy conversations with my cultural liaison and with colleagues who were conducting similar ethnographic studies. During these conversations it was important to me to identify the ways in which this particular study might be perceived by the Karen community and to mitigate exploitation.

General Procedures and Study Structure

Study Sites

This study took place in two locations: in a resettled Karen refugee community in St. Paul, Minnesota and in refugee camps and Karen communities along the Thai-Burma border in Thailand. Data collection in Minnesota took place from October, 2011 to January, 2012. Data collection in Thailand took place from February, 2012 to May, 2012. All data were analyzed between September, 2012 and January, 2013.

Data Types

Data was collected in each location through focus group interviews, individual interviews and participant-observation and while interview guides were similar for both locations, procedures differed slightly to allow for cultural and contextual considerations. Collecting data from multiple sites and in multiple ways allowed for a richer and more detailed exploration of the ways in which substance use was perceived and experienced throughout the trajectory of displacement and resettlement. Because Karen refugees

resettle from camp settings where they may have lived for ten to fifteen years, camp life may play a role in substance use even after resettlement.

This study had two units of analysis: the Karen community and Karen individuals. The choice of these levels of analysis was influenced by ecosystemic theory. Because the study explored the relational experience of a phenomenon, community interactions, descriptions and constructions were explored. Data was collected in three ways: individual interviews, focus group interviews, and participant-observation. Individual interviews consisted of one-to-one semi-structured interviews. Focus groups consisted of semi-structured interviews with two or more people. Participant-observation included observations during cultural events, community meetings and short stays in refugee camps in Thailand. Data also included notes from casual conversations and general observations throughout the study.

Use of Interpreters

In this study I used interpreters for the majority of focus group and individual interviews. In Minnesota I used two interpreters, one male and one female. In Thailand I used two interpreters, both male. In both locations I provided one hour of training to the interpreters prior to beginning interpretation. During this training I reviewed the interview guides with the interpreters to ensure full understanding of each of the questions. I also reviewed translation techniques, in particular emphasizing that I wanted to be sure I was hearing exactly what the participant was saying, rather than an interpretation or a summary. In Minnesota each of my interpreters had previously worked as professional interpreters and in Thailand one of my interpreters had worked for an international non-governmental organization as an interpreter.

Use of Cultural Liaisons

This study also employed cultural liaisons. Both in Minnesota and in Thailand I developed strong relationships with Karen individuals who agreed to act as a cultural liaison for the study. Cultural liaisons provided consulting on culturally appropriate recruitment strategies, introductions to key leaders who could facilitate recruitment, consultation on interview guides, and consultation throughout the data collection and analysis process. Cultural liaisons in both locations spent significant time reviewing my field notes and providing assistance with interpretation and understanding of findings.

Sample

In both locations this study used a convenience sample. Study participants in both locations included men and women above age 18 who identified as Karen and who had been displaced by political conflict outside of Burma. Inclusion criteria purposefully did not include a history of alcohol use because one focus of this study was to understand community-level constructions of alcohol use and required participants to speak to what they perceive in the community, regardless of their own history of alcohol use.

Formal individual and group interviews were conducted with 34 individuals in Minnesota and 28 individuals in Thailand for a total sample of 62 people. Table 1 below describes the demographics of participants in Minnesota and Table 2 describes the demographics of participants in Thailand. All participants in Minnesota were interviewed in focus groups. All participants in Minnesota had resettled with refugee status and so had arrived in the United States after living in refugee camps. The Minnesota sample of 34 individuals was 35% female (n=12) and 65% male (n=22). The mean age was 42.7 years and the range was 23 years to 71 years. The average time spent living in refugee

camps prior to resettlement was 12.8 years and the range was one year to 26 years. The average time living in the United States was 1.7 years and the range was one year to three years.

Participants in Thailand were interviewed individually and in groups. Individual interviews were conducted with six individuals and six group interviews were conducted with a total of 22 individuals. As described in Chapter 1, the sample in Thailand included both participants who are registered refugees with the UNHCR and participants who are migrants. The Thailand sample of 28 individuals was 36% female (n=10) and 64% male (n=18). The average age was 32.9 years and the range was 22 years to 68 years. Fifty-seven percent of the participants reported living in refugee camps at some point in their lives. The average time spent living in camps was 10.4 years and the range was 7 years to 17 years.

Table 1:

Minnesota Participant Demographics

Focus Group	**Number in Group**	**Sex**	**Age in Years Mean (Range)**	**Time Living in Refugee Camps in Years Mean (Range)**	**Time Living in US in Years Mean (Range)**
1	7	Male	40.1 (23 – 71)	10.6 (1-18)	1.6 (1-3)
2	7	Female	43.4 (32-52)	13.3 (5-20)	2.4 (1-3)
3	5	Female	39.9 (28-46)	12 (5-18)	2.2 (1-3)

4	5	Male	37.8 (27-46)	18 (14-26)	1 (1)
5	5	Male	42.4 (34-58)	12.4 (4-20)	1.2 (1-2)
6	5	Male	53.6 (63-46)	11 (10-15)	1.8 (1-3)

Total N = 34

Table 2:

Thailand Participant Demographics

Focus Group	**Number in Group**	**Sex**	**Age in Years Mean (Range)**	**Time Living in Refugee Camps in Years (if applicable) Mean (Range)**
1	4	2 Male 2 Female	25.8 (24-28)	10.5 (8-14)
2	2	1 Male 1 Female	36.5 (35-38)	13 (11-15)
3	2	Male	43 (58-28)	11 (5-17)
4	4	2 Male 2 Female	24.3 (22-26)	10 (10)
5	2	1 Male 1 Female	33.5 (32-35)	9.5 (11-8)
6	8	4 Male 4 Female	32.1 (22-45)	
Individual Interviews		**Sex**	**Age in Years**	**Time Living in Refugee Camps in Years (if applicable)**

1		Male	36	10
2		Male	26	
3		Male	40	
4		Male	35	7
5		Male	32	
6		Male	68	

Total N=28

Specific Procedures: United States

The United States portion of this study took place with a Karen community in St. Paul, Minnesota and consisted of focus group interviews and participant-observation. I also conducted two interviews with individuals in Minnesota who were not Karen, but were social service providers who worked closely with the Karen community. After reviewing these interviews I felt that they did not contain information that was different in nature from what Karen participants reported and in fact these outsider voices risked taking away or distracting from Karen voices being the primary source of data for the study. For these reasons I chose not to include them in the study.

The Karen community in Minnesota is comprised primarily of the Sgaw Karen and the Pwo Karen, two linguistically distinct groups. Before beginning this study a Karen man with whom I have a personal and professional relationship agreed to partner with me as a cultural liaison to the Karen community. He has worked with me in the past as an interpreter and through that work we developed a friendship. He is a leader in the Karen community and well connected with both Sgaw and Pwo Karen communities in St.

Paul. He has also worked extensively as an interpreter in the court system and has identified alcohol use as a significant issue for his community.

Recruitment and Participants

A significant portion of time was spent during the data collection and analysis phase of this study building trust in the Karen community. To build relationships and trust I attended Karen cultural events, worked at a health clinic that serves the majority of Karen people in St. Paul, and worked closely with my cultural liaison and other Karen acquaintances to gain trust within the community before beginning research. I also met with the directors and Karen staff of three social service agencies to describe my study and ask for cooperation in recruitment. At each of these meetings members of the Karen community expressed a strong desire to be part of this research.

Participants for the focus group interviews were chosen using a convenience sampling method. I recruited participants from three social service agencies in St. Paul that provide ESL courses and social work services to Karen people. Recruitment procedures were slightly different at each location to allow for the needs and culture of each agency. At two agencies I attended several ESL classes over the course of a week to explain the study. Through an interpreter I explained the purpose and procedures of the study. Interested potential participants were asked to speak with the teacher of the ESL class if they were interested in participating. This allowed individuals to have privacy while indicating interest in participation. I contacted interested participants with an interpreter to schedule focus group interviews. At the third agency I gave social service workers a flyer that explained the purpose and procedures of the study and asked them to

ask their clients if they were interested in participating. I then contacted interested parties to schedule focus group interviews.

Data collection

Data collection in St. Paul consisted of focus group interviews and participant-observation. Procedures for each will be explained separately below.

Focus group interviews. Six focus group interviews were conducted with a total of 34 people. These groups were divided by gender and consisted of four male groups and two female groups. Prior to the start of the group the researcher and interpreter read through informed consents (Appendix A) with each participant. These consent forms contained information about the purpose of the study, the procedures and risks and benefits of participation. Participants were asked to sign the consent form if they wanted to participate in the focus group and were assured that their consent or refusal to participate would have no bearing on their relationship with the social service agency through which they were recruited. Participants who agreed to participate in the study signed two copies of the consent form. The participants were offered a copy of the signed consent to keep.

Focus group interviews were conducted by the researcher with a trained, paid interpreter who was not the cultural liaison. Focus group interview questions (see Appendix B) addressed community-level perceptions and experiences of alcohol use. Focus group interview questions were pilot-tested with the cultural liaison. Adaptations were made to the questions as needed, paying particular attention to the cultural and linguistic relevancy of the questions.

Focus group interviews were audio-taped after securing permission from the group and resulting recordings were transcribed for analysis. Focus group interviews lasted between one and two hours and were held at the relevant social service agencies. Participants were given $10 gift cards to a grocery store as a token of appreciation for participation and food and beverages were served during each focus group interview.

In phenomenological research Moustakas, (19940 and van Manen (1990) recommend "sampling to saturation," meaning that rather than starting with a definitive sample size, individuals are interviewed until there is information saturation and no new information is being learned from interviews. I was able to reach saturation across most emerging categories after six focus group interviews.

Participant-observation and field notes. During the data collection process in Minnesota I attended cultural events and spent time in informal conversation with Karen individuals and Western-born social service workers who work with Karen clients. When alcohol and alcohol use was brought up during these conversations I took detailed notes in field journals. These writings were included in the data analysis. Madison (2005) recommends keeping memos as part of critical ethnography. Writing analytic and self-reflective memos allows the researcher to collect and preserve thoughts and ideas throughout the data collection process and to include these observations in the analysis. In addition, keeping memos allowed me to bracket ideas, values, and beliefs as part of the ethnographic and phenomenological methodology traditions I used.

Specific Procedures: Thailand

The Thailand portion of this study took place in refugee camps and Karen communities near two cities in Thailand along the Thai-Burma border: Mae Sot and Mae

Sariang. As with recruitment in Minnesota I spent a significant amount of time in Thailand meeting people and participating in cultural and social events in order to build trust and relationships with the Karen community. Recruitment procedures in Thailand differed from Minnesota because of cultural and geographic contexts along the border. Rather than recruiting participants through social service agencies I spent significant time developing relationships with Karen individuals working for Western NGOs, Karen indigenous rights and health care worker groups and individuals who work along the border. These relationships resulted in introductions to potential research participants.

For semi-structured interviews with individuals and groups I always secured an introduction from a Karen person and explained the study thoroughly prior to obtaining consent for participation. In order to address concerns about transparency I consistently identified myself to everyone I met as a researcher and explained thoroughly the nature of my study. Prior to travelling to Thailand I contacted colleagues and acquaintances at three non-governmental organizations (NGOs), including International Rescue Committee, DARE Network and the United Nations. Each of these contacts agreed to meet with me once I was in Thailand and to introduce me to potential study participants. One of these contacts from DARE Network, a Karen man, acted as my cultural liaison while I was in Thailand.

Recruitment and participants

Participants for this portion of the study were recruited through a convenience sampling method. While in Thailand I spent five weeks in Mae Sot and five weeks in Mae Sariang. While in each city I was introduced to Karen aid workers, medics, refugee leaders, and advocates as well as Western employees of non-governmental organizations

including World Education and the International Rescue Committee by my contacts. In Mae Sariang I volunteered for four weeks with DARE Network, the only drug and alcohol treatment entity for Karen refugees on the Thai-Burma border. With DARE I was able to interview several of their staff members and several people who had gone through their treatment program, as well as other Karen individuals to whom they introduced me.

In Mae Sot I conducted individual interviews with two people, one focus group interview with eight people and conducted participant-observation. In Mae Sariang I conducted individual interviews with four people, six focus group interviews with a total of 14 people and conducted participant-observation.

While in Mae Sariang I worked as a volunteer with DARE Network for four weeks. DARE Network (no affiliation with the DARE program in the United States) is a non-governmental organization providing culturally grounded, non-medical substance abuse treatment and prevention education to displaced persons along the Thai-Burma border. Staff with DARE Network arranged my entry into two refugee camps, Mae La and Mae Ra Moo. I worked closely with staff of the DARE Network to learn about the camps and to gain entry into the camps and at the same time provided volunteer support to their organization. Working with an organization that is already established in camps and has relationships with Karen refugees, as well as the Thai government and United Nations not only eased my entrance into the camps, but, more importantly, provided me with on-the-ground experts who have knowledge and insight into alcohol use in Karen refugee communities.

Data collection

This portion of the study has three types of data: individual interviews, focus group interviews, and field notes from participant-observation. As described above, participants were recruited through contacts and introductions. Each person who participated in a formal interview was first asked if they were interested in learning more about participating in the study by a mutual contact. I was not present during these conversations to minimize coercion to participate. If potential participants expressed interest, I was introduced to the participant by our mutual acquaintance. Prior to beginning individual interviews I obtained verbal consent. Many Karen are not literate in either Karen or English and written consent forms were not practical. Instead, I developed a verbal explanation of procedures and read it to participants with an interpreter (see Appendix C). Participants then gave verbal consent.

Individual interviews. While in Thailand I conducted individual interviews with people both in refugee camps and in Karen communities along the border. Prior to beginning the interviews I obtained verbal consent as described above. Each interview took place at a quiet restaurant or tea shop or at the offices of the Karen Health Workers Group, a Karen NGO based in Mae Sot, or at the DARE offices in each of the refugee camps. These interviews were semi-structured (see Appendix D) and tape-recorded with the interviewee's permission. Semi-structured interview guides were developed with a cultural liaison and pilot-tested and adapted for cultural relevance. Interviews were between one and two hours in length. Focus group interviews were conducted with a trained interpreter. All recordings were transcribed for analysis. Cultural liaisons and Karen acquaintances in Thailand agreed that giving participants cash as a token of

appreciation would be culturally inappropriate. Instead I conducted all interviews over lunch or dinner and paid for the interviewee's meal.

Focus group interviews. Six focus group interviews were conducted in refugee camps and in Karen communities along the border. Focus group interviews were conducted with a trained interpreter, as described above. Focus group interview guides were developed with a cultural liaison and pilot-tested and adapted for cultural relevance. Focus group interviews were conducted in the offices of World Education, in international NGO in Mae Sot and in the offices of DARE at each of the refugee camps. Focus group interviews were semi-structured (see Appendix D), were tape-recorded and were one to two hours in length. Resulting recordings were transcribed for analysis. I provided a full meal for each group as a token of appreciation for participation.

Participant-observation and field notes. As in Minnesota, participant-observation was a significant part of data collection. Because I was living in predominantly Karen communities and spending multiple nights in refugee camps I had the opportunity to immerse myself in experiences beyond formal interviews. I had numerous conversations and experiences that provided data for this study. After each conversation or experience in which alcohol was discussed I took detailed field notes. Throughout my time in Thailand I worked closely with my cultural liaison to explore and interpret these field notes.

Ethical Considerations

This study involved participants who were vulnerable on a number of levels. First, refugees have experienced multiple forms of traumatic events and displacement and may have ongoing physical, psychological, and social symptoms of trauma. Second, refugees

in camps in Thailand are, in many ways, a captive population and are vulnerable to exploitation because they are not able to leave the camps or access the Thai justice system.

Because this study involved a vulnerable population, special attention was paid to issues of confidentiality. Participants were told that all data would be kept confidential and that data would be stored securely. In focus group interviews participants were asked to respect the confidentiality of other participants and to not talk about what was said in the group in the larger community.

Because this study involved vulnerable populations, particular attention was paid to ensuring informed and non-coercive consent. All participants were asked to sign consent forms or give verbal consent and were given copies of these forms where relevant. All forms were read and explained by an interpreter when needed.

Data Analysis

Data collected during this study was in text form and consisted of transcripts of interviews, memos, and field notes. All audio recordings were transcribed by the researcher and the original recordings were kept in digital format on a secure server. Transcripts were kept as digital files and stored on a secure server. Signed consent forms were kept in a locked file cabinet in a locked office. Memos and field notes were typed or scanned and kept as digital files.

Data was analyzed using Spradley's (1979) domain analysis. Spradley (1979) describes domain analysis as "a search for the larger units of cultural knowledge" (p. 94). Domain analysis is a way of discovering through language and observation the "parts, the relationship between parts and their relationship to the whole" (p. 92) of a phenomenon

within a cultural group. Spradley's domain analysis involves eliciting themes from textual data and then grouping those themes into categories that allow for understanding the ways in which group documents and organizes cultural knowledge.

This method was chosen because it provides a method for incorporating multiple forms of data into a unified analysis. Domain analysis involves developing categories of themes from the data. Data is coded into units of meaning that are grouped into themes. For example, some codes included "health," "medicine," and "fighting." These themes are then further grouped into categories, which Spradley defines as having unifying semantic relationships. For example, in this study two recurring themes were 1) some Karen people drink alcohol for medicine or to stay healthy; and 2) some Karen people drink alcohol to deal with negative emotions. These two themes can be grouped into the category "Reasons for Alcohol Use."

Data from each location was initially treated separately (see Appendix E for a table of data analysis steps). First, with the Minnesota data, I read through all written materials to get a sense of the whole. Next, I read all written materials a second time and jotted notes in the margins where ideas and thoughts began to emerge. These notes became the initial set of codes. I developed a complete set of codes for the Minnesota data and then coded each transcript using the initial set of codes. Finally, I read through the text for each code and collapsed the codes into themes. Then I set the Minnesota data aside and went through the same procedure with the Thailand data. After developing themes for the Thailand data I saw that the themes for each location were similar and sometimes even the same and that the data could be further analyzed and presented in a geographically integrated format, making sure to identify where themes diverged by

location or where a theme was present in one location but not another. With all themes from both locations together, I then collected themes into categories, writing extensive descriptions for each category and taking notes on thoughts, ideas, and interpretations as they emerged. Finally, I reviewed each category with study participants and cultural liaisons from Minnesota and Thailand to get feedback and further interpretation.

After completing data analysis in January 2013 I contacted one person who was part of the Minnesota sample and one person who was part of the Thailand sample and asked them to participate in member checking. I chose each of these participants because they were people with whom I had developed a rapport during interviews and who had expressed an interest during the interviews in participating further with the study if any opportunity arose.

After all participants agreed I set up individual meetings to conduct member checking. In Minnesota I met with the participant at the offices of the social service agency through which she had been recruited. This meeting was conducted with an interpreter. The participant was read a brief description of the categories and emerging themes and were asked to respond to several questions: 1) In what ways do parts of these descriptions seem accurate to you or fit with your experience? 2) Are there parts of these descriptions that you disagree with or do not fit with your experience, and why? 3) Is there anything you want to add to these descriptions that would make them more accurate or fit better with your experience and knowledge of the Karen community?

With the participant from Thailand I set up a meeting using an internet-based video conference call service. This participant spoke English relatively well and member checking was conducted without an interpreter. Prior to our virtual meeting I emailed him

the same written descriptions of categories and themes that were given to the participant in Minnesota. The participant in Thailand was asked the same three questions.

In both member checking meetings participants agreed with the findings and had very little to add to the descriptions of categories. Places where they had recommendations for changes were only to make certain statements stronger or more clearly defined, rather than adding or deleting information.

In addition to member checking, I also conducted a version of peer debriefing with my cultural liaison in Minnesota. During a two hour meeting with him I gave him descriptions of the categories and themes I had developed and asked him the same questions I had asked during member checking meetings. Similar to the member checks, this person verified the categories and themes and added information to support them.

The findings are organized into categories which contain themes that emerged from the data. A theme was developed when endorsed by five or more participants in two or more individual or focus group interviews. Some themes have more representational weight than others because they were endorsed by many participants. In the findings section I indicate representational weight by noting which themes were endorsed by many participants or almost all of the participants and which themes were endorsed by only a few participants.

Data analysis, while conducted in earnest after the completion of the data collection phase, was ongoing throughout the data collection phase and as ideas, themes, thoughts, or concepts emerged they were worked into subsequent interviews and conversations. For example, in several early interviews in both Minnesota and Thailand participants used the phrase “he is following his heart” when talking about someone who

uses alcohol over the limit. As this phrase was used more and more often I began to incorporate questions about the meaning of the phrase into subsequent interviews. As with much qualitative research, analysis influenced the types of questions asked during interviews and new questions arose and were added as new ideas came to light.

Trustworthiness

There are limitations and threats inherent in qualitative designs that impact trustworthiness and I will next address potential threats in my research design along with steps I took to mitigate those threats. Lincoln and Guba (1985) define trustworthiness in qualitative research as the researcher's ability to persuade her audience that the results of a study are rigorous and "worth paying attention to" (p. 290). Lincoln and Guba (1985) suggest four questions to determine the trustworthiness of a study: 1) How did the researcher establish confidence in the *"truth value"* of the findings for the participants? 2) How did the researcher establish the extent to which the findings of her study are *applicable* to other contexts? 3) How did the researcher determine if her findings are *consistent* across study participants? 4) How did the researcher ensure *neutrality*, making sure that findings are not influenced by the biases and perspectives of the researcher? Lincoln and Guba (1985) suggest a variety of techniques for ensuring the credibility and trustworthiness of the findings of qualitative inquiry including triangulation of data, peer debriefing, and the development of an audit trail, member checking, and reflexivity, each of which were used in this study and will be described below.

Triangulation of Data

Triangulation of data in qualitative research involves collecting data from multiple sources and in multiple contexts to ensure that data is rich, comprehensive, and

robust (Lincoln & Guba, 1985). In this study I utilized several forms of data including individual and group interviews in multiple settings, participant-observation, memos, and conversations with cultural liaisons. These sources of data provided a way to compare data across multiple sources and allowed me to assess consistency across study participants, to assess the truth value for participants, and to assess applicability across multiple contexts.

Peer Debriefing and the Development of an Audit Trail

Because there was only one researcher in this study it was essential to utilize peer debriefing and an audit trail to ensure a rigorous design, fidelity to that design, and accurate interpretation of findings (Lincoln & Guba, 1985). Peer debriefing consisted of occasional meetings with my dissertation advisors who have experience working with refugees and regular meetings with other colleagues who were conducting qualitative research. I developed an extensive audit trail including a detailed explanation of all steps of the research process including how design decisions were made. One of my advisors, Liz Wieling, provided periodic auditing throughout the entire study process including participating in an initial focus group interview, reviewing design decisions and alterations during data collection, reviewing initial coding, and reviewing data analysis. These techniques allowed me to ensure consistency across findings and to maintain neutrality.

Member Checking and Cultural Liaisons

The use of cultural liaisons familiar with the community was strategic. These partners provided invaluable assistance with the entire study and also provided member checking and review of resulting themes and findings. Member checking is recommended

by Lincoln & Guba (1985) and Madison (2005) as a way to ensure consistency of findings and to assess the truth value of findings for participants. I utilized both formal and informal member checking by reviewing my findings with one study participant from Thailand and one from Minnesota.

Reflexivity and Bracketing

Field notes allowed me as the researcher to adapt questions, to assess the progress of the project, and to ensure reflexivity throughout the study. Conversations with interpreters after interviews helped with understanding non-verbal or cultural cues that may have been missed and were an additional source of data. Lincoln and Guba (1985) suggest memos as ways to elaborate on decisions about codes, deepen analysis, ask questions, and to keep track of the process of developing themes.

In all qualitative research, because the researcher is the instrument, there is a risk of bias or lack of neutrality (Lincoln & Guba, 1985). To increase neutrality I utilized bracketing techniques. "Bracketing" is a unique and essential part of data analysis in a phenomenological study (van Manen, 1990). Bracketing is the act of setting aside preconceived assumptions, ideas or taken-for-granted knowledge that the researcher might have about the phenomenon under study. Phenomenology is predicated on the idea that knowledge is "socially constructed" (Berger & Luckmann, 1967). Everyone experiences phenomena from within their own culture and identity and individuals in communication with each other will have multiple ways of interpreting or describing a situation. Each is subjectively true and the negotiation of these multiple experiences constructs or builds a shared reality (Berger & Luckmann, 1967). Thus, in order to gain a

true and deep understanding of the study participants' expressions of the phenomenon, researchers must bracket out or elide their own interpretations and understandings.

As the researcher I attempted to bracket out my own beliefs and experiences through the use of memos and field journals throughout the research process. By identifying and describing my own experiences and beliefs about trauma, substance use, and culture I was better able to set those ideas aside while analyzing the data. This process was facilitated with the use of memos and field notes.

Chapter 4: Findings

Chapter Overview

In this chapter I describe the categories and themes that emerged from the domain analysis of multiple sources of data, including focus group interviews, ethnographic interviews, field notes, and reflexive memos based on participant-observations in both study contexts (Minnesota and Thailand). As described in Chapter 3 above, I developed themes for each location separately. When it became clear that there was consistent overlap between most of the themes that emerged in each location, I merged the presentation of findings together and continued the analytical process by organizing the data within a matrix that accounted for core themes from within and across geographic locations. I present the categories and themes in this chapter in an integrated manner, identifying where specific themes or details of themes might differ by geographic location.

Consistent with domain analysis (Spradley, 1979) I collected common themes that emerged from the data into the following categories: Reasons for Alcohol Use, Consequences of "Over the Limit" Alcohol Use, Beliefs about Alcohol Use, Ways of Stopping Alcohol Use, Women's Ways of Using Alcohol and Youth's Ways of Using Alcohol (see Appendix F for a table of categories and themes).

I have included themes that were endorsed by four or more participants in two or more focus groups or individual interviews in the categories described in this chapter; however, some themes have more representational weight than other themes because they were endorsed by many participants over multiple focus groups and interviews. In order to better understand representational weight of themes across interview modalities I

looked at the data within the six individual interviews and the 56 participants represented within the 12 focus groups by counting the number of times they spoke about each thematic meaning unit. As a form of additional member checking and to establish representational weight I frequently asked participants in focus groups interviews questions such as "What do other people in the group think about what has been said so far about this topic? Does anyone have a different or similar experience?" I was often able to see numeric representation of agreement or disagreement within group interviews. I then developed a representational weight that accounted for participants in both focus groups and individual interviews (N=62) for each of the themes and used the following language throughout this chapter: few (5 to 15 participants), some (16 to 32 participants), many (33 to 51 participants) and most (52 to 62 participants). It is important not to interpret these numeric representations as having more or less truth but rather as a way to further contextualize participants' experiences.

The themes in the first four categories described below emerged with very high representational weight. Within these categories it was clear that both men and women were describing *men's* ways of drinking as the normative way of drinking. Women's and youth's ways of both consuming and relating to alcohol were described separately from men's ways of drinking and were much less developed throughout interviews and subsequent analysis. For this reason, I have grouped themes related to women's and youth's ways of drinking or relating to alcohol into separate categories.

I have taken quotations in this chapter directly from transcripts and have edited them for clarity. It is important to note that most interviews were conducted with a translator so all quotations have been interpreted into a second language, which limits

consideration of quotations as direct. All interviews and focus groups were conducted either with interpreters who were trained as described in Chapter 3 above or with participants who are fluent in English. However, for all participants and interpreters English is a second or even third or fourth language. Therefore, grammar and sentence structure in English are not always accurate. In any editing I have remained as true as possible to the participant's words and sentence structure and only edited for clarity and readability. Parentheses after quotes indicate location of participant (MN or TH) or text from field notes (FN).

Category I: Reasons for Alcohol Use

All participants in both locations indicated that there were multiple reasons for using alcohol and that each person was different, with different reasons for use. Further, all participants identified both appropriate and inappropriate reasons for drinking alcohol. Consequently, this category, Reasons for Alcohol Use, consists of two themes: 1) Appropriate Reasons for Using Alcohol; and 2) Inappropriate Reasons for Using Alcohol. These themes contain as sub-themes specific reasons for using alcohol such as "Drinking Alcohol for Health or Medicine" or "Drinking Alcohol to Feel Free."

Theme 1: Appropriate Reasons for Using Alcohol

Most participants reported that there were some appropriate reasons for using alcohol and that alcohol, particularly homemade alcohol was a significant part of Karen celebrations and ceremonies. Appropriate reasons for using alcohol included drinking alcohol for health or as medicine and drinking alcohol the "old way" (MN) such as during cultural events and ceremonies or to relax after work with friends. Most

participants said that when a person used alcohol for these reasons he or she did not cause problems, even when he or she may have used in excess or gotten drunk.

Drinking for health or medicine. Most participants in both Thailand and Minnesota said that the primary appropriate use of alcohol was for medicine or to maintain a healthy body. Alcohol was used to treat headaches, colds, fevers, and other sicknesses. One participant in Minnesota said that using alcohol as medicine was "good." He explained, "When I have fever I will take two Tylenol and a glass of alcohol. That will be better." (MN) One participant said that especially older people drank alcohol to promote better health in old age: "If you get older for you to have a good body shape you have to drink alcohol to . . . keep you in good shape." (MN)

Alcohol was also used to "warm up" (MN). One participant explained, "For some people because it's the cold weather, they go to work and come home and drink a little bit to make themselves warmer and they go to sleep and the next day they go back to work." (MN)

Some participants explained that alcohol was used as an appetizer: "If you put it down like food, you know, cook curry and alcohol, people are going to reach the alcohol first." (MN) Another participant reported:

> Some . . . people just use for their health or like as a medicine or before [a] meal and then like kind of to make the appetizer or something. So before you eat something you just drink a couple alcohol and then make you like good appetite. So some people just use like this not use more so maybe not a problem. (TH)

Drinking the old way. Appropriate reasons for drinking appeared to be more prevalent among older people or in the villages in Burma. Using alcohol for health or

medicine was reported to be something that older people did, and that younger people did not do anymore. One participant called this drinking alcohol the "old way," meaning drinking alcohol according for culturally appropriate reasons. One participant explained that drinking alcohol for health or medicine was the "old way" and was part of culture:

> People who live in the village, they drink it simply. And only oldest people drink alcohol and after work for them to relax they drink and to have good appetites, they drink alcohol. And as a culture also when they celebrate things, they also drink it. (MN)

A participant in Thailand said:

> Inside [Burma] people use old culture. They use alcohol in ceremonies when they have a new house ceremony or New Year, wrist tying ceremony. Inside [Burma] they use it this way. They use just a little, they have the rule of a little bit. (TH)

Another participant agreed with her, saying:

> So first reason is because most of Karen people, by the traditional way like many people use because of the culture or something. But in the past is like kind of they have very limited and they have a like kind of the rule, how to use in the culture, ceremony. (TH)

Alcohol was also used to relax after work with friends, which was another appropriate way of drinking. One participant said, "After we work we get tired and we want to relax and we get together and drink. To have a good feeling. Only in the afternoon, after work." (MN)

A participant in Thailand explained that this was the traditional way of drinking alcohol and was very much a part of Karen culture. He said:

> I want to start by telling you about the way things were traditionally, according to Karen culture. In Karen culture alcohol is a tradition, many thousands of years. Karen people have always used alcohol and it is a cultural material. On the farm they sacrifice to the spirit for looking after them. They sacrifice a chicken with alcohol. They use the alcohol for spiritual, traditional reasons and there is never a problem for the family. It causes no problems. (TH)

Theme 2: Inappropriate Reasons for Using Alcohol

All participants listed multiple inappropriate reasons for using alcohol. Almost every participant indicated that inappropriate reasons for using alcohol were far more common than appropriate reasons for using.

Drinking to forget loss and difficult emotions. Emotions were frequently given as inappropriate reasons for using too much alcohol. One participant said, "Yes, we do [use alcohol] to get rid of bad memories . . . It might happen, it might happen like hopeless, you know, and give up in their life, so they just do whatever like a lot of drinking." (MN) Another participant said "They keep on seeing their image, in their imagination that pain. Sometimes they think if I drink it will help me think differently. I'll see differently. I'll forget it for a little while." (MN) Yet another participant said that people often drank because they were sad. She said, "So they are sad and they can't sleep and they will drink until they are out of their mind trying to get over the situation." (MN) A participant in Thailand, who was in recovery from alcohol, said, "I started using alcohol when my brother, my father and my sister died. I used it to feel happy. I used it to stop thinking. It made me stop thinking." (TH) Another participant said the main reason

people used alcohol was "because of feeling. People have a bad feeling and they want to fix that feeling." (TH)

Many participants cited trauma resulting from the conflict as a cause of problematic alcohol use. One participant reported:

> Some of them they even [commit] suicide because of, they are living in the village in Burma and the Burmese government forced them, they have to escape away sometimes, they run out of food sometimes . . . so there's a lot of problems like that. They came to Thailand and they start being hopeless and living because there is no future for them . . . the Burmese soldiers are killing their child, their wife, you know, that's why they cannot forget that pain. (MN)

Drinking because they follow their heart. The phrase "he is following his heart" (MN, TH) was used by most participants to describe someone who was drinking over the limit or engaged in problematic alcohol use. It was used by participants in every focus group in Minnesota and in almost every conversation and interview I had in Thailand. Saying that a person was following his or her heart was often given as a reason or cause of problematic alcohol use. A person who followed his or her heart was someone who followed what they wanted or needed to feel better rather than thinking about their family or community. A person who followed his or her heart was using alcohol "to feel happy" (MN, TH). A participant explained "Somebody follows their heart when they do whatever they want to do. Without any reason. Without thinking, without thinking about their family." (TH)

Following one's heart was described as a selfish type of personal behavior, such as one's choice to turn away from community thinking—thinking about family, community, and culture—and thinking only about one's self. A participant in Minnesota said that a person who followed his heart just "does what he wants to do." Another participant in Minnesota used the word "individual" when describing someone who followed his heart. He said, "They just follow what they want to do, its individual problem. The early generation, they use it as a medicine, culturally, you know, just a little bit, but now people use it over and it has become an individual problem." (MN) Another participant said, "He only think of himself. Because he like, he like alcohol so he don't think of his family he only think of himself. He selfish." (MN) A participant in Thailand agreed with her, saying, "They just follow their heart. And also they don't have a job, nothing to do, so they just drink." A participant explained it this way:

> Yeah. Let's say if a person is following their heart, they are in a bad relationship and they got really hurt or a broken heart they will choose to relieve their pain with that, bad decision, like drinking, you know, they will forget about their family or saving or people around them. They will do whatever, you know, will make them happy. (MN)

It was often described that a person who followed his or her heart was "following their feeling" (MN). My cultural liaison described the phrase to me and I wrote the following in my field notes after that conversation:

> [Name withheld] says that following one's heart is like this: Someone has a bad feeling in their heart, like sadness or hopelessness or a broken heart

> or fear or something. So they drink alcohol to get rid of those feelings. They are following what their heart wants and only thinking about themselves. They are being selfish because they are not thinking about others, their family, their community. Following one's heart is following those bad feelings toward drinking. He also said that following your heart is sort of like wanting or craving something bad or negative, rather than wanting good. (FN)

Several participants equated following one's heart with repressing or erasing negative emotion. When I asked why some people follow their hearts one participant explained:

> Some people I have seen like to get freedom, maybe in their family they are not peaceful, maybe something happen, maybe they are not listen to each other or something else so to get free, free from the family. So kind of drinking, follow their heart. (TH)

Another participant reported, "This person who create the problem, because they are just following their heart and also take only from the negative side." (TH) Participants in two different focus groups in Minnesota said that people who follow their hearts "just want to feel good" (MN) or "to feel happy." (MN)

A secondary aspect of this phrase was that it sometimes seemed to imply an inability or lack of desire to stop using. One participant explained, "What I understand [about] why they cannot stop is . . . that maybe people don't want to stop, just want to follow their heart." (TH) Another participant agreed, saying "But some people they know that [alcohol is bad], but they kind of they follow

their heart. So even [though] they know that they decide to use." (TH) After a conversation with my interpreter in Minnesota I wrote the following field notes:

> I asked [name withheld] to clarify what the participant today was saying about regret and following your heart. She said that when people drink they do things they regret. Then when they are sober they feel that regret and stop. People who follow their heart do things they regret but don't care. They can't stop or don't want to stop. (FN)

A participant in Minnesota reported, "As my view, people who are addicted to drugs, they are, like last time we said, they follow their heart. They know that it's bad, but they will keep on doing it." (MN)

Drinking to feel free. The concept of freedom was unique to participants in the refugee camps in Thailand and was not part of conversations and focus groups in the United States. Being drunk was frequently equated with feeling free. After a conversation with several Karen health workers I wrote the following in my field notes:

> Freedom appears to be a salient concept for Karen people. They have been fighting for freedom for years—generations, really—and it defines every conversation I have about the conflict. People want to be free. When they leave Karen State and come to the camps it's like a cruel joke—their freedom is even more constrained. They can't leave, they can't work, they are stuck. So many people have described the camps as being a place of no freedom. The health workers today told me that people just want to be free and being drunk is like being free. (FN)

The word freedom and the concept of wanting to be free appeared in many conversations and interviews in Thailand. One participant said the main reason people in the camps drink alcohol was because they want to be free. He said, "The main thing that you will hear—no freedom. We have no freedom, yeah, so that's the main reason." (TH) Another participant explained, "[In the camps] there is a sense of not being at home . . . People do not have choices. Being drunk equals being free." (TH)

Drinking because they just want to. Many participants said that one of the reasons people drank alcohol was because they just wanted alcohol or they just liked to drink, almost as if there were no reason, they just wanted to do it. One participant said, "But for some people they just used to it, they just like to drink." (MN) Another participant related this to the good feelings being drunk provided, saying, "Some of them since they started they don't want to stop it, if they like the feeling, then they continue doing it." (MN) For a few participants this seemed to be a reason that was given when another reason could not be found. After listing several reasons that people drink alcohol one participant finally said forcefully, "And then for some of them they just like to drink, that's why they drink." (MN) A woman in Thailand said:

> People would say they use too much because they like it. They like their own fun and they use it to have fun and use until they have no money left. Just keep using and using because of fun, instead of culture. (TH)

Men drink because they are men. Most women in Minnesota stated that one of the reasons Karen men drank was because they were taking advantage of their dominant role in the household; they drink "because they are men." (MN) This reason did not appear in interviews or conversations in Thailand. One woman explained:

> Some of them they want to take advantage of their family because they are the dad they . . . [think], "Oh, I am the father in the house, everybody need to listen to me, respect me, you know, I am the man" and things like that. "You have to do this for me, you have to go there for me you have to bring this for me, you know, you have to do what I ask you to do." (MN)

Another woman explained that men often used their role as the head of the household as an "excuse" (MN) to drink alcohol over the limit. This was not given as a reason for alcohol use in interviews in Thailand.

Drinking is caused by the Burmese government. Alcohol use was reported to affect interactions between Karen people and the Burmese government. Some participants said that alcohol was used to control Karen people. One participant in Minnesota said, "Because the government . . . if they get people drunk it is easier for them to control . . . it's easier for them to control the people." (MN) Another participant concurred, saying "Plus the Burmese government . . . if they use alcohol it's easier for them to keep control." (MN)

Drinking to deal with the Burmese government. Many participants said alcohol was used to facilitate relationships between Karen people and Burmese soldiers. In my field notes after meeting a Karen leader in Thailand I wrote:

> [Name withheld] told me today how he escaped captivity with the Burmese military. He had been held for about a week and forced to porter for the *tatmadaw*. He had been beaten and was told that he would be killed very soon. In one village he was able to get some alcohol that he gave to one of his guards. With this bribe he was able to escape. (FN)

Many participants described a process of "friendship" where Karen people used alcohol to facilitate relationships with the Burmese military soldiers. One participant described it this way: "Friendship mean is, like . . . you have to deal with so many kind of people, like you have to meet with Burmese government and all people like that, um, to build up friendship you will buy them alcohol and drink together then you became like closer and you become a friend, so it's easier for you to deal with. For your own safety." (MN)

Drinking to get rid of fear. One reason for alcohol use put forward by many people in several different focus groups and in interviews in Thailand was that people drank to get rid of fear or to feel brave. Many participants explained that there was a taboo in Karen culture against speaking out in anger or addressing hurt between friends or acquaintances (FN). Drinking allowed a person "to get rid of fear" (MN, TH) and speak about anger. One participant explained it this way:

> [Another] reason that people drink is . . . this person hurt him before for some reason . . . by word or . . . physical or emotional abuse [and] he [is] not happy with this person so he invite him to come and drink with him. He has something in his heart but he cannot open so they drink together and so when they drunk he know [say] I'm not happy with you [and] he will hit him so hard. (MN)

Getting rid of fear was a phrase that was frequently used when discussing the fighting and violence that frequently occurred with drinking alcohol. Individual participants stated the following when describing fighting and violence related to alcohol use:

> Some of them they are used to that attitude, if they get drunk they want to get in fight. By drinking alcohol they get rid of fear. (MN)
>
> But the youth they drink it to get rid of scared . . . so that they can fight. (MN)
>
> When you are drunk you are not shy. (MN)
>
> There's problems like, sometimes, like they will get in violence, you know, they will take out their knife, and you know, fight and things like that. And sometimes they don't even care if they die, you know. They are very careless of their life. (MN).

Very few participants were able to identify specific things of which people are afraid. Rather, it seemed that alcohol helped people to deal with a general fear or helped people to "feel brave" (TH) or "strong" (MN). In field notes composed after a conversation with some Karen colleagues over dinner in Thailand I wrote:

> There was a long conversation at dinner about how in Karen culture there is a reluctance to speak about anger, to speak about problems, to speak about negative feelings or sadness. I heard this from [name omitted], too. Karen and Burmese people are taught from a very young age to not speak about feelings. Drinking allows people to say what they are feeling inside. This is why drinking makes people fight. They have anger and stress inside and they drink and let it out. (FN)

Being drunk appeared to lead to people speaking out in anger as opposed to speaking "softly" when not drunk. One participant said:

> For example, now I am not drinking so if people are yelling to me or people are talking to me very pain, maybe I can talk with very soft way . . . But if I drink if people are yelling to me I have a different reaction. (TH)

Drinking because of friendship. This concept of drinking because of friendship described between Karen people and the Burmese government was echoed in discussions of friendship between Karen people, as well. While mentioned by only two participants in Minnesota, friendship between peers was cited by most participants in Thailand as a reason for drinking alcohol. In Thailand, one participant explained, "Most of the Karen they drink together . . . Not by their self. Most of them they drink with their friend or with their community." (TH) He went on to say later in our conversation:

> They just want to be happy, to be happy with their friend because most they like to drink with their friend and their friends come and so they drink and then they talking and then, like, follow the tradition, the Karen they do like that. (TH)

Many participants in Thailand said that while friends provided a social group for drinking and often shared the costs of alcohol they were also a source of pressure to continue drinking. One participant explained, "Sometimes like the friends temptation, maybe his friend talk to him you are not a man, like you are afraid or something like that so maybe he and so and then he drink." (TH)

Often trying alcohol was motivated by friendship and led to more excessive use. A male participant in Thailand said:

> At the beginning his friends like kind of temptation or like offer him even he don't want but they offer like often, often and then first ok let's try to know the, to get the experience or to know the taste or something like that and then after that he start to try and later slowly and slowly he more and more use. (TH)

Drinking because of conditions in the refugee camps. Many participants in both the United States and Thailand said that people, especially youth, in refugee camps

felt isolated, bored, trapped, and hopeless for the future. They had nothing to do and could not work, so they drank. One participant said:

> Ok, in the camps some of the people they, many different kinds why they use alcohol and drugs there, some of them because of there's no other things to do in the camp, they have to go through stress, there's no job there, they wake up there's nothing to do, they been through stress, so they drink. For some of them they just like to drink, that's why they drink. (MN)

In addition to the significant pain caused by these traumatic experiences refugees who flee to camps in Thailand faced boredom, hopelessness and isolation. One participant said:

> Ok, in the camps . . . why they use alcohol and drugs there, some of them because of there's no other things to do in the camp, they have to go through stress, there's no job there, they wake up there's nothing to do, they been through stress, so they drink. (MN)

Another participant in Thailand said:

> The youth that grow up in the camp because they see no clear future they waste their time with friend and try to keep themselves happy. When you have no future you have needs like any people, but you have no way to fulfill them in the camps. They try to find a way, any way that they can fulfill themselves and be happy. They are hopeless and trapped with no idea or way to fulfill their human needs, so they are looking for alcohol to help them feel better. (TH)

Another man agreed, saying:

> Before in Karen State they have culture and village and religion to stop people from using. People don't use too much. But then the SPDC burn the village down and people lost their family and their land and then they came to the camp. There, they have nothing. Alcohol is easier to get, so they start using it all the time. In the camps, they can't go outside, they can't work, they have many free time. (TH)

Another woman in Thailand said:

> But once they come here there are no jobs and they are staying and there's more time. There's more time and then because of then there are no jobs and then they headache and sometimes they boring or something sometimes they have no jobs and then they, ok well they drink and it make them happy or something. (TH)

Drinking because of resettlement stress. The impact of resettlement in a third country on problematic alcohol use was a recurring theme in the data from Minnesota. The stressors, changes and responsibilities that occur with resettlement had unique impacts on alcohol consumption in the Karen community. According to most participants in Minnesota resettlement affected people in one of two ways. Either people used alcohol to deal with the stress of resettlement and engage in problematic alcohol use or people quit or limited their alcohol consumption after resettlement because of the increased responsibilities in the United States.

It is unclear from participants whether perceived prevalence of alcohol use increased, decreased, or remained the same after resettlement. Participants gave a range of observations including knowing people who stopped drinking after resettlement, people who increased their drinking after resettlement and people

who continued the same pattern of consumption after resettlement. What was clear was that there were additional resettlement-related reasons for alcohol consumption that impacted alcohol use.

The primary reason given for continued or increased alcohol use in the United States was to deal with the stress and worry that happened with resettlement. Participants reported increased worries and stress related to finances, their children's education and acculturation, learning a new language, finding and keeping employment, housing, weather, and learning a new culture. One participant said:

> There's a lot of problems, like the language, don't understand the language, sometimes you start working for a few months and then all your family, they cut your Medicare and like that and plus you have to pay for the rent. It's expensive." (MN)

The words "stress" and "worry" were repeated words when talking about alcohol use in the United States, as evidenced in the following excerpts:

> If they drink they don't, it's like, relieve them from, why they drink is to relieve them from worries. (MN)

> Some of them when they drink, the stress they have in their mind, it's like relief, the relief of that stress when they drink. (MN)

Many participants reported that drinking alcohol helped to keep people warm during cold weather. Part of conversation about alcohol for health or medical reasons touched on the idea that alcohol helped with feeling cold. Because Minnesota is significantly colder than Thailand many participants said

that the weather became an excuse for drinking alcohol. One woman reported, "Over here they drink because of the weather. Because it is cold out." (MN) Another man agreed, saying, "For some people because it's the cold weather, they go to work and come home and drink a little bit to make themselves warmer." (MN) After a conversation with a social service provider who worked with Karen refugees I wrote the following field notes:

> [Name withheld] and I talked about the growing number of Karen going to Alexandria and Worthington to work in the meat packing plants. It seems to be a growing employment option for men. She said that because they are working in refrigerated conditions they are starting to drink a lot more because they are cold after work. (MN)

One of the reasons given for increased alcohol use in the United States was the increased availability and variety of alcohol. Several participants said that there seemed to be more alcohol available such as in liquor stores or at convenience stores. One man reported, "When I went to the store I [saw] a lot of different kind of alcohol in the store, in the liquor store . . . I see people go to liquor store and get alcohol, get drinks all the time . . ." (MN) Another participant explained, "Some of them [drink too much] because the alcohol, the liquors are very cheap." (MN) Yet another woman reported, "Because of they used to drink [in Thailand] and they came [to Minnesota] and easier to get it so they drink." (MN)

Two participants in two different focus groups said that one of the reasons people drank more alcohol in the United States was that they brought their

drinking habits with them from Thailand. In fact, one of the participants said that past drinking behavior was a more significant motivator for continued alcohol use than the stress of resettlement. She said:

> They will but only for like for 25% of the problem cause them by drinking alcohol by the problems causing them make them drink alcohol is only like 25% but the 75% is because of they already know how to drink they used to drink . . . (MN)

Another participant said "Plus some of them they used to drink it in Thailand, so they miss it. They get used to it." (MN)

Several participants said that alcohol use may actually have decreased for some people after resettlement. There appeared to be two reasons for this. First, the increased responsibilities of resettlement including finding and keeping employment, providing for family, paying rent and utilities, and managing finances decreased alcohol use. Second, laws governing drinking were stricter in the US, leading to more severe consequences for drinking, which limited alcohol use.

Two different participants described the ways in which increased responsibilities after resettlement affected drinking. One participant said:

> For some people because they have to take care of the family if they lose their job it's not going to be easy for them so lesser than it used to be . . . because the consequence between the job and the family and the policy, the work. (MN)

Another participant described someone she knew in Minnesota from the refugee camp in Thailand who stopped drinking after arriving in Minnesota. She told this story:

> I used to teach in the camps. I have a student who when he was there he drink and I was worried no matter how we help him to stop he won't stop but when he come here he go to school he work and he trying to help his parents back in Thailand, now he stop drinking. (MN)

Category II: Consequences of Alcohol Use

All participants agreed there were several negative consequences to drinking too much alcohol. The primary negative consequences of drinking alcohol mentioned by almost every participant in both locations were *fighting* and *violence* both between non-related adult males and between spouses or parents and children. Other consequences mentioned by many participants included *health problems*, *addiction*, and problems because of various *laws and rules* both in the camps and in Minnesota.

Theme 1: Fighting and Violence are Consequences of Drinking Too Much

Fighting and violence (both between non-related men and between family members) were two of the most frequently given consequences of drinking alcohol over the limit. In this theme violence between family members is addressed as a sub-theme of fighting and violence.

Participants in Minnesota reported frequent fighting and violence happening "every day" (MN) in the refugee camps prior to resettlement. Participants in Thailand confirmed the prevalence of frequent fighting and violence, most often between male teenagers and between adult men. One man explained:

> Because after you drink you feel brave, active, like kind of aggressive. Like doing without any consideration. According to the youth I know and they why they, because after they use, in Mae La specifically they use alcohol, marijuana and sometimes other drugs and after they use they feel like they are famous and they are brave and that they want to, but even they fight within their friends. (TH)

Fighting between non-family members didn't appear to happen as often after resettlement. As one participant explained, "They don't get in fights as much as in Thailand because we don't visit each other, we live in individual family." (MN) Additionally, one participant noted, "In Burma even though people drink, there's not much fighting going on, but in the camp there's so much fighting, so much problem." (MN) Another participant confirmed that fighting and violence have not traditionally been part of Karen culture and were a new development since displacement. He said, "[it is a] kind of cultural abuse . . . and then the things that shouldn't happen [do] happen. Like fighting or murder." (TH) Participants in every focus group in Minnesota reported fighting in the camps, saying that "after people get drunk they will fight, sometimes . . . until the point of violence, until they kill each other." (MN)

Participants could not often articulate explanations for why violence was so prevalent after drinking. One participant said:

> There's not much problem why they have to fight, there's not much reason. When they're not drinking or they're not drunk . . they talk to each other, they listen, they try to agree with each other, but when they are drunk it's like, "I have to be right and you have to be right" and that's how they start it. (MN)

In discussions with participants in Thailand the concepts of lost balance or lost control were frequently associated with fighting. One participant explained:

> The problems that people have because of alcohol are the same in all the areas. When they drink a lot they [commit] domestic violence, they have problems with their children, their wives. They have violence, they fight. They have no job and no money. They disturb the community. They are not angry, but they have lost their mind, they have lost the ability to have balance in their mind, to control their mind. They can't control themselves and so they fight with their friends. (TH)

Another participant said that people who drank "cannot balance themselves," (TH) which led to fighting.

Family violence is a consequence of drinking too much. Violence between spouses and, to a lesser extent, between parents and children was another significant consequence of problematic alcohol consumption or drinking over the limit. Both men and women talked about the marked increase in family violence (including arguing, hitting, and beating) that occurred with the increase in alcohol consumption. Most participants agreed that while violence between spouses did happen when people were not drinking it was far more common when people were drinking and grew as a concern after displacement and living in refugee camps and continued after resettlement. One participant said, "the using family [has] more violence than [the] non-using family." (TH) Another participant equated drinking with family problems, saying, "The problems that people have because of alcohol are the same in all the areas. When they drink a lot they become domestic violence, they have problems with their children, their wives. They have violence, they fight and divorce." (TH) After resettlement, family and partner

violence continued to be a significant concern. A participant in a Minnesota focus group said that domestic violence has become "like a culture" since resettlement.

Participants in Minnesota and Thailand both discussed the prevalence of family and partner violence, but there were differences in the contexts given in each location. In Minnesota participants reported that family violence was a result of the drinking spouse "not listening" to his or her partner. One participant said, "There's fighting happen[ing] in the family because if the person who is drunk, they won't listen to anybody, whatever they say is right, like they won't listen to other[s] and they won't follow the rules." (MN) Another participant said:

> When they are drinking, when the men drink, he won't listen to anybody. When . . . the wife tell[s] him something that he will not agree and he will get angry like that for any reason and he won't listen to the wife. Whatever the wife has to say is wrong, he won't agree at all. (MN)

When clarifying these points with my cultural liaison he explained that after resettlement women gained more power in the family and community because they often work outside of the home. He said that women in the United States had more social rights and power than women in Karen families did and encountering this level of social and legal equality was difficult for both men and women. As women began to speak up within their families, men had difficulty listening to them.

In Thailand participants did not speak about listening in families but instead cited family problems such as financial strain due to a partner's drinking as a significant consequence of alcohol use. Families living in the camps subsisted on rations of rice donated by aid organizations and supplement their diet by growing small amounts of

vegetables. They were also given rations of bamboo poles and leaves for housing construction. Many participants reported that frequently in families with a drinking member food and housing rations were sold to pay for alcohol. One participant said:

> So when they drink they . . . don't have money coming and they [can't] buy the food to eat. And also their kids when they go to school they also need some pocket money or something . . . so if they drink too much they don't have money to buy that so the kids . . . they [are] not happy . . . in the school. (TH)

Another participant said:

> Because of using alcohol . . . violence happen in their family and then . . . they are selling their ration to get their alcohol so and then they have a fighting between their family. And then . . . because of the ration cut down and then they [do not have] enough rice, not enough leaf, not enough poles. And some . . . they drink alcohol and then . . . they take their ration or their leaf or their bamboo [to sell]. (TH)

Theme 2: Health Problems are a Consequence of Drinking Too Much

Some participants in both locations said that health problems were a significant result of drinking too much and were often a motivator for stopping or reducing alcohol use. Some participants listed problems such as hepatitis, cancer, memory problems, liver disease, heart disease, and general pain as consequences of drinking too much. One participant said, "[They have] physical health problem, you know like, losing the time, and then abdominal pain and gastro pain and headache or kind of losing the memory or something like that." (TH) Another participant explained that his alcohol-related health problems motivated him to stop using. He said, "When I drink I vomit and then like

gastro pain or something so I, if I continue to use it's not good so that's why I decide [to stop]."(TH)

Theme 3: Problems with Laws and Rules are a Consequences of Drinking Too Much

Many participants in both Minnesota and Thailand cited legal consequences in both locations to drinking too much alcohol. These legal consequences happened in a variety of ways and had a variety of effects. Each of the nine camps along the Thai-Burma border has a different regulatory approach to alcohol. Two of the camps in which I conducted interviews were at the time developing rules to ban the production or selling of alcohol. Other camps had implemented similar legislation. Consequences for breaking these rules included jail time and fines. One participant explained:

> Sometimes arrest the people who are selling the alcohol can help. In my section there are some people they ask the teenager or the children to go outside and buy alcohol and bring back and then they are selling in the camp and when the authority find out so they go and arrest him and put in a detention place and then after that they tag or they fine or something and then the seller afraid to do again. (TH)

There was wide-spread agreement among the participants that these types of rules are marginally effective. After attending a meeting in which camp leadership was debating the banning of alcohol production or selling in the camps I wrote the following field notes:

> At the meeting today three different Karen people separately told me that these rules won't work. They said that the Thai soldiers who work in the camps make too much money from selling alcohol and so they will continue to do it, regardless of the rules. They said that making it illegal will only push it underground. One person, though, agreed that in Noe Pu camp they have started to decrease alcohol problems with these rules. (TH)

A participant in an interview agreed, saying:

> When in camp to keep a stable community they have made a rule that alcohol is forbidden. Camp authorities learn that crises in the camp are caused by alcohol so to solve this issue they have forbidden alcohol. However, because in Thailand it is legal to have alcohol, so can't actually totally outlaw it, but essentially, the camp people have decided to outlaw or make alcohol illegal. (TH)

The comparatively strict laws and regulations that govern alcohol use in the United States appeared to be a deterrent to drinking over the limit. Participants said that because laws were stricter in the United States there was more to lose when drinking. One participant said:

> In refugee camp there's a rule . . . there is a rule to follow, but . . . over here it's like the rules are more tight. Tighter. And then they scared of, they afraid . . . OK, in America if you drink it the way you drink in Thailand you become homeless . . . it's easier to lose. (MN)

Another participant explained that alcohol use in the United States was less than in the camps "because of the rules that they have to follow. If they drink they cannot drive and things like that but in the camp there's, you know, you don't have to follow anything." (MN) Another participant said:

> [In] this country they have the law and the credit so they afraid that they will, that the credit will, how do you say, their credit will bad. So if they have bad credit so they cannot find job and if he don't have job and then he cannot work for his family. He has kids and wife . . . so some people they don't drink. (MN)

Participants agreed that there was "more to lose" (MN) in the United States. The possibility of losing a job, housing or ruining credit acted as a motivator to prevent drinking. One participant said, "Because of the consequences, because of that they are able to control themselves." (MN)

Theme 4: Addiction is a Consequence of Drinking Too Much

Some participants cited addiction as a consequence of drinking too much alcohol. Participants said that addiction happened slowly, after someone drank frequently over a period of time. One participant explained, "At first they drink for fun. But later, like they, if they don't drink they cannot live. That's the only thing. Addict. Addicted." (MN) Another participant in Thailand explained:

> They kind of become addict, like that, become addict for their using. Like in the beginning only start from a small problem and then they try to solve the problem and then find a solution with drinking. After drinking they thought the feeling or the problem will be gone. But later the problem not

gone so and then they feel bad and bad and continue to use and use and then become addict and cannot stop. (TH)

People who were addicted to alcohol were described as "shaking" (MN, TH), or people who "can't live without it" (MN), or will be "sick with diarrhea" (MN) if they do not drink. Addiction seemed to be a term used when a person needed alcohol to physically function. A participant in Minnesota explained "For someone who is addicted to drug, to alcohol, they will be shaking and if they don't get to drink they will get sick . . . They know that it's bad, but they will keep on doing it." (MN) Here there is an element tying addiction to an internal way of being, rather than just physical signs.

Category III: Beliefs about Alcohol and Alcohol Use

Participants described several different beliefs or ways of thinking about alcohol and about alcohol use that provided a context for drinking. This category describes the ways in which people talked about alcohol and alcohol use that were different from reasons or consequences of alcohol, but related to more general thinking about the context of alcohol use. These beliefs are described in the following themes: alcohol is good but people choose to use it wrongly, alcohol use changed after displacement because the culture was broken, people learn how to drink from others, and there is a culturally appropriate limit to alcohol use.

Theme 1: Alcohol is Good But People Choose to Use it Wrongly

Regardless of the types of reasons or consequences for over-the-limit alcohol use, most participants agreed that alcohol was considered good, healthy, and natural in the Karen community and that people who drank too much were using alcohol in the wrong

way. One participant said that people who drank alcohol didn't believe it was a problem because " . . .they [make alcohol] with sticky rice that's why they believe that no problem for them . . . No problem because the nature or something like this." (TH) One participant in Minnesota said, "I think alcohol is good, but people are bad." (MN) Another participant in the same focus group agreed with him, saying, "Alcohol is not the problem. The people are the problem." (MN)

Often participants responded to the question, "Why do people drink alcohol?" by starting, "OK, there are many reasons. It depends on the person . . ." (MN) This phrase, "it depends on the person" (MN, TH) was used in both locations to indicate that motivation or intent in consuming alcohol was dependent upon the personality or personal experience of the individual. One participant said that past experience determined how a person chose to use alcohol. She said, "It [excessive alcohol use] really depends on what they had to go through in the past." (MN) Another participant said "It really depends on the person how they use it . . . It's like if it, if they use it as a medicine it will benefit for them." (MN) Another participant explained, "[Reasons for alcohol use] depend on that person that drink [only] he can say why . . . because nobody force you to buy." (MN) Participants in Thailand agreed that alcohol use was motivated by personality or personal experience. One participant said, "The way they use depends on each person. Each person uses according to their attitude. The reason that some people can drink and not have problems and some people drink same amount and do have problems depends on their personality." (TH) Another participant agreed, indicating that drinking behavior was innate: "Maybe . . . [he] was born with this kind of behavior." (TH)

This dependence on personality or personal experience was encapsulated in the following story that was related to me by several participants in both Thailand and Minnesota:

> [How you drink] depend[s] on the first time you start [to] drink. If that person . . . drink[s] too much the first time [and] end[s] with fighting . . ., then next time he will fight with the people. He will find the people to fight with. And then some people they drink too much and ending with, the first time ending with crying. So next time they will cry all the time . . . And then some people . . . they drink and then when they drunk they just go to bed and sleep nicely and [those] people will be that all the time. (MN)

People explained that the behavior one exhibited the first time one was drunk determined the kind of drinker he or she would be going forward. There was an implied sense of pre-determinism in the story. After discussing this story with my cultural liaison I wrote in my field notes:

> [Name withheld] agrees that the story of the first time you drink is a common story. He said it means how you drink is already determined. You are either a crying drinker or a fighting drinker or a sleeping drinker or a laughing drinker. You are that way because of who you are and you find that out the first time you drink. (FN)

Theme 2: Alcohol Use Changed After Displacement Because Our Culture Was Broken

Many participants in both locations discussed the ways in which Karen culture has changed or been disrupted since conflict and flight into Thailand and

again since resettlement. Prior to flight into Thailand, alcohol use happened primarily within a cultural context that included limits, rules, and boundaries for use. While problematic alcohol use happened and people drank over the limit it was clear that alcohol use and the attendant problems increased after displacement into the refugee camps in Thailand. It was also clear that culture was again disrupted after resettlement.

Almost all participants in both Minnesota and Thailand agreed that alcohol use and the negative consequences of alcohol use increased exponentially in the refugee camps. One participant said, "In Burma even though people drink, there's not much fighting going on, but in the camp there's so much fighting, so much problem, plus even little kids know how to drink, how to use alcohol or tobacco." (MN) A man in Thailand said:

> Life changes, everything changes when people leave Karen State. It changes a lot, there are many different kinds of people, they are exposed to a different kind of environment and they copy for that. There is no work, they are not busy like they were at home, they don't have to struggle for anything. So they use alcohol to reduce the stress and the boredom and lack of opportunity or future. The youth use it together in groups and it is hard to control. The community is so big that it is hard to control the community, it is hard for the community to be strong together because of so much change and different people all together. So they use too much. (TH)

Participants said that after displacement communities and families were separated. Different ethnic groups lived close together and the cultural structures that used to exist

to protect from problematic alcohol use were no longer there. In my field notes after a conversation with Karen health workers I wrote:

> In Thailand, though, there is less social structure. People can't find jobs, they are hopeless, they have no money, no land, no resources, things are harder, they are more separate from a cohesive community—often people come from all over and live near each other, but it isn't a community. There is more anger, gambling and beating when people are drinking too much. (FN)

This cultural disruption happened after resettlement, as well. Several people in focus groups in Minnesota explained that after resettling in the United States, Karen people were even more separated and did not live as closely together as they did in the camps. One person said, "Personally, I don't see much Karen people, so I see less amount of using alcohol." (MN) Another participant agreed, saying, "I don't know [about alcohol use in the US] because we don't visit each other, we live in individual family." (MN)

Theme 3: People Learn How to Drink From Others

When speaking about the various way in which people use alcohol, most participants used the language of "learning" to drink or "knowing how" to drink from someone else, either a friend or a parent or the older generation. Participants spoke of learning to drink when talking about both appropriate or culturally condoned alcohol use and inappropriate alcohol use. There were two main ways that people spoke of learning to drink. First, people learned to drink from their elders. One participant said:

> It is generation. For people who are addicted to drink, it's generation because they get to see it, if the parents are drinking, they get to see it then they get to touch it

they get to try it. But in the family if there's no people that drinking they only get to hear, so it's harder to get, you know, close to it. (MN)

Second, people learned to drink during cultural celebrations or ceremonies. One participant reported, "Sometimes they learn it from celebration, they will drink, they will learn how to drink like there, you know, time after time, they will, time after time they get addicted to it." (MN) A participant in Thailand explained, "People also use alcohol for special occasions like weddings and New Year. In many places alcohol is widely used, but it never causes problem. This is because people learn to use it in good ways like this." (TH)

People also learned how to drink from their friends. This was mentioned in both Thailand and Minnesota. A man in a focus group in Minnesota reported, "Sometimes when they visit a friend, like they visit a friend, who know how to drink and when they visit there and came to their house and drink and he cause problems, too." (MN) A participant from Thailand explained that close proximity led to seeing alcohol use all around. He said:

In the camp, people live really, really close so because of what they see so they will try, first time try as a little bit then they get used to it and then get into fights. The kids are learning from the parents because the parents use it as a cultural thing, you know as celebration thing and the kids learn it from them then. (TH)

Participants explained that an individual's personality or personal experience influenced his or her reasons for consuming alcohol. These reasons were generally either appropriate or inappropriate and led to both inappropriate and appropriate consequences. All participants agreed that there was a non-numerical limit over which consumption of

alcohol became problematic. Drinking alcohol, whether appropriately or inappropriately, was a behavior learned from older generations, participation in cultural events or ceremonies or from friends.

Theme 4: There is a Culturally Appropriate Limit to Alcohol Use

It was generally agreed among participants in both Thailand and Minnesota that there was a limit of alcohol that was appropriate to consume. While only one participant put a number to this limit ("one or two glasses" [MN]), almost every participant acknowledged that inappropriate reasons for using alcohol always led to drinking "over the limit." (MN, TH) It was clear that there was a limit over which alcohol use was problematic. One participant explained it this way in the following exchange:

> [Jennifer]: So what is the limit, where is the limit?
>
> [Participant]: No matter how much you drink, but if you know how to drink and if you, if you don't create a problem, that's [OK], but for people, doesn't matter how much you drink, but if you create a problem . . . (MN)

Another participant explained that culture is part of determining the limit. He said "But in the past is like kind of they have very limited and they have a like kind of the rule, how to use in the culture, ceremony." (TH) Another participant explained "They drink alcohol and then but for the culture they have to drink like just for the limit not too much but some people they drink more than their culture." (MN) While one participant acknowledged that some people might drink over the limit and then go to sleep or not bother other people, most participants agreed that drinking over the limit always led to inappropriate consequences including drunkenness, fighting, and violence.

Almost every participant described problematic behavior and consequences as a result of drinking alcohol over the limit. It was acknowledged that some people drank alcohol for appropriate reasons and had appropriate consequences like falling asleep or just getting drunk and not causing any problems. However, most participants agreed that while appropriate consequences always had appropriate causes, inappropriate consequences were the result of both appropriate and inappropriate causes. One participant explained it this way:

> For people who like to drink, some of them they know how to cope with the alcohol, they know how to make it, they used to it since they were young, it became as a culture, they drink, but they drink how they supposed to drink and they still work they still do what they have to do. But for people who stressed, they drink and they don't know how to control themselves, then because of their stress they drink and they will . . . it's like things that they keep, because of the stress that they keep it inside and when it come out they do such things that you know, to kill the stress and that thing becomes problems for the family. (MN)

Theme 5: Some Alcohol Use is an Abuse of Culture

While traditional, cultural, and health reasons for alcohol use were considered appropriate, there was widespread agreement among most participants that a person could also use over the limit or inappropriately even when using for what appeared to be appropriate reasons. One participant in Thailand called this an "abuse [of] culture" (TH), meaning that people were abusing Karen culture by using these opportunities to drink over the limit, rather than drinking according to cultural norms. This abuse of culture was relatively new and had developed since displacement. One participant explained:

> The first reason that people drink alcohol is for fun, to socialize and to celebrate. But in the background it is because of depression and no job, no work, the lack of freedom that people have in the migrant communities and in the camps. (TH)

Another participant stated:

> Like for example . . . when you kind of make some kind of ceremony just use two bottle that they call a male and a female. Then they just share [with] everybody or sometimes if [there is alcohol left after the ceremony] they just pour on the side of the tree or something like this. This is finished. But some people just take advantage. So they have a chance to drink so they make more. Instead of two bottle they make a lot. That kind of thing. (TH)

Yet another participant explained that even if people were using for inappropriate reasons in the background, underneath there were the same problems and difficulties that caused drinking in other people. He said:

> After they are working so hard all day long in the fields and they are very tired at the end of the day, they want to relax so they drink to feel better, to be less tired and then they forget they were tired. They sleep very well but it is the same background, the same problems as the [other people who drink too much], even though they drink for different reasons, they have the same feelings and problems underneath of sadness and stress and hopelessness, being away from their family, no future. (TH)

Theme 6: Alcohol Use is a Serious Problem in the Karen Community

Participants rarely overtly estimated the magnitude of the seriousness or scope of alcohol use in either refugee camps or in Minnesota. Instead, almost every participant

alluded to the perception that alcohol use was widespread in the Karen community. Many participants said that they saw alcohol use or the consequences of alcohol use "every day." (MN, TH) A few participants in two focus groups in Minnesota estimated that two-thirds of the population of the camps they had lived in used alcohol over the limit. Another participant in Thailand said that the problems related to alcohol affected "the whole community, everyone," not just the people who drank.

Category IV: Ways of Stopping Alcohol Use

Participants in both Minnesota and Thailand reported a variety of ways in which both communities and individuals addressed stopping using alcohol. The following themes emerged in this category: stopping drinking is a personal choice, women are hopeless that men will ever stop drinking, people stop drinking because they start thinking about other people, and the community is responsible to help people stop drinking.

Theme 1: It is a Personal Choice to Stop Drinking

It was generally agreed among participants that stopping problematic use of alcohol (drinking over the limit or engaging in problematic behavior after drinking) was a personal, individual choice. Participants believed that families and communities had a limited ability to influence that choice. However, one of the most frequently cited methods for addressing problematic alcohol use was talking to the individual or individual's family about the behavior. Additionally, it was stated that most people who did successfully choose to stop drinking did so because they developed significant health concerns or because they recognized the impact their behavior had on their families and communities.

Problematic alcohol use was often perceived as a personal choice by participants in both Thailand and Minnesota. People were said to "choose" to drink over the limit even when they knew the consequences. An important aspect of this choosing was that others did not have an influence on this personal choice. There appeared to be a sense of futility or hopelessness when talking about choosing to drink alcohol. One participant said, "For people who are really addicted to alcohol it is because they don't, that's really a choice. Nobody can do anything about that. They choose to do it." (MN) Another woman said "It really depends on that person who is addicted to alcohol. That's really their choice and nobody, I cannot . . . no one on this earth, anybody, can help." (MN) Participants in Thailand used similar words: "People . . . depend on . . . their self to change. Nobody can change their life." (TH) Another man agreed, saying,

> They have to change their life. Some people they just only hear about the information so they change their life. They know that, 'Oh, yeah, this alcohol has made problem for our community,' so they just change. But some people are, they know very well about this but they do it [anyway]. We cannot change their life, they have to change their life and they have to, their self. (TH)

Participants talked about stopping using alcohol as a personal choice that no one else can influence. A participant explained, "For some people they only drink a little bit and they trying to, they trying to see the consequences and for some people they don't think of anything, they just drink. That's really their choice." (MN) Participants in Thailand who were in recovery concurred with the idea that stopping alcohol use was a personal choice. One said about stopping, "It was my own strong decision." (TH)

Theme 2: People Stop Drinking Because of Health Concerns

Regardless of the feelings of hopelessness or being unable to influence personal choices to quit drinking, participants in both locations had a variety of suggestions about how to help people stop problematic alcohol use. Particularly important comments came from participants in Thailand who were in recovery from alcohol abuse and talked about what influenced their decisions to stop. Almost all participants indicated that there are two main reasons a person chooses to stop using alcohol. First, a person stopped because he or she was faced with significant, often life-threatening, health concerns. Second, a person stopped because he or she realized the impact alcohol use had on their family and community.

Health concerns such as liver damage, heart disease, cancer, and diabetes—especially if they were life-threatening—were one of the most frequently given reasons for stopping using alcohol both in Thailand and Minnesota. One participant said,

> In my life I have only seen one person . . . who quit drinking. Why do he quit? Because the doctor [told] him that if you don't stop drinking you will die. And . . . he quit and stopped because of the disease. (MN)

A participant in Thailand who was in recovery from alcohol explained his reasons for stopping drinking this way:

> Because like I also learn . . . about the alcohol, how [it] hurts . . . the human, their body or their . . . like kind of the consequence from the addiction. [When I] drink I vomit and then like gastro pain or something so if I continue to use it's not good so that's why I decide [to quit]. (TH)

Theme 3: People Stop Drinking When They Start Thinking About Other People

Thinking about the effects of alcohol use on family and community was frequently cited as a reason for quitting drinking alcohol. As described above, people who drank alcohol over the limit were perceived as thinking only about themselves and not thinking about their family or their community. Therefore, beginning to think about family and others was seen as an essential and foundational part of quitting drinking. One participant said "It can also be because he think of his family, even if I keep on drinking I'm not going to, you know, live, you know, long enough to take care of my family." (MN) A participant in Thailand explained it this way:

> [People who drink too much] have no sympathy or empathy to other people. Some people believe that one day everybody will die even [if they] drink or not drink. So this means they have no future hope, no future life. [And] those people who stop [drinking] . . ., maybe one day their mind or their decision change and they understand about their family and then they have a kind of empathy to other people. And then so . . . they will think for their children's future. So how my children will live for the future. So . . . OK, so I should stop for my children. So some people will have a strong decision. OK, I will stop. (TH)

Theme 4: Education Will Help People To Stop Drinking

Ideas about how to address alcohol use differed slightly by location. Most participants in Minnesota suggested education as the most effective way to reduce problematic alcohol use. Participants suggested that providing educational classes or meetings for the Karen community that address issues like drinking and driving, illnesses

and diseases caused by alcohol consumption and the effects of alcohol use on family problems may help people to choose to stop drinking.

Several women suggested increased fines or even jail sentences for problematic alcohol users. In fact, one woman disagreed with another participant who suggested educational approaches to dealing with alcohol use by saying, "it is impossible to give a lesson, things like that. I only believe that the government or the police can help." (MN)

Participants in Minnesota said that mainstream, Western models of alcohol treatment were often ineffective with Karen people because of a failure to consider cultural and political contexts. One participant said:

> I think it would be helpful if we have treatment [specifically designed] for the Karen, like way that they can understand, the way, if they go to get treatment with everybody else, they don't understand, that's why. It will be helpful if you educate, if you make home visit and try to educate them, talk to them personally, like in person. I believe it will help. (MN)

In Thailand participants suggested education as an effective method for helping people to stop drinking but also spoke about a community-level response to alcohol use that doesn't appear in the Minnesota data.

Theme 5: The Community Is Responsible To Help People Stop Drinking

Participants in interviews and focus groups in Thailand described a complex community-level response to problematic alcohol use that didn't appear in the Minnesota data. The refugee camps along the Thai-Burma border are organized and run by committees of predominantly Karen refugees, as well as other ethnic groups. People in the camps live in extremely close proximity to one

another. Because of these close quarters problematic alcohol use has a significant effect on neighbors and immediate geographic communities. Camp leaders have developed a variety of ways to address problematic alcohol use including detaining heavy users in jail and fining people who make or sell alcohol. In addition to formal alcohol-related legislation, participants described an informal system for addressing problematic alcohol use in which leaders spoke with the family members of drinkers. Finally, participants in Thailand spoke frequently about the importance of having strong community support for people who are trying to stop drinking.

In addition to camp rules, participants described informal conversation as the primary means of addressing problematic alcohol use. When someone was identified as having problems with alcohol a community leader or non-family member spoke with either the person who was drinking or with the family of the drinker. The content of this conversation seemed to focus on describing the negative consequences for family and community of problematic alcohol use. One participant described the content of these conversations this way:

> So we speak to them so 'you should take care of your children. If you drink too much it's not good for your life and also not good for your health' or something like that. And then 'if you going to buy the alcohol to drink I think [it is] better if you buy the milk or egg or something. If you cook and eat with your children and family it will be more healthy and more strong.' (TH)

Participants also said that speaking directly to the drinker was rare. Instead, this conversation was directed at the family of the drinker because "someone from outside have more authority than their family member." (TH) One participant said, "They talk not directly to the, not directly to the addict. Sometimes they talk through the family. Kind of. And then the family talk to their, like their family." (TH) Another participant said:

> You have to tell people to change in a secret way. You have to give them unconscious social teaching. You have to tell them, oh, in our culture it used to be like this, but don't tell them directly that they need to change or else they won't listen. (TH)

After speaking with a woman in Thailand whose Karen husband had quit his problematic alcohol consumption because of this type of talking I wrote the following field notes:

> [Name withheld] told me today about her husband. She said that he used to drink a lot and was known around town as being an alcoholic and causing a lot of problems. She said that after a while one or two people starting "talking in his ear," saying that he was losing respect and reminding him of what he could have if he didn't drink. It was these conversations that she thinks contributed the most to his quitting drinking. (TH)

Community support seemed to be one of the more significant factors in helping people to stop drinking, according to participants. One participant said:

> Many people relapse because of community neglect. The community doesn't support them after they stop. They go back into the community and it is the same—no job, no money, no hope, same friends drinking, and so they relapse. The people who don't relapse have a job and a role in the community and the community respect them. Some people decide to stop because they see the way other people have stopped and the community supported them. They see that their life is better, so they want to stop too. (TH)

The close proximity of people in the camp seemed to contribute to the idea that community support is necessary for people to stop drinking. Another participant said:

> But in the camps and in the migrant community everyone lives right next to each other, right on top of each other and they can't be apart. So the community doesn't support someone who wants to stop drinking, they can't get away from the environment. There is no way out. If they try to quit there is no way out, they have to go away, but then when they come back if it is all the same—no job, no respect, no role in the community, if the community doesn't support them they relapse. People cannot stop drinking alone, they need support. Many people don't know they have a problem, or they don't think they have a problem, they need support realizing they have a problem. If you are weak and you don't know yourself, then you don't realize you have a problem. You might quit for

family pressure, but this doesn't happen very often because it also has to be a personal choice. (TH)

This way of addressing alcohol use through informal conversation with the drinker's family seemed to be carried over from Burma. One participant said, "For example similar to the village, like maybe in the village if they have a problem with that mostly the head man take response and then talk with this family." (TH)

Perhaps because of the unique situation of the refugee camp with coordinated leadership and extremely close living quarters there appeared to be a loosely coordinated community response to problematic alcohol use. Camp leaders have implemented policies regulating or banning the production or selling of alcohol. Infractions result in jail time or fines. In addition to legislative responses community leaders often approached the family of a person who engaged in problematic alcohol use to discuss the use. This discussion often focused on emphasizing the negative consequences of problematic alcohol use for the family and community.

Category V: Women's Ways of Using Alcohol

In all of the themes described above the predominant assumption was that men did most of the drinking and engaged in the most problematic alcohol use. In fact, one participant said, "I don't really see women drinking [in the United States]. Most of them are men . . . When I was in the camp I see more women, but over here I don't see it. They stop." (MN)

It was universally agreed by participants in both Minnesota and Thailand that women rarely drink alcohol and when they did they rarely had the kinds of problems such as violence, fighting, or addiction that men had. In fact, women had unique reasons for using alcohol that differed from men's reasons. Therefore, women's ways of using and relating to alcohol became a category as specific themes related to women's alcohol use and women's relationships to alcohol emerged.

Theme 1: Women Do Not Use Alcohol as Much as Men

All participants, male and female, agreed that women did not use alcohol as much as men did and that they did not use as much alcohol as men did when they did drink, either in Minnesota or in the refugee camps. However, participants in Minnesota reported that there were more women in the camps who used alcohol than there were women who used alcohol in Minnesota. One participant explained that, "since I've been to America, I never see woman drinking." (MN) The same participant said that even in the camps the number of women who drank was "very few, very tiny." (MN) A man in Minnesota reported that when women did drink they often drank for cultural or religious reasons. He said, "I think, woman are probably maybe very few or, few percentage. For women they use it . . . Most women in Burma who use alcohol is as religion tradition, they use it." (MN) A male interviewee in Thailand told me, "Inside [Burma], a lot of women use. But they use in the cultural, traditional way. Even in the camps and in the migrant communities the women use, but they don't use as much as men do." (TH) Another female interviewee in Thailand agreed, saying, "I have seen women

also drink but I do not see a big problem as men. They are using . . . because of the cultural ceremony. Like the Thai wrist tying." (TH)

Many participants said that women did not drink as much as men did because they thought about their families and their children. This thinking about others helped to keep women from drinking. The following quotations describe this thinking:

> We have a second thought. We think for the future. We think of the future, we think of our children. (MN)
>
> There is, mothers are, between mothers and children the relationship are closer but father and children relationships is a little farther. That's the reason mothers can control themselves. (MN)
>
> Women have children, babies, so they don't drink as much . . . Women have to take care of the babies, but the men can go and be with their friends. Women can control themselves more than men can. Women can control themselves because they think about their future. They have to think about children and their families and their babies which helps them to control themselves. (TH)
>
> The mother thinks for her children, but the father does not think for his children. This is why women drink less than men, because they think for their family. Mother is close to the children so she is less likely to drink. (TH)

Theme 2: Women's Reasons for Using Alcohol

Women who did use alcohol over the limit or outside of cultural events had reasons for using that differed from men's reasons. Participants in Minnesota did not talk about women's reasons for drinking alcohol, but participants both male and female in Thailand agreed that there were two primary reasons that women drank alcohol over the limit: to feel equal to men and to have revenge on their husbands for drinking.

Women drink to feel equal to men. Most women and men in Thailand agreed that women often drank alcohol in order to feel equal to men. One woman in Thailand explained, "So like kind of the equality. Men can use, why cannot we use. They want to copy men." (TH) Another woman said, "Because they can't stop their husband from drinking . . ., so they cannot stop drinking. If you know how to drink than why not me, you know? Why not me? I also know how to drink . . . Like that and then later on they get addicted to drinking. Some women." (TH) Another participant explained:

> I saw many woman who are drinking, but it's not inside the camp, it's outside when they go for their daily work so and then they want to put [themselves] the same like men . . . That's why they start to use. (TH)

Several men in interviews alluded to women drinking to feel equal so that they could be sexually active with men. The following quotes are representative of these comments:

> But especially for women, why they are using . . . I don't want to blame my people, like I don't want to blame the female . . . so now it happen that

> the young women or young girl are sometimes kind of how to say that, relationship like kind of want to make the equality . . . Like equality with men and then also one close relationship with men and . . . they want to temptation to the men, like they want men to interest to them and then like when they if they not drink they are afraid or they are shy, they want this thing, but if they drink then they close. (TH)
>
> So, so, more kind of want to give a chance to the men. Like the same thing [another participant] said for . . . like kind of sex. That's why they start to use. (TH)

All of the participants who reported that women drank to feel equal to men so that they could be sexual with men were men themselves. Women were extremely reluctant to talk about this when I asked about it in interviews. I spoke with my interpreter in Thailand who is a woman, as well as another Karen woman who provided member checking and wrote the following in my field notes after that conversation:

> [Names withheld] both said that women definitely drink to feel equal to men and that some women do have sex outside of marriage when they are drunk, but they were reluctant to call that a "reason" for drinking. Instead they said that sexual violence and rape has increased exponentially in the camps and that they believe men use women's drinking as an excuse to take advantage of women. (FN)

It is clear that this is an area in which there may be disagreement between men and women and an area that warrants much further analysis and exploration

in a future study of women's beliefs, perceptions, and experiences of alcohol and alcohol use.

Women drink to get revenge on their husbands for drinking. The concept of "revenge" was present in many interviews in Thailand. After several interviews in which participants talked about women wanting revenge on their husbands I wrote the following in my field notes:

> So many people (men and women) have said that women drink in the camps because they want "revenge" on their husbands. [My interpreter] explained that men are drinking and drinking and so women start drinking, too, to get revenge on them. He said they are tired of asking for it to stop and so they just give up and start drinking. (FN)

Most of the male and female participants in Thailand agreed that revenge was the primary reason women used alcohol. One woman said:

> [One] reason is because wife trying to encourage or trying to talk to the husband about problem happen with alcohol like kind of don't drink, like kind of you have to stop or something, you have to change. But finally she cannot talk to him and then he not change and then the wife want to revenge . . . like kind of so you can drink I can drink. So you can do I can do. That's why the women start to drink. (TH)

Theme 3: Women's Consequences of Alcohol Use

Most participants agreed that women had two significant, unique consequences to their alcohol use: problems between mothers and children and risk of sexual violence.

When women drink their children suffer. Participants in Thailand agreed that the primary consequence to women drinking too much was that their children suffered. One participant said:

> The difference between men and women drinking in the camp is, um, we do have some women who drinking in the camp, but they drink, they don't fight, but they, like, they have, such a family problems, children lose their mom, they don't get attention of mothers, because of their drinking, we have that kind of problem and because family relationships are, it's not good as it used to be when mothers start drinking, but if men, they have more violent when they drink. (MN)

A participant in Thailand agreed, saying, "Children suffer more when the mother drinks than when the men drink because women take care of children, not men." (TH)

When women drink they are at risk for sexual violence. Only a few participants in Thailand mentioned that sexual violence was a risk for women who drink. These few participants' observations are represented by the following quotes:

> The other thing is something happen to the women after they drink so like the thing that should not happen, but happen. For example some young girl, like because of drinking they don't know anything what happen to them and they get . . . raped. (TH)

> There is violence, teen violence against girls. They see girls and they do sexual abuse because they can't control themselves. (TH)

Most women and men were reluctant to talk about this during interviews, however, I did speak with several Karen leaders who confirmed that rape and sexual violence have increased in the refugee camps. One man who is a leader of a section of a refugee camp

spoke with me about increased sexual violence and I wrote the following in my field notes:

> I talked to [name withheld] today and he said the same thing all the health workers said—rape is happening a lot in the camps, even though no one wants to talk about it or admit it. He said that rape doesn't happen very often in Burma but in the camps there seems to be so much more of it. He said it seems to be happening much more with younger people, but that it is too common and should be stopped. (FN)

Themes 4: Women Are Hopeless That Men Will Ever Stop Drinking

A sense of hopelessness about influencing choices to stop drinking was especially present in women's conversations about alcohol use. Women in the Minnesota groups expressed a particularly deep sense of hopelessness when talking about their spouses' ability to stop drinking. There seemed to be a pervasive belief among the women that nothing could be done about excessive alcohol use and that even though they had asked the men in their lives to stop using alcohol, the men had not listened to them and did not stop. One woman said, "I believe nothing can help them. People who drink, no matter how, no matter what, they will keep on drinking." (MN) Another woman said, "My tears are dry. My heart is broken. But he will never stop drinking." (MN)

Category VI: Youths' Ways of Using Alcohol

Like women, participants identified unique reasons and consequences of alcohol use for youth. Most participants reported that youth drank alcohol because they want to fight, because they want to experiment with it, and because they had broken hearts. A second theme emerged when older people spoke about youth

losing their culture and drinking outside of cultural reasons. Frequently participants said that youth did not have the old ways of drinking and had been deeply influenced by growing up in the camps. In the United States, participants worried about their children's rapid acculturation and perceived rejection of Karen culture, leading to increased alcohol use.

It appeared from the data that alcohol use for youth happened in a significantly different context from men. Exploring this further is important and indicates the need for further focused inquiry in a separate study.

Theme 1: Youths' Reasons for Using Alcohol

Participants gave three primary reasons for youth's alcohol use that differed from men's and women's reasons: to fight, to experiment with it, and because of broken hearts. Each of these reasons is a sub-theme of youth's reasons for using alcohol. While these reasons were similar to reasons given for adult men's alcohol use, these three reasons were the only reasons given for youth's use of alcohol and seemed to be uniquely important to understanding youth's experience in refugee camps, with displacement and with alcohol.

Youth use alcohol to fight with each other. While most participants agreed that fighting was a consequence of using too much alcohol, when participants spoke about youth it seemed that wanting to fight was a reason for using alcohol among youth. The following quotes exemplify this:

> But for the youth there's no opportunity so by drinking as a group that, they like it, they have fun, they can start having problems like fighting and then they will be used to it. It's seen like, can't stop. (MN)

> Because after you drink you feel brave, active, like kind of aggressive. Like doing without any consideration. According to the youth I know that's why they use . . . After they use they feel like they are famous and they are brave and that they want to . . . fight within their friends . . . And also they are proud of themselves. They have been in the detention place for many times and so they thought when people see them, oh, this youth are, these people are often going to the detention place, they thought that people will be afraid to them or other people will kind of listen to them or because "oh, he is very kind of this or.." they proud of themselves to be that. (TH)

There was also an element of feeling proud and having an identity present in this text. Some participants said that youth used alcohol to feel brave to fight and that this fighting brought attention, power and identity to the youth. This was often coupled with talking about the ways in which youth were disenfranchised by living in refugee camps.

Youth use alcohol to experiment with it. Many participants agreed that youth often used alcohol because of "the teenager nature. They want to test, they want to try from what they saw from their friends." (TH) Participants in Minnesota agreed that youth often used alcohol to experiment. One participant said:

> Especially like the teenager, no, there are many people in the community and then at the beginning they just start to get experience and they just try.

> Later once they meet with many friends and they often using, using and then cannot stop. (MN)

Many participants in both Minnesota and Thailand said that one of the primary reasons youth used alcohol is to experiment. Similar to adult men, they saw their friends using or were encouraged by their friends to try alcohol which led to increasing use and occasionally addiction.

Youth use alcohol because of broken hearts. Some participants said that youth used alcohol when their hearts were broken. In refugee camps in Thailand these broken hearts were sometimes the result of a boyfriend or girlfriend resettling to a third country and leaving their partner behind. Two quotes exemplify this:

> And then the other reason is that teenager nature like falling in love something like maybe or for example he give that like he loved that other girl, maybe the other people love this girl too and then maybe it feel bad. (TH)

> And now after that the other reason is now like the mostly the teenagers, the youth. He saw that like after the resettlement happen, so they are like fall in love, like maybe their girlfriend go to third country, maybe their boyfriend go to third country . . . (TH)

After returning to Minnesota I spoke with my cultural liaison about this concept. His explanation is summarized in my field notes:

> [Name withheld] laughed when I told him that some people said youth drink because of broken hearts. He told me that Karen people are very

emotional when they are in love. He described the Karen custom of boys writing emotional love letters to their girlfriends before they get married. He said because of this Karen people take being in love very seriously and they are very sad when love is not returned or when they break up. (FN)

Like adult men who said that negative emotions were a significant reason for using alcohol, youth used alcohol to deal with negative emotions. For youth, though, a "broken heart" seemed to be an accepted reason for using alcohol.

Theme 2: Youth have lost their culture

Adult participants in both Minnesota and Thailand talked about the ways in which they believed youth had lost their culture or turned their backs on traditional Karen culture and how this led to drinking. In Minnesota, in particular, adults talked about their fear that youth's acculturation would lead to increased drinking. In Thailand participants said the following:

> With the youth, they are, they use it, it's not because of the culture. They use it overly, they just want it, too. (TH)
>
> And then now the new generation like mean the new teenager, eleven, up to the eleven year age old now they start to engage with using drugs and alcohol and they are not listen to their parents or they are not respect to their environment and also like they are not interest to learn or study in the school. (TH)
>
> They commit crimes and steal things, as well. They hang out in gangs with friends. Young people use alcohol not in a good way. They have lost the good way. (TH)

In Minnesota participants said the following:

> There's a lot of problem with the children after 18 years old, "don't tell me, I am 18 years old I am and adult now." They are American, they get to go to school so they won't listen to us. (MN)

> Over here youth and children have so much right, people, like the parent don't have right to tell them, they cannot tell them, they cannot control, so they get spoiled and they take so much advantage of it. (MN)

Summary

The findings above describe a variety of interrelated factors that contribute to substance use in Karen refugee communities, as well as the range of consequences of alcohol use. Participants described important contextualizing beliefs about alcohol use and spoke at length about how to stop alcohol use. Women and youth's unique perspectives and experiences were highlighted. In the next chapter I will further explore these findings and relate them back to the literature and theoretical frameworks that contextualized this study. I will also point out new information and knowledge that contributes to the gaps in the literature about refugee substance use after conflict-related displacement. Finally, I will address implications of this study for social work policy and practice.

Chapter 5: Discussion

Chapter Overview

In this chapter I will critically discuss the findings described in Chapter 4 from the perspective of the theoretical frameworks and models outlined in Chapter 2, pointing out where the findings are consistent with or diverge from existing literature as well as where the findings add to and address gaps in knowledge about the perceptions and experiences of alcohol use in communities displaced by political conflict. As noted previously, the findings from each location (Minnesota and Thailand) were highly interrelated and I will describe them together, noting where themes differ by location. Rather than discussing the findings in the same order as they were presented in the results section, namely by emerging categories and themes, I will discuss the findings of the study in relation to the originally proposed research questions that were developed to guide the study. These research questions are:

1. How do Karen refugees in multiple sites of displacement perceive and experience alcohol use?
    a. How do Karen refugees perceive and experience the *reasons* for alcohol use in their communities?
    b. How do Karen refugees perceive and experience the *consequences* of alcohol use in their communities?
    c. What individual, family, and community level factors including cultural, political, geographical, situational, historical, and familial contribute to alcohol use?

d. What do Karen refugees see as the relational impact of alcohol use at individual, family, and community levels?
e. What do Karen refugees believe would be effective in stopping problematic alcohol use?
f. What are the similarities, differences, and changes between locations of refuge (refugee camps) and resettlement (United States)?

Each of these sub-questions represents areas of further investigation and follow-up to the over-arching grand tour research question. In this chapter I will address how research findings inform each of these sub-questions in turn. It is important to note that these questions were used as a general template and guide for the multiple individual and focus group interviews I conducted. The questions were not intended to be asked in a structured way across all participants. Therefore, the discussion that follows is an attempt to integrate key elements from the information that was gathered and observed into a coherent narrative within each of these areas. Some questions and topics yielded thicker description and emerging themes than others and this discussion is not meant to provide a weighted synthesis of findings, which was already done in Chapter 4, but instead an overall understanding of how Karen refugees in both Minnesota and Thailand experience and perceive alcohol use after conflict-related displacement and the relative position of these findings within the extant literature. As might be expected, for several questions there is a closely related category comprised of emerging thematic findings while others draw from themes across multiple categories. I will conclude this chapter with a discussion of the ways in which these sub-questions contribute to an overall

understanding of the perceptions and experiences of alcohol use in Karen communities that have been displaced by political conflict.

Sub-questions (a) and (b): How Do Karen Refugees Perceive and Experience the Reasons for and Consequences of Alcohol Use?

I have chosen to respond to the first two sub-questions together because the findings from this study indicated a relationship between the reasons for and consequences of alcohol use in Karen refugee communities. In developing a response to this research question I drew from the themes and sub-themes in Category I: Reasons for Alcohol Use and Category II: Consequences of Alcohol Use.

There are three important findings that emerge in response to this research question. First, reasons for and consequences of alcohol use are related and a model of patterns of alcohol use was described by participants that seems consistent in some ways with extant literature about substance use in refugee communities (D'Amico, Schell, Marshall, & Hambarsoomians, 2007; D'Avanzo, Frye, & Froman, 1994; Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; O'Hare, & Van Tran, 1998; Westermeyer, Lyfoung, & Neider, 1989; Westermeyer, 1993; Yee, & Nguyen, 1987). Second, the model of reasons for and consequences of alcohol use described in this study adds to and expands current knowledge regarding reasons for alcohol use in refugee communities by moving beyond first-hand trauma experiences as the single or primary motivating reason for alcohol use to describe a constellation of reasons that are influenced by both culture and traumatic experiences related to displacement. This model considers *both* culture and displacement, which addresses critiques of the acculturation model of alcohol use and the self-medication and trauma models of alcohol use currently applied to refugee and other

ethnic minority communities (Cook, Mulia, & Karriker-Jaffe, 2012; Walters, Simioni, & Evans-Campbell, 2002). Third, participants in this study said that the single most concerning consequence of alcohol use in their communities was fighting and violence. This is consistent with literature that describes a complex relationship between alcohol use and violence (Boles & Miotto, 2003). This finding also contributes new insights to existing literature because it describes specific political and cultural factors that contextualize the relationship between alcohol and violence in Karen refugee communities that have not been previously explored in the literature.

An Emerging Model of Patterns of Alcohol Use in Karen Refugee Communities

In the Karen community, as reported by participants in this study, the use of alcohol when consumed for appropriate reasons with appropriate intentions almost always led to appropriate behaviors, even when drunkenness was involved. People who used alcohol for health or to relax with friends after work did not cause problems, even when drunk. However, inappropriate reasons for using alcohol almost always led to inappropriate consequences including fighting and family violence. Additionally, and most importantly for this study, appropriate reasons for drinking alcohol were based on traditional cultural beliefs, values, and norms about drinking alcohol, while inappropriate reasons for drinking alcohol were almost all based on elements of being displaced due to political conflict. Reasons for using such as to deal with the emotions resulting from exposure to traumatic experiences, because of isolation and hopelessness in refugee camps and because of the stress of resettlement can all be mapped to elements of the displacement experience, from pre-flight experiences, to flight, to living in refugee camps and to resettlement.

The findings described in the previous chapter contributed to the development of a model of the relationship between reasons for and consequences of alcohol use in Karen refugee communities. Figure 1 below is a pictorial representation of these multiple pathways of alcohol use. Moving through the figure from left to right, an individual's personality or personal experiences influenced his or her reasons for using alcohol. These reasons were either appropriate or inappropriate reasons for using alcohol. Alcohol use may or may not have been over the limit, but when it was, there were consequences which were either appropriate or inappropriate. Most often, when alcohol was used for appropriate reasons with appropriate intention, such as for health or in cultural ceremonies, the consequences were also appropriate. However, when alcohol was used for inappropriate reasons, or when appropriate reasons were an excuse or a cover for over-the-limit drinking, inappropriate consequences occurred, such as fighting and domestic violence. The concept of drinking over the limit was almost always applied to problematic alcohol use or problematic behavior related to alcohol use and not used when speaking about appropriate reasons with appropriate outcomes. While participants acknowledged that people did get drunk when they used alcohol for medicine or for cultural ceremonies, if the reason and resulting behavior were appropriate this was not considered "over the limit drinking," even when drunkenness resulted.

This model of the relationship between causes and consequences of alcohol use in Karen communities after displacement and in resettlement communities provides a way of understanding the multiple factors that contribute to alcohol use and the ways in which people understand resulting behavior. It also provides an overview of the ways in which people move from personal experience to reasons for drinking to over the limit

consumption to problematic behavior. To date there are no functional models of patterns of alcohol use in communities displaced by political conflict (Ezard, 2011; Weaver & Roberts, 2010). Instead, models of substance use such as disease models, social learning models or self-medication of trauma symptoms models are applied to refugee communities (D'Amico, Schell, Marshall, & Hambarsoomians, 2007; D'Avanzo, Frye, & Froman, 1994; Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005; O'Hare, & Van Tran, 1998; Westermeyer, Lyfoung, & Neider, 1989; Westermeyer, 1993; Yee, & Nguyen, 1987). These models often prioritize first-hand experience of trauma as the motivating reason for alcohol consumption and fail to consider either the range of traumas experienced throughout displacement or the cultural and political contexts that influence alcohol consumption and may obscure important information about how Karen refugees conceptualize and experience alcohol use.

This model of alcohol consumption in Karen communities is a work in progress. It provides a platform for understanding the contexts of alcohol use in one particular ethnic group. It may also provide a springboard for exploring alcohol use in other ethnic communities that have been displaced by political conflict. This model is different from other models of alcohol use applied to displaced ethnic minority groups for two reasons. First, it identifies a range of cultural, political, social, and displacement-related reasons for alcohol use. Other models often contain a limited number of reasons for alcohol use and don't always identify the cultural, social and political factors behind these reasons. Second, this model describes a relationship between reasons for using and consequences of using alcohol that is rarely seen in other models. Participants in this study identified a strong link between reasons for drinking and consequences of drinking that helps to

shape understandings of what constitutes appropriate and inappropriate or problematic alcohol use. This may model provide useful insight for the future development of measures of alcohol use and abuse that are culturally relevant to displaced communities.

Future research that explores the experiences of alcohol in other ethnic groups will help to test the model and could help to determine which parts of this model might have more generalizability or universality in terms of experiences related to displacement and which might be culturally and contextually bound. Further development of this model may be useful in the creation and testing of culturally and politically relevant substance use treatment modalities for refugees.

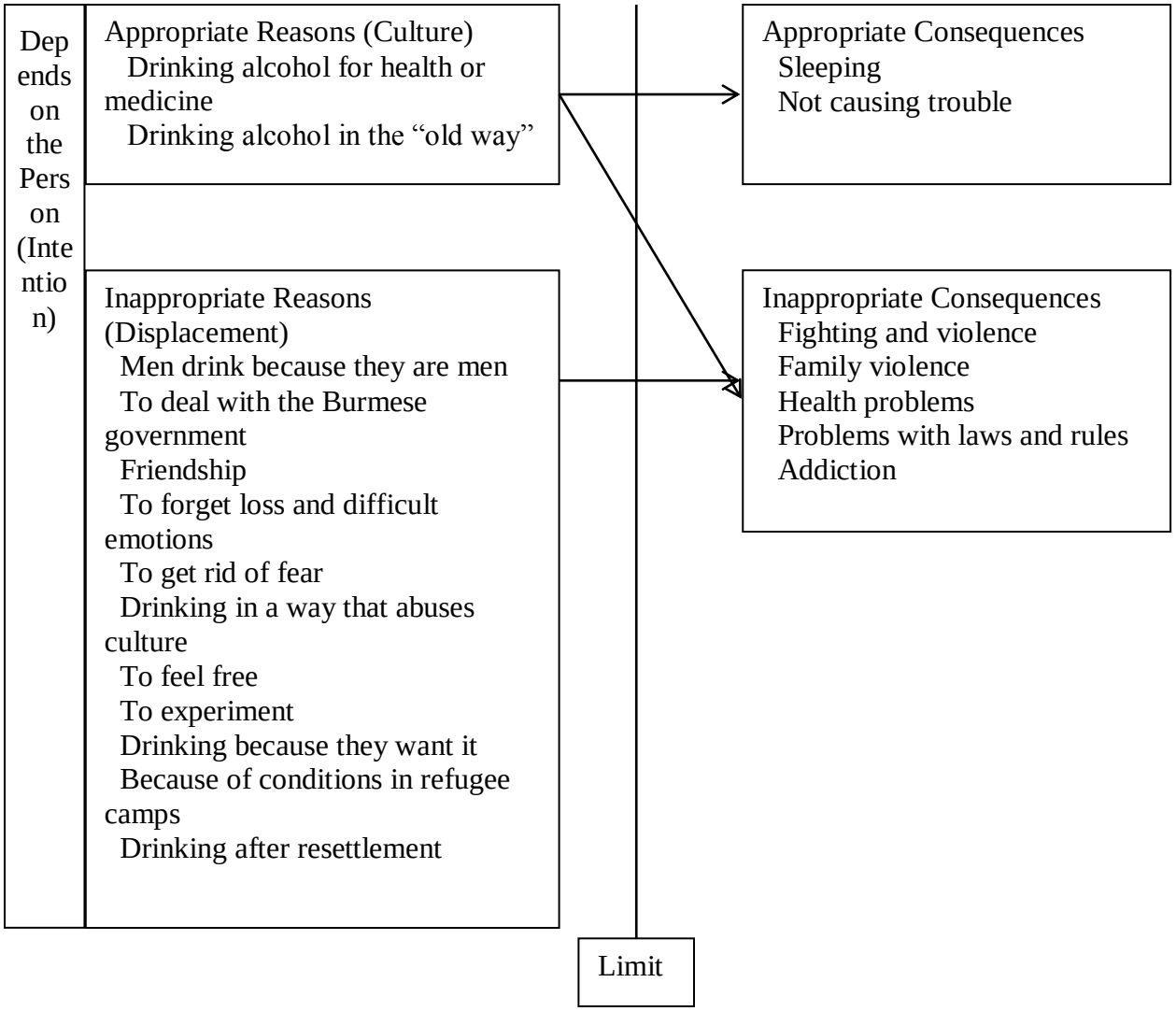

Figure 1. Multiple Pathways of Alcohol Use

For Karen Refugees

An Ecosystemic Understanding of the Reasons for Alcohol Use

Previous research on alcohol use in Southeast Asian and other immigrant and ethnic minority communities in the United States has often taken an ecosystemic approach to understanding the microsystem and macrosystem factors that influence alcohol use (Hong, Lee, Grogan-Kaylor, & Huang, 2011). Consistent with that research, the reasons for using alcohol identified by participants in this study can be categorized into intrapersonal, interpersonal, and contextual reasons for alcohol use. Intrapersonal reasons such as drinking to forget loss and difficult emotions were identified as reasons that involved one individual's personal feelings or internal emotions. Interpersonal reasons included reasons such as drinking to deal with the Burmese government and drinking because of friendship. These reasons were identified as reasons that involve relationships between two or more individuals. Contextual reasons for drinking, such as reasons specific to geographic locations of displacement were identified as involving reasons specific to geographic location. Categorizing reasons for alcohol use in this way allows for an ecosystemic evaluation of the ways in which micro, meso, macro and exosystems influence alcohol use.

By using an ecosystemic interpretation of reasons for alcohol use I am positing that an individual's reasons for using alcohol can have multiple layers and influencing factors. Additionally, I am arguing that there are multiple spheres of influence on reasons for drinking alcohol including internal feelings or emotions, immediate environmental factors, and relational factors. True to Bronfenbrenner's conceptualization, a Karen individual's relationships with and within multiple systems including microsystems, mesosystems, macrosystems and exosystems influence reasons for using alcohol.

Findings from this study are consistent with extant literature that explores motivations for alcohol use and abuse through an ecosystemic lens, particularly among ethnic minority communities in the United States (Aguirre & Watts, 2010; Marsiglia, Miles, Dustman, & Sills, 2002). In the next section I will further explore each of these systems of reasons for alcohol use and the ways in which Karen refugees experience these reasons for using alcohol.

Intrapersonal Reasons for Using Alcohol

Intrapersonal reasons for using alcohol can be described as reasons that originate within the individual's mind or self. For study participants these reasons included drinking to forget loss or difficult emotions, drinking because one was following one's heart, drinking in a way that abused culture, drinking to feel free, drinking to experiment with it, and drinking just because one wanted to drink.

Most Karen refugees have experienced horrific human rights abuses including rape, forced labor, imprisonment, torture, or witnessing the death of family members. After fleeing into Thailand many people remain separated from family or don't know where their family members are. Conditions in refugee camps are often dismal with little access to adequate food, clean water, health care, or education opportunities. People are left with little to do and participants reported feeling trapped, bored, stuck, and hopeless. After resettlement, Karen people struggle to adjust to new cultures and languages and often remain separated from family and community. The emotions that result from these experiences can include depression, sadness, anxiety, fear, and intrusive memories of horrific experiences. Most participants reported that drinking alcohol helped to soothe these difficult emotions.

Drinking because of difficult or painful emotions was directly correlated to drinking because one was "following one's heart." This phrase was dominant in all of my conversations and interviews during the course of this study. It seemed from participants and cultural liaisons that experiencing difficult emotions had a direct impact on one's heart. Karen people often locate emotion or physical illness in the heart. Many emotion words in Karen contain the word heart: sad heart, lonely heart, worried heart, scared heart. When one has a heart hurt or damaged by terrible experiences, one follows one's heart toward negative behavior. Following one's heart was often explained as a type of selfishness or turning away from what was good to follow negative or harmful emotions toward negative or harmful behavior.

People who followed their heart were also described as people who did not think about others, but instead thought only of themselves. These internal emotions resulting from horrific experiences appeared to cause a break from traditional communal thinking and a turning inward or focus on self rather than community. Following one's heart appeared to mean turning away from family and community toward self, which was perceived as negative.

Turning away from community toward self was sometimes described as an abuse of culture. Many participants said that people who had negative emotions in their hearts—emotions such as sadness, fear, hopelessness—used cultural ceremonies such as weddings and funerals as excuses to drink over the limit. In this way, one person said, they are "abusing their culture." (TH) Rather than acting in a culturally appropriate way by remaining communal and integrated, people who used ceremonies as an excuse to become drunk were following their hearts, abusing culture, and turning inward.

Interpersonal Reasons for Using Alcohol

Interpersonal reasons for using alcohol can be described as reasons that originate in or are contextualized by relationships between individuals or groups of individuals. These reasons include men drinking because they are men, drinking to deal with the Burmese government, drinking to get rid of fear and drinking because of friendship.

The concept of friendship was a substantial part of interpersonal reasons for drinking among most participants. Friendship, as described by participants, appeared to have several meanings. It can perhaps best be described as a transactional relationship between two parties that has benefits for each party. Friendship was used to describe both friendly relationships between Karen peers as well as relationships between Karen people and the oppressive Burmese military government. The key element that occurred in each of these relationships was that there is a transactional element in both.

Among Karen peers alcohol appeared to function as an agent of social cohesion. Men drank together to celebrate, to relax after working together and simply to spend time together. The influence of friends using alcohol was one of the most frequently cited reasons for using alcohol among participants in both Minnesota and Thailand.

Friendship was also used to describe transactional relationships involving alcohol between Karen men and the Burmese military government. Participants reported that supplying alcohol to Burmese government officials facilitated the development of businesses and facilitated bureaucratic tasks. Participants also reported that supplying alcohol to Burmese military captors ensured less violent treatment or even escape or release from captivity.

Contextual Reasons for Using Alcohol

Contextual reasons for drinking alcohol can be described as reasons that are related to geographic context including drinking because of conditions in the refugee camps and drinking because of resettlement.

Ecosystemic theory (Bronfenbrenner, 1979) provides a way of contextualizing Karen refugees' unique relationship to geographical contexts. Bronfenbrenner's *macrosystem* refers to the political and cultural systems that influence human development and behavior. For refugees, geographical contexts can be located in the macrosystem. Ungar (2002) posits that individuals are constantly adapting their behavior to respond to environmental contexts. In this study these adaptations become apparent when behavior is viewed across the spectrum of displacement. Overall participants described similar ways of constructing alcohol use across multiple geographic contexts. However, context impacted drinking in different ways. In refugee camps the difficult and dismal aspects of camp life contributed to increased alcohol use. Resettlement stress either increased alcohol consumption or acted as a protective factor in preventing or decreasing alcohol consumption. It was clear from this study that context was an important factor in drinking for Karen refugee.

In Bronfenbrenner's conceptualization there is room for moving from one geographical context to another, such as from school to home or even moving from one place to another to live. However, refugees' unique relationship to geographical displacement and occupation of multiple locations at once stretches ecosystemic theory to contain multiple locations. Karen people, in just one or two generations, might live in Burma, be forced to take refuge in Thailand for many years and finally resettle in a third

country. Each of these locations has distinct and quite different cultures, languages, climates, and political realities. Refugees moving through these three locations must adapt to each place yet often retain an attachment to home. Almost all refugees have family, friends or neighbors who have stayed behind in Burma or remain in Thailand or have resettled in the United States.

Violence is a Concerning Consequence of Alcohol Use

Fighting and violence were the most often cited consequences of alcohol use in Karen communities. Almost every participant spoke about problems with violence, particularly in refugee camps, but continuing after resettlement, as well. Fighting appeared to be the most important and concerning result of increased alcohol use after displacement. Fighting most often occurred between adult men who were friends or acquaintances, but fighting was also reported between male teenagers and between spouses. When participants spoke of fighting between spouses it included yelling and arguing as well as physical violence. Every participant agreed that violence between spouses was perpetrated by men against women.

This finding also responds to the sub-question of the individual, family, and community-level relational impacts of alcohol use. Almost all participants indicated that the single most concerning impact of alcohol use on their families and communities was the resulting violence both between adult men and between spouses.

There is no existing literature exploring the relationship between violence and alcohol use in refugee communities, but in research on Western populations a complex relationship between alcohol use and violence has been established, as well as a correlation between domestic violence and alcohol use (Graham, Bernards, Wilsnack, &

Gmel, 2011). Findings from this study that confirm a relationship between violence and alcohol use are consistent with this established literature. Research on non-familial aggression or violence and alcohol use indicates that while alcohol is often associated with violence, it is exceedingly difficult to establish alcohol as a causal factor of violence because of the wide range of psychosocial, environmental, cultural, and situational factors that also impact violence perpetrated while using alcohol (Boles & Miotto, 2003). Among adolescents, alcohol use has been established as a predictor for violent behavior (Maldonado-Molina, Reingle, & Jennings, 2011). Research exploring the relationship between domestic violence and alcohol use in Western populations indicates that alcohol use increases the likelihood that a conflict between partners will become violent (Martin & Bachman, 1997). Similar to non-family violence, alcohol use has not been established as a causal factor of intimate partner violence. However, it is clear from research that alcohol use increases both the likelihood of domestic violence as well as the severity of the violence (Graham, Bernards, Wilsnack, & Gmel, 2011).

While the findings from this study about violence as a salient consequence of alcohol use are consistent with existing literature, the ways in which participants described and talked about this violence add an important understanding of the contextual factors that influence violence resulting from alcohol use. Fighting between adult male non-family members was related to the use of alcohol to get rid of fear. Many male participants said that people often drink to get rid of fear "so that they can fight." There appears to be a significant amount of anger and feelings of powerlessness for Karen men in refugee camps. This is most likely related to oppression by the Burmese government and forced displacement into refugee camps in Thailand. The feelings of impotence, fear,

and lack of freedom that occur after displacement appear to lead to increased drinking as well as increased aggression. This aggression against friends and acquaintances may be a way of expressing or dealing with internalized anger and rage.

This idea is supported by the finding that some men used alcohol in order to speak out what is in their hearts. Participants reported that Karen culture often places a taboo on speaking out in anger or confronting someone over perceived slights. Drinking alcohol allowed people to speak out the emotions that were in their hearts, particularly when those emotions were based on interpersonal relationships or interactions.

Sub-question (c):

What Individual, Family and Community Level Factors Contribute to Alcohol Use?

To respond to this research question I drew from Category III: Beliefs About Alcohol Use. Particularly important themes were "Alcohol Use Changed When Our Culture Was Broken" and "Some Alcohol Use is an Abuse of Culture." In the above section I discussed participant's perceptions about beliefs about the individual reasons that motivate alcohol use and the consequences for individuals, families and communities. I also discussed the ways in which these reasons could be considered intrapersonal, interpersonal, or contextual. In this section I move from discussing beliefs about why individual people use alcohol to discussing beliefs about alcohol use in general, or the ways in which Karen people perceive and experience higher-order factors that contribute to the development of individual reasons for alcohol use. I understand this differentiation this way: when I asked participants about why people drank alcohol they responded with specific reasons that a person might give for drinking. Further discussion of these reasons almost always included discussion of beliefs about what motivated those

reasons or the historical, political, familial, community, or cultural factors that led to the development of these more individual reasons. These more contextual factors were often expressed as general beliefs about alcohol and the role alcohol played in the Karen community. In this section I use these beliefs about the factors that influenced alcohol use to describe the individual, family and community level factors that contributed to alcohol use as described by participants.

There are four important findings that emerged in response to this sub-question. Participants in this study identified both culture and displacement-related factors as influential over alcohol use. Second, participants in this study explained that culture and displacement interact with each other as factors, rather than standing alone, particularly when they talked about the ways in which displacement disrupted culture. These findings are consistent with literature that describes the ways in which culture influences alcohol use and the ways in which displacement influences alcohol use. The finding that culture and displacement are reciprocally influential may indicate a new way of understanding the experience of alcohol use after displacement. Third, participants identified a uniquely political aspect to patterns of alcohol consumption and for many Karen people viewing alcohol use from a political perspective provides a deeper understanding of how and why Karen people use alcohol in problematic ways. Finally, viewing factors that contribute to alcohol use in Karen communities through a human rights lens opens up a new way of conceptualizing the health and well-being of refugees. One way of interpreting participants' conversations about the political and historical factors that influence alcohol use such as the influence of the Burmese government or the desire to feel free is through a human rights lens. This lens prioritizes health as a fundamental human right without

which refugees cannot begin to heal from the human rights violations experienced in Burma. There is a body of literature that names health, including freedom from alcohol abuse, as a fundamental human right and this finding is consistent with that literature (Gruskin, Plafker, & Smith-Estelle, 2001). However, within social work knowledge and practice, alcohol use or refugee health and mental health are rarely viewed through a human rights lens or as human rights concerns (Reichert, 2003). Framing participants' responses with this lens allows for a deepening discussion within the field of social work that names health as a fundamental human right.

Both Culture and Displacement-Related Trauma are Reasons for Alcohol Use

Consistent with scholarship about the correlation between substance use and trauma (Breslau, Davis, & Schultz, 2003; Najavits, Weiss, & Shaw, 1997), participants indicated that traumatic experiences resulting from conflict, displacement, living in refugee camps, and resettlement contributed to problematic alcohol use. This finding supports concerns about refugees' increased risk of substance use and abuse related to PTSD and psychological trauma symptoms (Keyes, 2000). However, findings from this study indicate a more complex constellation of factors that contributed to substance use in refugee communities than traumatic experiences alone. Trauma, rather than being the main or only motivating factor for problematic alcohol use, was part of a constellation of factors that included cultural practices, historical factors, familial factors, gender, geo-political realities, and social networks. Very often, trauma was not the only or primary reason cited for problematic alcohol use among participants. Rather, traumatic experiences and the resulting psychological and emotional consequences were almost always listed together with reasons such as culture, friendship or following one's heart.

One the one hand, this finding supports the development of a culturally relevant model of substance use in Karen and other refugee communities that considers a constellation of factors in addition to the trauma of political conflict and displacement as motivators for problematic alcohol use. On the other hand, further research is needed to understand how trauma is conceptualized and expressed within this community because it might be that language and narratives provided here simply endorse a cultural description of how trauma symptoms are expressed within this community.

Participants identified a range of culturally appropriate reasons for using alcohol such as for medicine or health or to relax with friends or at religious and cultural events like weddings and funerals. However, almost exclusively these reasons were described with a sort of nostalgia, as happening "back in Burma" or "only among the older generation." There was a general agreement among most participants that "it used to be this way, but things have changed." (MN) It seemed that the more inappropriate reasons for using have become more prevalent and the old ways of using with limits and protective cultural structures have become less common. In addition, these cultural ways of using have become excuses for drinking over the limit and cultural limits are no longer respected. This seems to have happened after conflict and displacement and has been carried into resettlement. As culture becomes more disrupted, old ways of using appropriately become less common.

This intersection of cultural and displacement related reasons for using alcohol represents a new and important way of viewing and understanding alcohol use in Karen refugee communities. Research on the reasons for alcohol use in Southeast Asian immigrant populations and in refugee communities have typically focused on either first-

hand trauma experience as the single motivating factor for alcohol use (D'Amico, Schell, Marshall, & Hambarsoomians, 2007; D'Avanzo, Frye, & Froman, 1994; Dupont, Kaplan, Verbraeck, Braam, & van de Wijngaart, 2005) or on culture or acculturation as motivating factors for alcohol use (Weaver & Robert, 2010). Virtually no studies have explored the intersection between culture and displacement together as motivating factors for alcohol use. The findings from this study indicate that both culture and the trauma of displacement contribute to reasons for using alcohol and must be explored together to understand more of the picture of refugee alcohol use.

One way in which culture and displacement interact as reasons for using alcohol is exemplified by many participants stating that people used culturally appropriate reasons for drinking alcohol such as weddings and funerals as excuses to get drunk. One participant called this "abuse of culture," meaning some people abuse Karen culture by using it as an excuse to drink to excess. Most participants noted that this abuse of culture began happening after fleeing Burma into Thailand. In this way the traumas inherent in displacement including loss of family, land, and community interact with previously held cultural norms and values to cause increases in problematic drinking.

Displacement Disrupts Culture Which Leads to Drinking

Many participants in both Thailand and Minnesota discussed the ways in which Karen culture had been disrupted or "broken" during conflict, flight, displacement, and resettlement. This is evident in the ways in which participants spoke about the "old ways" of living in Karen State and in Burma, which included adherence to traditional cultural values and practices. In respect to alcohol, most participants agreed that cultural traditions such as using alcohol for medicinal and health reasons and using alcohol to

socialize after long days of working together on farms provided a protective structure for drinking. Drinking in these situations was a culturally acceptable practice and these cultural structures provided a way to drink that lessened or eliminated negative consequences such as violence. However, most participants agreed that because of the conflict with the Burmese military government and because of the need to flee Burma into refugee camps in Thailand these cultural structures were disrupted and broken.

Many participants said that in the refugee camps in Thailand their families and communities were separated. Karen people were coming into prolonged contact with other ethnic groups in the camps as well, often for the first time. Cultural practices often could not be carried over into the camps. Most participants talked about this disruption in culture as being connected to increased problematic alcohol use as well as increased negative consequences of alcohol use. One participant in Thailand evocatively said that domestic violence has now become "like a culture" instead of the traditional ways of drinking.

After resettlement, participants in Minnesota reported that culture was once again disrupted. After resettlement, families and communities were further separated, both geographically and socially. The pressure of acculturation, including learning a new language and culture, finding employment, learning the school system, and finding housing also disrupted traditional cultural structures. In Minnesota, as in Thailand, cultural disruption contributed to increased drinking and increased negative consequences of alcohol consumption.

When speaking with my cultural liaison and during member checking both in Minnesota and in Thailand this concept of *cultural disruption* or *broken culture* as a

major cause of increased problematic alcohol use resonated with almost every participant. This finding is consistent with Maria Yellow Horse Braveheart's (1999, 2003) writing on historical trauma. Braveheart writes that the generations of community-wide traumatic events experienced by Native Americans in the United States, including forced removal of children from homes, removal from land, massacres and suppression of cultural practices, have cumulated to create a disruption or destruction of Native American culture. This disruption of culture has contributed to elevated rates of depression, suicide, alcoholism, and violence in Native American families. Karen people have experienced similar levels of genocide, trauma and cultural destruction during conflict with the Burmese government, during displacement and after resettlement. Like in Native American communities, this disruption has contributed to increased rates of alcohol use.

This finding is important for the development of culturally appropriate prevention and treatment modalities for Karen and other refugee groups. Building an awareness of cultural destruction and finding ways to rebuild culture after displacement may be central to developing relevant and effective responses to refugee alcohol use.

The Political Context of Alcohol Use

There are several themes that emerged from the data that have political connotations including: Drinking is caused by the Burmese government, drinking to deal with the Burmese government, and drinking to get rid of fear. Many participants reported that they believe the Burmese military government supplies alcohol to Karen people in Burma in order to "control" them or make them easier to manipulate. While it is nearly impossible to independently verify this information, it is clear that the belief affects the way Karen men think about and relate to alcohol. This connection is particularly clear

when men talk about the need to use alcohol in their relationships and dealings with the Burmese government. In order to facilitate bureaucratic processes many men described needing to bribe government or military officials with alcohol. Often this meant also drinking with the official to build friendship or social bonds. In addition to needing to drink to build social networks with government and military officials, Karen men talked about drinking to deal with fear of the Burmese military government and to deal with the kidnapping and forced labor. All three of these themes are interrelated in the ways in which they indicate a political context to alcohol consumption as well as beliefs about the utility of alcohol in securing both business success as well as personal safety.

The need to rely on alcohol in order to deal with the Burmese government clearly instills fear in Karen people in Burma. After flight into Thailand, Karen people continue to be subject to multiple hierarchies and controlling governmental and non-governmental systems (Moonineida, 2012). Life in refugee camps, including employment, health care, and possibilities for resettlement or repatriation, is dictated by Thai government officials and by the various non-governmental organizations that provide aid in the camps. The types of support that refugees receive, including the amount of food rations and the structure of health, education, and social services, continues to be influenced by politics. For example, when international aid to refugee camps lessens, food rations are often cut with little or no warning to refugees (Moonineida, 2012). In this way, refugees continue to be subject to and at risk of the political motivations of governmental and organizational entities. This may contribute to continued feelings of oppression, lack of freedom and fear, leading to increased alcohol use.

Alcohol Use and Health as a Human Right

There are two ways that human rights scholarship has framed the study of health as a human right. First, analysis has addressed the ways in which the right to health and health care has been addressed using a variety of international humanitarian legal documents (Kinney, 2000). Second, the violation of human rights has been identified as a factor that impacts health and well-being (Mann, 1997).

Using a human rights lens to frame alcohol use in Karen refugee communities provides a mechanism to explore and address societal factors such as displacement or poverty that significantly impact health outcomes. It also links the promotion of health and well-being to the promotion of human rights and dignity. A human rights analysis of alcohol use in Karen communities exposes and names the rights violations that contribute to alcohol use (Mann, 1997). Participants in this study identified two kinds of rights violations that affected alcohol use. First, participants reported that people often drank to feel free. Implicit in this text was the fact that conflict, displacement, and living in a refugee camp fundamentally denied refugees a feeling of freedom. Second, participants reported that many people drank alcohol to deal with fear and to deal with the Burmese military. Again, implicit in this language is evidence of the impact of the Burmese government's violation of Karen people's dignity and human rights.

In Thailand (but not in Minnesota) participants spoke of the ways in which drinking alcohol helped people feel free. When talking about the desire to feel free all participants related this to feeling oppressed by the Burmese military or to feeling trapped in refugee camps. Drinking alcohol allowed people to feel a sense of freedom from oppression or entrapment. This lack of freedom is a direct result of both conflict and

displacement, which constitute human rights violations. Human rights violations against the Karen are clearly documented (Amnesty International, 2010; TBBC, 2012) and participants in this study stated strongly that these violations directly impact unhealthy behavior like alcohol use. Human rights violations resulting in disability, disease, and mental and emotional distress are well-documented in refugees. However, there is less scholarship that directly relates human rights violations to behavioral issues such as alcohol use and domestic violence.

Participants also spoke of the ways in which alcohol was involved with interactions between Karen people and the Burmese military. There was a belief espoused by some participants that the Burmese military supplied alcohol to Karen people in order to control them through addiction. Participants also reported that people frequently had to use alcohol when dealing with the Burmese military. For example, supplying alcohol to or drinking with military or government personnel smoothed bureaucratic tasks. Even further, a few participants spoke about drinking alcohol because of fear of the Burmese military or to escape from imprisonment by military personnel. The threat of violations at the hands of the military engendered great fear in almost every participant in this study. Drinking helped to alleviate this fear. In this way, these violations or threats of violations could be construed as significant factors that impact Karen refugees' alcohol use.

Sub-question (d): What Are the Relational Impacts of Alcohol Use at the Individual, Family and Community Level?

This sub-question is partially addressed above in the discussion of violence and family violence as consequences of alcohol use, therefore I will not address it again here.

In responding to this question I drew from the following themes: "Drinking because they follow their heart" and "People stop drinking when they start thinking about other people." There are three significant findings that respond to the question of relational impacts at individual, family, and community levels. First, participants indicated that alcohol use disrupts communal ways of thinking and communal relationships and causes selfishness or turning inward. Second, and perhaps related, participants said that one of the most effective means of stopping alcohol use is a return to communal thinking or a repair of relational breakdowns. This finding is discussed in more detail in sub-question (e) below.

The phrase "he is following his heart" was repeated over and over in interviews and conversations throught data collection in both Thailand and Minnesota. The phrase became so important in talking about alcohol use that very early in the data collection process I began asking interviewees about the phrase and its meaning and spent time with my cultural liaisons and interpreters discussing the meaning of this phrase. Participants reported that a person who was following his or her heart was someone who had negative or difficult emotions in his or her heart. He or she was following these emotions, or following his or her heart, toward a negative consequence, such as drinking too much alcohol. In addition, people who followed their hearts were people who had stopped thinking about other people, including their families and their Karen community, and had started thinking only about themselves.

This finding appears to be quite important in understanding the ways in which alcohol impacts individual, family and community relationships. Karen culture is communal and community responsibility is often paramount to individual responsibility.

Many Karen people prioritize thinking about family and community as being a marker of Karen identity. A person who turns away from community sensibility or relational ways of interacting harms those relationships. This is consistent with the ways in which women talked about the differences between men's and women's drinking patterns. Both women and men in this study reported that men drink more alcohol than women. The primary reason given for why women do not drink alcohol is because they think about their children and their families. They "have a thought for the future," as one participant put it.

In extant literature about alcohol use a relational perspective has primarily been applied to women, which is consistent with findings from this study (Covington & Surrey, 1997). This literature supports the idea that relationships are central to women's lives and a significant part of their psychological development and perspectives (Covington & Surrey, 1997). This perspective has been important to developing alcohol treatment models that support women's emphasis on the importance of relationships. However, this relational perspective has been less evident in literature about men's drinking. Findings from this study indicate Karen women may place importance on family relationships which acts as a protective factor against drinking. Findings also indicate that there may be opportunities to emphasize the importance of men's relationships to community and culture from a relational perspective as protective factors against drinking.

Sub-question (e): What Do Karen Refugees Believe Would Be Effective In Stopping Problematic Alcohol Use?

To develop a response to this question I drew from Category IV: Ways of Stopping Alcohol Use. In particular I drew from the themes "It is a personal choice to stop drinking," and "People stop drinking when they start thinking about other people."

Three important findings emerged from the data about how to stop or address alcohol use in Karen refugee communities. First, participants said that stopping alcohol use is a personal choice and that others have little influence over whether or not someone stops using alcohol. In fact, women in Minnesota expressed high levels of hopelessness about their husbands ever stopping their problematic alcohol use. Second, despite beliefs that people have little influence over others' decisions to stop using alcohol, participants said that community support and education are two ways to help people to stop problematic alcohol consumption. These two approaches to stopping were geographically specific. In Thailand participants talked about community support as being essential to stopping alcohol and in Minnesota participants talked about education as being essential to stopping alcohol use. Third, participants said that when someone does stop using alcohol it is most often because he or she stops thinking only of themselves and starts thinking of their families and their community.

A brief examination of the ways in which prevention and treatment have been previously explored in substance use literature will help contextualize these three findings. The first two findings—that stopping using alcohol is a personal choice and that community support and education are important to prevention and intervention efforts—are supported by substance use literature (Rollnick & Miller, 1995). Motivational

Interviewing (Rollnick & Miller, 1995) is an evidence-based practice focusing on motivating personal choice to stop using alcohol that has been successfully culturally adapted for use with Hispanic populations (Lee et al., 2011). Community support is an essential part of Alcoholics Anonymous and other mutual-support recovery models (Valentine, 2011). Most of the literature that explores community support in recovery defines community as other people in recovery. Recovery communities are defined as networks of relationships between individuals who are all working to recover from alcohol use (Valentine, 2011). Some more recent literature emphasizes the importance of non-alcohol using family and community relationships in recovery (Garrett, Landau, Shea, Stanton, Baciewicz, & Brinkman-Sull, 1998). While this body of literature is small, it is growing, particularly in models of treatment for ethnic minority communities in the United States (Walters, Simioni, & Evans-Campbell, 2002). Related to the third finding, existing literature supports the efficacy of culturally relevant public education campaigns to prevent problematic alcohol consumption (Thomas, Donovan, Sigo, Austin, & Marlatt, 2009).

Consistent with existing literature, participants in this study reported that alcohol use and quitting or stopping alcohol use was a personal choice. This clearly affected motivation for quitting, which was especially apparent in the corresponding sense of hopelessness or lack of belief in the ability to influence alcohol use on the part of non-alcohol users. Many participants, women in particular, reported that because quitting alcohol was a personal choice, there was very little that non-drinkers could do to influence this choice.

Despite this sense of futility in outside support for quitting, most participants in Thailand indicated that community support was an essential part of helping people to quit drinking. This finding is quite important in developing culturally relevant treatment models for Karen people. An ecosystemic framing of alcohol use in the Karen community emphasizes the importance of treatment that involves family and community relationships as part of the recovery process.

Sub-Question (f): How Does Geographic Location (Refugee Camp or Country of Resettlement) Impact Alcohol Use?

To respond to this question I drew from themes in several categories including Category I: Reasons for Using Alcohol, Category II: Consequences of Alcohol Use, and Category III: Beliefs about Alcohol Use. I collected data from two locations in this study in order to explore the ways in which geographic location influenced alcohol use. Geographic contexts in academic literature about refugees' experiences tend to be discrete and chronological, meaning the focus or emphasis is on refugees in refugee camps or refugees in countries of resettlement but rarely on the ways in which *both* locations influence behavior and experience (Ezard, 2011). Research often puts geographic locations in chronological order as well, emphasizing that refugees have left behind countries of origin or countries of refuge in order to start new lives in countries of resettlement (Weaver & Roberts, 2010). Experiences in past geographic locations of refuge are contextualized as happening in the past and current events are rarely considered as factors that might influence behavior or experience in refugees' present location. This is especially true for research conducted with refugees after resettlement. While camp or pre-flight experiences are mentioned as contributing factors to behavior or

experience, these experiences are constructed as "past" rather than ongoing. This is consistent with beliefs about resettlement that consider refugees as starting new lives or acculturating to a new location, which implies a letting go of previous geographic locations.

As has been discussed above, participants in this study indicated that geographic context had some impact on reasons for using alcohol. For example, conditions in refugee camps contributed to feelings of hopelessness, isolation, and lack of freedom which, in turn, contributed to increased consumption of alcohol. Participants also noted that after resettlement acculturation stress sometimes increased alcohol use but also sometimes acted as a protective factor in limiting alcohol use.

It is difficult to ascertain from the data concrete information about changes in alcohol use between Burma, Thailand, and Minnesota. All participants agreed that Karen refugees in Thailand drank more alcohol more often and had more negative consequences than when living in Burma. However, participants were mixed in beliefs about the increase or decrease of alcohol use after resettlement. What was clear, though, in conversations about changes in use between locations is that people who drank a lot in refugee camps often brought that behavior with them to Minnesota. Further, participants in Minnesota often talked about or referred to their experiences in camps in Thailand to explain or contextualize alcohol use after resettlement. Similarly, participants in Thailand often spoke about their experiences in Burma or Karen State to contextualize their beliefs about alcohol use in the camps. This indicates that refugees continue to think about past geographic contexts when thinking about current behavior. This is consistent with Bronfenbrenner's chrono-system in which past systems influence current behavior and

relationships to current contexts. This also suggests that models of treatment may be more effective if they recognize and incorporate other geographic contexts rather than conceptualizing the displacement experience as geographically static.

Women's and Youth's Ways of Using Alcohol

Two important categories emerged from the data that were not anticipated by the research questions that guided this study: Women's Ways of Using Alcohol and Youth's Ways of Using Alcohol. These findings are included here because they suggest important areas for future study. The emergence of unique patterns of use and relationships to use are not surprising. A substantial body of literature exists that describes adolescent alcohol use and women's alcohol use as being significantly different from adults and from men. The findings are described briefly here because they suggest important avenues for future research.

Women's Ways of Using Alcohol

Women's ways of both using alcohol and relating to alcohol emerged as important in the findings described in Chapter 4. Both women and men described women's ways of drinking and relating to alcohol as different from men's ways of drinking and thinking about alcohol. Specifically, findings in this study indicated the following: 1) women do not use alcohol as much as men because they have to think about their families and their children; 2) when women do drink they drink because they want to feel equal to men, and because they want revenge on men for drinking; 3) when women drink their children suffer and they are at increased risk of sexual violence; and 4) women are hopeless that men will ever stop drinking.

Unlike other themes in this study, these themes did not reach saturation and must be considered as preliminary findings. There is strong indication that further study is needed to fully understand the ways in which Karen women related to alcohol and use alcohol after displacement and resettlement. However, because such an important difference emerged in the data it is important to acknowledge the findings.

Findings from this study about women's ways of relating to alcohol are consistent with literature that describes women as relating to alcohol differently than men (Corte, Rongmuang, & Farchaus Stein, 2010; Karoll, 2010; Najavits, Weiss, & Shaw, 1997; Sales, Brown, Vissman, & DiClemente, 2012). In particular, Sales, Brown, Vissman & DiClemente note that women who use alcohol are at increased risk of sexual violence. In his review of two decades of research on women and alcohol Karoll (2010) writes that current understanding of women's ways of using and relating to alcohol grew out of a critical feminist critique of traditional alcohol treatment programs that were tested, validated and normed on men's experiences that prevented women from accessing relevant treatment for alcohol use disorders.

Viewing women's ways of drinking through a critical feminist lens (Dominelli, 2002) three important findings emerge that contribute to knowledge of Karen women's ways of relating to alcohol after displacement. First, women do not use alcohol as much as men do because they think about their families. Participants overwhelmingly agreed that women do not use alcohol as much as men do. The single reason given for this is that women think about their children and their families more than men because they have a unique responsibility to care for children. One of the main consequences cited of women's drinking is that children and families suffer when women drink.

Second, when women do use alcohol they use it to feel equal to men and to get revenge on men for drinking. This finding is unique and suggests the need for further inquiry. Women and men reported that women often drink because men drink and they want to feel equal to men or to get revenge on men for drinking. This appears to be a phenomenon that has increased since displacement. It also seems that this finding may be connected to the finding discussed below that women feel hopeless that men will ever stop drinking. Often drinking for revenge was described in combination with a sense of hopelessness. Women have tried to get men to stop drinking but when they don't stop, women start drinking instead with a combination of both hopelessness and revenge for men's behavior.

Third, women feel hopeless that men will ever stop drinking. Women, much more than men, discussed a feeling of hopelessness that alcohol problems in the Karen community can be stopped. Women overwhelmingly reported feeling hopeless or convinced that men will always drink and there is nothing to be done about it. Along with this hopelessness was a sense of frustration and sadness.

These findings indicate that women seem to think of alcohol in a uniquely relational way. Much of women's use of and thinking about alcohol is connected to the kinds of relationships women have to their children, their husbands and their communities. Relationships act both as protective factors against drinking as well as catalysts for drinking. The important relationships for women in these findings are between women and their children and women and their husbands. Women's relationships with each other are missing from discussion about women's alcohol use.

Youth's Ways of Using Alcohol

Youth's ways of drinking alcohol emerged as different from adults' ways of using alcohol in two ways. First, youth had unique reasons for using alcohol: to fight with each other, to experiment with it, and to heal broken hearts. Second, many participants said that youth have lost their culture after displacement and that growing up in refugee camps instead of Burma has led to a distancing from traditional Karen culture and a hopelessness about the future, which contributes to drinking over the limit.

All participants in this study were adults over the age of eighteen. Participants identified youth as "teenagers" ages thirteen to eighteen. Findings related to youth, while consistent across multiple groups and confirmed through cultural liaisons and member checking, were reported by adults speaking about youth. For these reasons these findings are preliminary and warrant further exploration through research with youth themselves. However, because youth were identified as having different experiences from adults, it is important to acknowledge these findings.

There is a robust set of literature about youth's ways of using alcohol in the United States (Danielsson, Wennberg, Tengstrm, Romelsjo, 2010; Weinberg, Rahdert, Colliver, & Glantz, 1998). Social learning theory has been applied to youth's ways of using alcohol to explain the ways in which social networks contribute to youth experimentation with and consequent addiction to alcohol (Tomlinson & Brown, 2010). Findings about youth from this study are consistent with this literature, in particular when participants suggest that a major reason for youth alcohol use is experimentation with friends. There is very little academic literature that describes the effects of loss of culture in refugee camps on alcohol use or mental health (Van Ommeren et al., 2001). However,

an extensive literature about acculturation after immigration or resettlement to Western countries has identified youth acculturation as a significant risk factor for increased alcohol use (Pedersen, Hsin Hsu, Neighbors, Lee, & Larimer, 2013). The findings from this study that suggest that youth use alcohol because of broken hearts and because of acculturation or loss of culture are consistent with established literature.

A potentially important finding from this study that contributes to new ways of understanding Karen youth's alcohol use is that youth in Karen communities use alcohol to fight with each other. This finding may be related to the finding that Karen youth use alcohol because they have lost their cultural identity and because displacement has caused hopelessness among youth. Participants said that youth who fled Burma at a young age and grew up in the refugee camps have lost traditional cultural identities. In addition they feel trapped, bored, isolated, and hopeless living in the refugee camps. There are few opportunities for education or employment in the camps and youth often spend long days simply hanging out with each other with nothing to do. The conflict and resulting displacement has led to feelings of powerlessness as well as taken away youth's sense of freedom. Placing this finding in the context of the finding that youth often use alcohol to feel brave and to fight with each other highlights the ways in which youth might use alcohol to gain a sense of power and identity.

Conclusion

Each of the sub-questions discussed above contribute to an emerging understanding of the grand-tour research question: How do Karen refugees in multiple sites of displacement perceive and experience alcohol use? Themes and categories emerging from the data trace a wide range of historical, political, cultural, familial,

individual, and geographic factors that influence a person's reasons for using alcohol, the consequences of over-the-limit alcohol consumption and beliefs about alcohol use. This study has the potential to contribute valuable information to a better understanding of the ways in which Karen refugees think about alcohol use during and after displacement as well as the development of culturally relevant prevention and treatment programs and policies both in refugee camps and countries of resettlement. Extant literature clearly shows that culturally relevant alcohol treatment programs may be more effective than alcohol treatment programs that do not consider cultural or contextual factors. The questions discussed above contribute to the grand-tour research question in four ways. First, building on what is already known about alcohol use, both culture and traumatic experiences during displacement and resettlement contribute to changing levels of alcohol use as well as patterns of use and beliefs about use. Second, culture appears to be disrupted during displacement, particularly when families and communities are separated, because of conditions in refugee camps and after resettlement, which contributes to elevated levels of drinking as well as using alcohol in ways that conflict with cultural values and beliefs. Third, Karen culture prioritizes community and relational ways of thinking over individuality. When Karen people drink above the limit they are thought to be following their hearts or thinking only of themselves and not of other people, including their families and communities. Returning to a communal way of thinking and relating is frequently a substantial factor in quitting alcohol use. Fourth, in part because of the strong communal nature of Karen culture, community support is an essential part of quitting alcohol use.

All of these pieces of information begin to paint a more complete picture of the ways in which Karen refugees think about, experience, and perceive alcohol use after conflict-related displacement and resettlement. They also have important contributions to the development of social work knowledge, policy, and practice, which will be discussed further in the next chapter.

Chapter 6: Conclusion

Chapter Overview

In this chapter I will review the ways in which the findings discussed in Chapter 5 contribute to social work knowledge, practice and policy. I will also discuss the limitations to this study and suggest avenues for future research and exploration that emerged from this study.

Implications for Social Work Knowledge, Practice, and Policy

The findings that emerged from this study can contribute to developing the social work knowledge base which may enhance alcohol use prevention and treatment models and could provide motivation for policy implementation and reform. The development of the social work knowledge base has a direct influence on the development of evidence-based best practices and this study contributes to the development of knowledge about the ways in which refugees experience and use alcohol across the spectrum of displacement. Karen refugees in this study reported that both culture and displacement-related traumas impacted alcohol use. Further, participants said that Karen culture was disrupted or broken by displacement and that this cultural disruption led to a breakdown in culture-based protective factors that previously limited alcohol use. Therefore, both alcohol use and the negative consequences of alcohol use increased after fleeing conflict to Thailand and after resettlement. Participants said that people who drink alcohol were often only thinking of themselves and had stopped thinking in a communal or community-oriented way. Supporting people who use alcohol to begin to return to a communal or relational way of thinking was identified as an essential part of the quitting process. This information can enhance and expand what is already known about alcohol

use among refugee groups. As a direct result of these contributions, culturally and contextually relevant prevention and intervention techniques can be developed.

There are several ways in which these findings contribute directly to the development of treatment modalities. Currently, refugees in the United States who enter mainstream Western alcohol treatment most often do so through mandate by the criminal justice system as a result of driving under the influence (DUI) charges or domestic violence charges. Because of a lack of familiarity with the treatment system, refugees are unlikely to voluntarily enter treatment (Weaver & Roberts, 2010). When in treatment, Karen refugees may encounter information about alcohol and alcohol use that differs from their own cultural beliefs. In addition, Western forms of treatment rarely take a political or human rights approach to treatment or consider wide communal and familial support in developing treatment plans (Weaver & Roberts, 2010).

I did not set out in this study to explore treatment and quitting problematic alcohol in particular. Rather, I strove to explore and understand Karen people's concepts of alcohol use with the idea that these concepts might be useful in moving toward treatment development or adaptation. Therefore, it is important to note that this research has implications for starting to think about and research treatment modalities for refugees, rather than directly contributing to more immediate treatment development. Instead, I would like to highlight two concepts that emerged from this study that will be important in future research on best treatment practices with Karen refugees. First, there are multiple social, cultural, political, and displacement-related factors that influence patterns of alcohol consumption and beliefs about problematic alcohol use in Karen refugee communities and these factors are essential to thinking about treatment and stopping

alcohol use. Treatment for Karen refugees should consider the cultural importance of alcohol use, especially in developing and enhancing social bonds. This is particularly important for resettling communities that are attempting to repair disrupted cultures and communities and repair social bonds. Treatment must consider the ways in which refugees who use alcohol to enhance social bonds may need to develop new ways of socializing while at the same time respecting the role of safe and healthy alcohol use within the culture. Treatment for Karen refugees should also move beyond an emphasis on traumatic experiences as the motivating factor for alcohol use and work to include consideration of the political context of the displacement and refugee experience and how that impacts patterns of alcohol use.

Second, many participants described the ways in which community is essential to stopping alcohol use. For many Karen refugees having the support of not just family members, but the wider community as well may be essential to stopping alcohol use. Treatment options in the United States often include family treatment or family bond enhancement strategies, yet rarely extend these strategies to a larger community. In thinking about adapting or developing substance use treatment programs for refugees it may be important to use community-wide strategies for reducing problematic drinking and enhancing health social bonds.

The strategies and ideas described above are grounded the assumption that it is necessary to develop Karen or refugee-specific modes of substance use treatment. However, this may not be politically or economically feasible in light of limited resources for behavior health services. Many well-respected and clearly effective treatment modalities and systems exist in the United States and it is possible that these services

could be adapted to be more welcoming to Karen and other refugees. I have been working with one of the social service agencies used in this study for participant recruitment to develop two such adaptation strategies. First, we have begun to develop a voluntary support group within the social service agency for Karen adult men who are receiving outpatient drug and alcohol treatment services from a Western agency. This group will provide a space for Karen men to come together and discuss treatment with other people who speak the same language and have similar cultural and political backgrounds. The group will be co-led by a social worker with chemical dependency treatment experience and a Karen social worker and will also provide culturally-relevant education about alcohol use. Second, we have begun to identify counselors at several substance abuse treatment agencies throughout St. Paul who are interested in receiving additional training in the cultural, political, and social contexts of Karen refugees and can then serve as key referral resources when Karen refugees do enter treatment.

The findings from this study may have potential implications for resettlement policy in the United States. Currently US resettlement policy provides federal funding to voluntary resettlement agencies and community-based organizations to provide resettlement support services to newly arriving refugees. These services include job training, English language classes, assistance with housing, and assistance with finding employment. These resettlement policies also contain outcome goals intended to define and measure successful resettlement and include finding and keeping stable employment with health insurance, reducing reliance on public welfare and learning English (Office of Refugee Resettlement, 2010b). Left out of these outcome goals are measurements of mental health and well-being and emotional stability (Public Welfare, 2006).

Consequently, there is little federal funding at the agency level for programs that address mental health, alcohol, and other drug use or domestic violence issues in refugee communities. Findings from this study indicate that alcohol use is an important concern for refugees both before and after resettlement and could provide motivation or influence on policy decisions that expand resettlement funding to include support for mental and behavioral health services for newly arriving refugees.

Limitations of This Study

There were four limitations to this study that must be addressed in order to further contextualize the findings discussed above. First, I am an outsider with an inherently etic perspective. Second, I do not speak Karen and conducted the majority of my data collection using interpreters, which places some limitations on the depth of analysis achieved in this study. Third, women and youth were underrepresented in this study leading to a lack of saturation in some themes and categories pertaining to women and youth. Fourth, my use of DARE Network for participant access and recruitment purposes in Thailand may have influenced the content of those interviews.

I am an outsider to this community and therefore had an inherently etic perspective to the research. Being an outsider can lead to several complications for research, namely that I may have been unable to reach a level of trust and access to Karen communities and people that would allow for significant depth and breadth in the resulting data. While I spent considerable time developing trusting relationships in both study locations, my status as a white, Western outsider may have limited my ability to communicate freely with my participants. I utilized several methods to address this limitation, including developing trusting relationships prior to starting the research, using

cultural liaisons to provide introductions and assistance with recruitment and triangulation of data. However, my outsider status is still a limitation that must be considered in the context of this study.

A second, related limitation is that I do not speak Karen and conducted the majority of my data collection using interpreters, which places some limitations on the depth of analysis achieved in this study. I spent a significant amount of time training interpreters and worked closely with them in order to ensure the best interpretation possible. However, because I do not speak Karen and was unable to interview people without interpretation, it is possible that some information was lost in the translation process.

A third limitation that must be considered is the limited participation of women and youth in this study. In both Minnesota and in Thailand I struggled to recruit women for this study. When women did agree to participate they overwhelmingly reported that the conversations were helpful and that they were very interested in learning more about the results of the study. However, it was clear that there was gender-based reluctance to participate initially. I discussed this with cultural liaisons in both Minnesota and Thailand and was told that this reluctance may be based on women's roles in the community. There are few female leaders or public speakers in the Karen community and women may have been reluctant to speak for their communities. It is clear from the findings that women's experiences with alcohol are different from men's and this study may be missing important information about the ways in which women relate to alcohol. This limitation suggests the need for research that focuses solely on Karen women's experiences with alcohol.

Finally, the findings in this study may have been limited by my reliance on DARE Network for recruitment in Thailand. About one quarter of my individual and group interviews in Thailand were conducted with DARE Network staff and current or former clients. DARE is the only drug and alcohol treatment NGO working on the Thai-Burma border and has a strong presence in several camps. The staff is clearly well-educated in both Western and Karen beliefs and values about alcohol use and treatment. It is likely that some of my interviews with DARE affiliates were influenced by DARE's mission statement and treatment orientation. It is also possible that DARE recruited participants to speak with me who would give a particular impression or image of DARE. For this reason and to address this limitation I read the transcripts from interviews with non-DARE affiliates from Thailand first and incorporated the DARE interview data after noting the few places where DARE interviews differed from non-DARE interviews. Overall, there were very few differences, but where possible I placed heightened emphasis on triangulation to ensure that a range of views were represented. This limitation must be considered in the context of this study.

Directions for Future Research

There are three important directions for future research resulting from this study. First, more exploration is needed to understand the unique ways in which women and youth relate to alcohol use in Karen communities. The findings related to women and youth did not emerge as completely as findings about the ways in which men drink. This may have been partially related to women and youth's limited participation in the study. Because such a noticeable difference did appear in the findings, it is clear that more study is needed to understand women's and youth's needs related to alcohol use.

Second, this study suggests that there are multiple cultural and displacement related factors that contribute to increased alcohol use in Karen refugee communities. The role of these factors in other ethnic communities that have been displaced by political conflict is unknown. The model that emerged from the data that depicts relationships between causes and consequences of alcohol use in Karen communities could be further tested by applying it to other ethnic groups. Because culture emerged as such an important factor in patterns of alcohol use after displacement there will clearly be differences for different ethnic groups.

Third, findings related to family and family relationships were underdeveloped in this study and there is certainly a need for further exploration of the ways in which families are impacted by alcohol use. Participants pointed out that women and men had differing relationships to alcohol and that family violence was a significant consequence of alcohol consumption. Both of these findings indicate that family relationships are affected by alcohol use. Further research would explore the ways in which families experience alcohol and would contribute to enhanced family supports for families experiencing alcohol problems.

References

Agaibi, C. E., & Wilson, J. P. (2005). Trauma, TPSD, and resilience: A review of the literature. *Trauma, Violence, & Abuse, 6*(3), 195-216.

Aguirre, R. T. P., & Watts, T. D. (2010). Suicide and alcohol use among American Indians: Toward a transactional-ecological framework. *Journal of Comparative Social Welfare, 26*(1), 3-11.

Akers, R. (1973). *Deviant behavior: A social learning approach.* Belmont, CA: Wadsworth Publishing.

ALTSEAN Burma. (November 2004). *Burma briefing: Issues and concerns.* Available at: http://www.altsean.org/Docs/PDF%20Format/Issues%20and%20Concerns/Issues%20and%20Concerns%20Vol%201.pdf.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Amnesty International. (2011). *Annual Report*. New York, NY: Author.

Amodeo, M., Peou, S., Grigg-Saito, D., Berke, H., Pin-Riebe, S., & Jones, L. (2004). Providing culturally specific substance abuse services in refugee and immigrant communities: Lessons from a Cambodian treatment and demonstration project. *Journal of Social Work Practice in the Addictions, 4*(3), 23-46.

Arnetz, J., Rofa, Y., Arnetz, B., Ventimiglia, M., & Jamil, H. (2013). Resilience as a protective factor against the development of psychopathology among refugees. *Journal of Nervous & Mental Disease, 201*(3), 167–172.

Bailey, R., & Brake, M. (1975). *Radical social work.* London, England: Edward Arnold.

Bandura, A. (1977). *Social learning theory.* New York, NY: General Learning Press.

Barrett, M. E. (2007). *Report on UNHCR substance use and HIV project (Thai-Burma border). Phase II: Strategy and action plan.* Geneva: UNHCR.

Beiser, M. N., Hou, F. (2006). Ethnic identity, resettlement stress and depressive affect among Southeast Asian refugees in Canada *Social Science & Medicine, 63*(1), 137-150.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge.* Anchor Books.

Boles, S. M., & Miotto, K. (2003). Substance abuse and violence: A review of the literature. *Aggression and Violence, 8*(2), 155-174.

Bonin, M. F., Norton, G. R., Asmundson, G. J. G., Dicurzio, S., & Pidlubney, S. (2000). Drinking away the hurt: The nature and prevalence of PTSD in substance abuse patients attending a community-based treatment program. *Journal of Behavior Therapy, 31*, 55-66.

Bracken, P. J., Giller, J. E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science & Medicine, 40*(8), 1073-1082.

Brady, K. T., Dansky, B. S., Sonne, S. C., & Saladin, M. E. (1998). Posttraumatic stress disorder and cocaine dependence. *American Journal of the Addictions, 7*, 128–135.

Braveheart, M. Y. H. (1999). Oyate ptayela: Rebuilding the Lakota nation through addressing historical trauma among Lakota parents. *Journal of Human Behavior in the Social Environment, 2*(1-2), 109-126.

Braveheart, M. Y. H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs, 35*(1), 7-13.

Bremner, J. D., Southwick, S. M., Darnell, A., & Charney, D. S. (1996). Chronic PTSD in Vietnam combat veterans: course of illness and substance abuse. *American Journal of Psychiatry, 153*, 369–375.

Breslau, J. (2004). Cultures of trauma: Anthropological views of posttraumatic stress disorders in international health. *Culture, Medicine and Psychiatry 28*(2), 113–126.

Breslau, N., Davis, G. C., Andreski, P., Peterson, E. (1991). Traumatic events and posttraumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry, 48*, 216–222.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Burgess, R. L., & Akers, R. L. (1966). A differential association-reinforcement theory of criminal behavior. *Social Problems*, *14*(2), 128-147.

Caetano, R., Clark, C., & Tam, T. (1998). Alcohol consumption among racial/ethnic minorities: Theory and research. *Alcohol Health and Research World, 22*, 233.

Cardozo, B. L., Talley, L., Burton, A, & Crawford, C. (2006). Karenni refugees living in Thai–Burmese border camps: traumatic experiences, mental health outcomes, and social -functioning. *Social Science & Medicine 58*, 2637–2644.

Centers for Disease Control. (2010). *Karen cultural profile*. Atlanta, GA: Author.

Cecchi, F., Elder, G., Schafer, M., Drouhin, E., & Legros, D. (2003). Consequences of armed conflict for an ethnic Karen population. *The Lancet, 362*(9377), 74-75.

Conquergood, D. 1991. Rethinking ethnography: Towards a critical cultural politics. *Communication Monographs, 58*, 180-194.

Cook, W. K., Mulia, N., & Karriker-Jaffe, K. (2012). Ethnic drinking cultures and alcohol use among Asian American adults: Findings from a national survey. *Alcohol and Alcoholism, 47*(3), 340-348.

Corte, C., Rongmuang, D., Farchaus Stein, K. (2010). Nursing knowledge about alcohol use and alcohol problems in women: a review of the literature. *Journal of American Psychiatric Nurses Association, 16*(4), 252-61.

Cottler, L. B., Compton, W. M., Mager, D., Spitznagel, E. L., & Janca, A. (1991). Posttraumatic stress disorder among substance users from the general population. *American Journal of Psychiatry, 149*, 664–670.

Covington, S., & Surrey, J. (1997). The relational model of women's psychological development: Implications for substance abuse. In S. Wilsnack & R. Wilsnack (Eds.). *Gender and Alcohol: Individual and Social Perspectives*. (pp. 335-351).

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among the five approaches.* Thousand Oaks, CA: Sage Publications.

Danielsson, A., Wennberg, P., Tengstrm, A., Romelsjo, A. (2010). Adolescent alcohol use trajectories: Predictors and subsequent problems. *Addictive Behaviors, 35*(9), 848-852.

D'Amico, E. J., Schell, T. L., Marshall, G. N., Hambarsoomians, K., (2007). Problem drinking among Cambodian refugees in the United States: How big of a problem is it? *Journal of Studies on Alcohol and Drugs, 68*, 11-17.

D'Avanzo, C. E., Frye, B., Froman, R. (1994). Culture, stress and substance use in Cambodian refugee women. *Journal of Studies in Alcohol, 55*, 420-426.

Davis, R. E., Kennedy, M. G., & Austin, A. (2000). Refugee experiences and Southeast Asian women's mental health. *Western Journal of Nursing Research, 22*(2), 144-168.

De Jong, J., Komproe, I. H., Ommeren, M. V., Masri, M. E., Araya, M., Khaled, M., et al. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *The Journal of the American Medical Association, 286*, 555-562.

Delang, C. O. (2000). *Suffering in silence: The human rights nightmare of the Karen people of Burma.* Parkland, USA: Universal Publishers.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Dominelli, L. (2002). *Anti-oppressive social work theory and practice.* New York, NY: Palgrave.

Dominelli, L., & McLeod, E. (1989). *Feminist social work*. Basingstoke, England: Macmillan.

Dupont, H. J., Kaplan, C. D., Verbraeck, H. T., Braam, R. V., & van de Wijngaart, G. F. (2005). Killing time: drug and alcohol problems among asylum seekers in the Netherlands. *International Journal of Drug Policy, 16*(1), 27-36.

Ezard, N. (2011). Substance use among populations displaced by conflict: a literature review. *Disasters, 36*(3), 533–557.

Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence, 23*(3), 316-338.

Ezard, N., Debakre, A., Catillon, R. (2010). Screening and brief intervention for high-risk alcohol use in Mae La refugee camp, Thailand: a pilot project on the feasibility of training and implementation. *Intervention, 8*(3), 223-232.

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet, 365*, 1309-1314.

Fink, C. (2005). *Living silence: Burma under military rule*. London, England: Zed Books, Ltd.

Fook, J. (2000). *Social work: Critical theory and practice.* London, England: SAGE.

Fuertes, A. B. (2004). In their own words: Contextualizing the discourse of (war) trauma and healing. *Conflict Resolution Quarterly, 21*(4), 491-501.

Fujimoto, K., & Valente, T. W. (2012). Social network influences on adolescent substance use: Disentangling structural equivalence from cohesion. *Social Science and Medicine, 74*(12), 1952-1960.

Galper, J. (1980). *Social work practice: A radical perspective.* Englewood Cliffs, NJ: Prentice Hall.

Garrett, J., Landau, J., Shea, R., Stanton, M. D., Baciewicz, G., & Brinkman-Sull, D. (1998). The ARISE Intervention: Using family and network links to engage addicted persons in treatment. *Journal of Substance Abuse Treatment, 15*(4), 333-343.

Gergen, K. (1999). *An invitation to social construction.* London, England: SAGE.

Giorgi, A., (1985). *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press, Pittsburgh.

Geertz, C. (1973). Thick description: toward an interpretive theory of culture. In *The interpretation of cultures: selected essays*. New-York, NY: Basic Books, pp. 3-30.

Graham, K., Bernards, S., Wilsnack, S. C., & Gmel, G. (2011). Alcohol may not cause partner violence but it seems to make it worse: A cross national comparison of the relationship between alcohol and severity of partner violence. *Journal of Interpersonal Violence, 26*(8), 1503-1523.

Green, B. L., Grace, M. C., & Gleser, G. C. (1985). Identifying survivors at risk: Long-term impairment following the Beverly Hills Supper Club fire. *Journal of Consulting and Clinical Psychology, 53*(5), 672-678.

Gruskin, S., Plafker, K., & Smith-Estelle, A. (2001). Understanding and responding to youth substance use: The contribution of a health and human rights framework. *American Journal of Public Health, 91*(12), 1954-1963.

Hahm, H. C., Lahiff, M., & Guterman, N. B. (2004). Asian American adolescents' acculturation, binge drinking, and alcohol- and tobacco-using peers. *Journal of Community Psychology, 32*(3), 295-308.

Haque, A. (2010). Mental health concepts in Southeast Asia: Diagnostic considerations and treatment implications. *Psychology, Health and Medicine, 15*(2), 127-134.

Heath, D. B. (2000). Drinking occasions: Comparative perspectives on alcohol and culture. London, England: Routledge.

Hendershot, C. S., Dillworth, T. M., & Neighbors, C. (2008). Differential effects of acculturation on drinking behavior in Chinese- and Korean-American college students. *Journal of the Study of Alcohol and Drugs, 69*(1), 121-128.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma *Journal of Traumatic Stress, 5*(3), 377-391.

Hein, D., Litt, L. C., Cohen, L., Miele, G. M., & Campbell, A. (2009). Trauma services for women in substance abuse: An integrated approach. *Washington DC: American Psychological Association*, 143-161.

Hodes, M. (2000). Psychologically distressed refugee children in the United Kingdom. *Child Psychology and Psychiatry Review, 5*(2), 57-68.

Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., . . . Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *Journal of the American Medical Association, 288*(5), 611-621.

Hong, J. S., Lee, N. Y., Grogan-Kaylor, A., & Huang, H. (2011). Alcohol and tobacco use among South Korean adolescents: An ecological review of the literature. *Children and Youth Services Review, 33*(7), 1120-1126.

Human Rights Watch. (2005). “They came and destroyed our village again" the plight of internally displaced persons in Karen State. New York, NY: Author.

Human Rights Watch. (2011). *Annual Report*. New York, NY: Author.

Hutchinson, M., & Dorsett, P. (2012). What does the literature say about resilience in refugee people? Implications for practice. *Journal of Social Inclusion, 3*(2), 13-23.

Ife, J. (2001). *Human rights and social work: Towards rights based practice.* Cambridge, England: Cambridge University Press.

International Human Rights Clinic at Harvard Law School. (2009). *Crimes in Burma.* Cambridge, MA: Author.

Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry, 158*, 1184-1190.

Jaranson, J. M., Butcher, J., Halcon, L., Johnson, D. R., Robertson, C., Savik, K., . . . Westermeyer, J. (2004). Somali and Oromo refugees: Correlates of torture and trauma history. *American Journal of Public Health, 94*, 591-598.

Johnson, H., & Thompson, A. (2008). Development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review, 28*, 36-47.

Karoll, B. R. (2010). Women and alcohol-use disorders: A review of important knowledge and its implications for social work practitioners. In K. van Wormer & B. A. Thyer (Eds.). *Evidence-based practice in the field of substance abuse: A book of readings.* (pp. 135-151). Thousand Oaks, CA: Sage Publications.

Keane, T. M., Caddell, J. M., & Martin, B. (1983). Substance abuse among Vietnam veterans with posttraumatic stress disorders. *Bulletin of Social Psychology and Addictive Behavior, 2,* 117-122.

Keyes, E. (2000). Mental health status in refugees: An integrative review of current research. *Issues in Mental Health Nursing, 21,* 397-410.

Kessler R. C., Sonnega A., Bromet E., Hughes M., Nelson C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52,* 1048-1060.

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders. *American Journal of Psychiatry, 142,* 1259-1264.

Khantzian, E. J., Mack, J. E., & Schatzberg, A. F. (1974). Heroin use as an attempt to cope: Clinical observations. *The American Journal of Psychiatry, 131*(2), 160-164.

Kinney, E. D. (2000). International human right to health: What does this mean for our nation and world? *Indiana Law Review, 34,* 1457 – 1477.

Kinzie J. D., Fredrickson R. H., Ben R., Fleck, J. & Karls, W. (1984). Posttraumatic stress disorder among survivors of Cambodian concentration camps. *American Journal of Psychiatry, 141*(5), 645-650.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley, CA: University of California Press.

Kozaric-Kovacic, Ljubin, T., Grappe, M. (2000). Comorbidity of posttraumatic stress disorder and alcohol dependence in displaced persons. *Croatian Medical Journal, 41*(2), 173-178.

LeCompte, M. D., & Schensul, J. J. (1999). *Designing and conducting ethnographic research.* Walnut Creek, CA: Altamira Press.

Leeies, R. Pagura, J., Sareen, J., & Bolton, J. M. (2010). The use of alcohol and drugs to self-medicate symptoms of posttraumatic stress disorder. *Depression and Anxiety 27*, 731-736.

Lincoln, Y. S. & Guba, E. G. (*1985*). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lindencrona, F., Ekblad, S., Hauff, E. (2008). Mental health of recently resettled refugees from the Middle East in Sweden: The impact of pre-resettlement trauma, resettlement stress and capacity to handle stress. *Social Psychiatry and Psychiatric Epidemiology, 43*(2), 121-131.

Lischer, S. K. (2006). *Dangerous sanctuaries: Refugee camps, civil war and the dilemmas of humanitarian aid.* Ithica, New York: Cornell University Press.

Macdonald, D. (2006). Rapid assessment of substance use in conflict-affected and displaced populations: Thailand (unpublished). Geneva: UNHCR/WHO.

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

Maldonado-Molina, M. M., Reingle, J. M., & Jennings, W. G. (2011). Does alcohol use predict violent behaviors? The relationship between alcohol use and violence in a nationally representative longitudinal sample. *Youth Violence and Juvenile Justice, 9*(2), 99-111.

Mann, J. (1997). Health and human rights: If not now, when? *Health and Human Rights, 2*(3), 113-120.

Marsiglia, F. F., Miles, B. W., Dustman, P., & Sills, S. (2002). Ties that protect: An ecological perspective on Latino/a urban pre-adolescent drug use. *Journal of Ethnic & Cultural Diversity in Social Work, 11*(3-4), 191-220.

Martin, S. E., & Bachman, R. (1997). The relationship of alcohol to injury in assault cases. In M. Galanter (Ed.), Recent Developmentsin Alcoholism 14. (pp. 41–56).

Milbrandt, J. (April 27, 2012). Tracking genocide: Persecution of the Karen in Burma. *Texas International Law Journal*, Forthcoming. Available at SSRN: http://ssrn.com/abstract=2047186.

Miller, K. E., & Rasco, L. M. (2004). *The mental health of refugees: Ecological approaches to healing and adaptation.* London, England: Routledge.

Moisander, P. A., & Edston, E. (2003). Torture and its sequel: A comparison between victims from six countries. *Forensic Science International, 137*, 133-140.

Mollica, R. F., Wyshak, G., & Lavelle, J. (1987). The psychosocial impact of war trauma and torture on Southeast Asian refugees. *American Journal of Psychiatry, 144*(12), 1567-1572.

Moreau, M. (1979). A structural approach to social work practice. *Canadian Journal of Social Work Practice, 5*(1), 78-94.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: SAGE Publications.

Mullaly, R. (1993). *Structural social work*. Toronto, Canada: Oxford University Press.

Najavits, L. M., Weiss, R. D. & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *The American Journal on Addictions, 6*(4), 273-283.

Nyar, K. S. (March 2012). KNU, DKBA and KNU/KNLA Peace Council find strength in unity. *Karen News*. Accessed 5/3/13 at: http://karennews.org/2012/03/knu-dkba-and-knuknla-peace-council-find-strength-in-unity.html/.

Odejide, A. O. (2006). Status of drug use/abuse in Africa: A review. *International Journal of Mental Health and Addiction, 4*, 87-102.

Odenwald, M. (2007). Chronic *khat* use and psychotic disorders: A review of the literature and future prospects. *Sucht, 53*(1), 9-22.

Odenwald, M., Hinkel, H., & Schauer, E. (2007). Challenges for a future reintegration programme in Somalia: outcomes of an assessment on drug abuse, psychological distress and preferences for reintegration assistance. *Intervention 5*(2), 109-123.

Office of Refugee Resettlement. (2012). *Fiscal year 2012 refugee arrivals*. Washington, DC: Author.

O'Hare, T., & Van Tran, T. (1998). Substance abuse among Southeast Asians in the U.S.: Implications for practice and research. *Social Work in Health Care, 26*(3), 69-80.

Partanen, J. (1991). *Sociability and intoxication: Alcohol and drinking in Kenya, Africa, and the modern world.* Helsinki, Finland: Finnish Foundation for Alcohol Studies.

Partners Relief and Development & Free Burma Rangers. (2010). *Displaced childhoods: Human rights and international crimes against Burma's internally displaced children.* Alstonville, Australia: Authors

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Payne, M. (2005). *Modern social work theory.* Chicago, IL: Lyceum Books, Inc.

Pease, B., & Fook, J. (1999). *Transforming social work practice: Postmodern critical perspectives.* London, England: Routledge.

Pedersen, E., Hsin Hsu, S., Neighbors, C., Lee, C. M., & Larimer, M. E. (2013). The relationship between collective self-esteem, acculturation, and alcohol-related consequences among Asian American young adults. *Journal of Ethnicity in Substance Abuse*, *12*(1), 51-67.

Polkinghorne, D. (1989). *Phenomenological research methods.* In R. S. Valle & S. Halling (Eds.). Existential-phenomenological perspectives in psychology: Exploring the breadth of human experience. New York: NY: Plenum Press, pp. 41-60.

Power, D.V., et al. (April 2010). Caring for the Karen: A newly arrived refugee group. *Minnesota Medicine.* http://www.minnesotamedicine.com/PastIssues/PastIssues2010/April2010/ClinicalPowerApril2010.aspx

Reichert, E. (2003). *Social work and human rights: A foundation for policy and practice.* New York, NY: Columbia University Press.

Rogler, L. H., Cortes, D. E., & Malgady, R. (1991). Acculturation and mental health status among Hispanics: Convergence and new directions for research. *American Psychologist, 46*(6), 585-597.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*(4), 325-334.

Rosenau, P. (1992) *Post-modernism and the Social Sciences: Insights, Inroads, and Intrusions*. Princeton, NJ: Princeton University Press.

Sakhong, L. (2005). *Federalism, constitution-making, and state building in Burma.* D. C. Williams & L. H. Sakhong, (Eds.). Designing federalism in Burma. UNLD Press.

Saladin, M. E., Brady, K. T., Dansky, B. S., Kilpatrick, D. G. (1995). Understanding comorbidity between PTSD and substance use disorders: two preliminary investigations. *Addictive Behaviors, 20,* 643–655.

Sales, J. M., Brown, J. L., Vissman, A. T., DiClemente, R. J. (2012). The association between alcohol use and sexual risk behaviors among African American women across three developmental periods: a review. *Current Drug Abuse Review, 5*(2), 117-128.

Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: Contributions of pre-migration and post-migration experience. *Australian and New Zealand Journal of Psychiatry, 45,* 299–307.

Shrestha, N. M., Sharma, B., Ommeren, M. V., Regmi, S., Makaju, R., Komproe, I., et al. (1998). Impact of torture on refugees displaced with the developing world. Journal *of the American Medical Association, 280,* 443-448.

Sideris, T. (2003). War, gender and culture: Mozambican women refugees. *Social Science & Medicine, 56*(4), 713-724.

Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *Journal of Nervous and Mental Disease, 187*(4). 200-207.

Soussoua, M. Craig, C. D., Ogrenc, H., & Schnakd, M. (2008). A qualitative study of resilience factors of Bosnian refugee women resettled in the southern United States. *Journal of Ethnic and Cultural Diversity in Social Work, 17*(4), 365-385.

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

Stewart, S. H. (1996). Alcohol abuse in individuals exposed to trauma: A critical review. *Psychological Bulletin, 120*(1), 83-112.

Strathdee, S., Stachowiak, J. A., Todd, C., al-Delaimy, W. K., Wiebel, W., Hankins, C., & Patterson, T. L. (2006). Complex emergencies, HIV, and substance use: No "big easy" solution. *Substance Use and Misuse, 14*, 1637 – 1651.

Steel, Z., Silove, S., Bird, K., McGorry, P., & Mohan, P. (1999). Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants. *Journal of Traumatic Stress, 12*(3), 421–435.

Sulaiman-Hill, C. M. R., & Thompson, S. C. (2012). "Thinking Too Much": Psychological distress, sources of stress and coping strategies of resettled Afghan and Kurdish refugees. *Journal of Muslim Mental Health, 6*(2), 63-86

Tempany, M. (2009). What Research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: A literature review. *Transcultural Psychiatry, 46*(2), 300-315.

Thai Burma Border Consortium. (2011). *Burmese border displaced persons: January 2011*. Bangkok, Thailand: Author.

Thai Burma Border Consortium. (2012). *Program Report 2012: January to June.* Bangkok, Thailand: Author.

Thomas, L. R., Donovan, D. M., Sigo, R. L. W., Austin, L., Marlatt, G. A., & The Suquamish Tribe. (2009). The community pulling together: A tribal community–university partnership project to reduce substance abuse and promote good health in a reservation tribal community. *Journal of Ethnicity in Substance Abuse, 8*(3), 283-300.

Tomlinson, K., & Brown, S. A. (2010). Self-medication or social learning? A comparison of models to predict early adolescent drinking. *Addictive Behaviors, 37*(2), 179-186.

Trimble, M.D. (1985). Post-traumatic Stress Disorder: History of a concept. In C.R. Figley (Ed.), Trauma and its wake: The study and treatment of Post-Traumatic Stress Disorder. New York: Brunner/Mazel. Revised from Encyclopedia of Psychology, R. Corsini, Ed. (New York: Wiley, 1984, 1994).

Ungar, M. (2002). A deeper, more social ecological social work practice. *Social Service Review , 76*(3), 480-449.

United Nations General Assembly. *Convention relating to the status of refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189. Retrieved from: http://www.unhcr.org/refworld/docid/3be01b964.html.

United Nations High Commissioner for Refugees. (2007). *Comprehensive Plan addressing the needs of displaced persons on the Thailand/Myanmar (Burma) border in 2007/2008.* Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees & World Health Organization. (2008). Rapid assessment of alcohol and other substance use in conflict-affected and displaced populations: A field guide. Geneva, Switzerland: Author.

United Nations High Commissioner for Refugees. (2009). *UNCHR global report 2009: Thailand*. Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees. (2010). *Statistical yearbook, 2010.* Geneva, Switzerland: Author.

United Nations High Commissioner for Refugees. (2011a). *Myanmar*. Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees. (2011b). *Thailand*. Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees. (2013a). *UNHCR Global Appeal 2013 Update: Myanmar.* Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees. (2013b). *UNHCR Global Appeal 2013 Update: Thailand.* Geneva, Switzerland: UNHCR.

United Nations High Commissioner for Refugees. (2013c). *UNHCR Statistical Online Population Database*. Data extracted: 03/01/2013 www.unhcr.org/statistics/populationdatabase.

United States Department of State (2012). *Background note: Burma.* Available at http://www.state.gov/r/pa/ei/bgn/35910.htm.

Van Der Kolk, B. (1989). *Psychological trauma.* Arlington, VA: American Psychiatric Publishing.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, Ontario, Canada: The University of Western Ontario.

Vonnegut, K. (1969). *Slaughterhouse-five, or, the children's crusade: A duty-dance with death*. New York, NY: Delacorte Press.

Walters, K. L., Simoni, J. M., & Evans-Campbell, T. (2002). Substance use among American Indians and Alaska natives: incorporating culture in an "indigenist" stress-coping paradigm. *Public Health Reports, 117*(1), 104-117.

Weaver, H., & Roberts, B. (2010). Drinking and displacement: A systematic review of the influence of forced displacement on harmful alcohol use. *Substance Use and Misuse, 45*(13), 2340-2355.

Weinberg, N. Z., Rahdert, E., Colliver, J. D., & Glantz, M D. (1998). Adolescent substance abuse: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(3), 252-261.

Weinstein, H. M., Dansky, L., & lacopino, V. (1996). Torture and war trauma survivors in primary care practice. *Western Journal of Medicine, 165*, 112-118.

Weissbrodt, D. S., Aolain, F. N., Fitzpatrick, J., & Newman, F. (2001). *International human rights: Law, policy and process.*

Westermeyer, J., Lyfoung, T., Neider, J. (1989). An epidemic of opium dependence among Asian refugees in Minnesota: Characteristics and causes. *British Journal of Addiction, 84*, 785-789.

Westermeyer, J. (1993). Substance use disorders among young minority refugees: Common themes in a clinical sample. *NIDA Research Monograph, 130*, 308-20.

Whitbeck, L. B., Adams, G. W., Hoyt, D. R., & Chen, X. (2004). Conceptualizing and measuring historical trauma among American Indian people. *American Journal of Community Psychology*, *33*(3-4), 119-130.

World Health Organization. (2011). *Global status report on alcohol and health 2011*. Geneva, Switzerland: Author.

Wronka, J. (2008). *Human rights and social justice.* Thousand Oaks, CA: Sage Publications.

Xiong, S., Finn, L., & Young, T. (2013). Unique sleep disorders profile of a population-based sample of 747 Hmong immigrants in Wisconsin. *Social Science & Medicine*, *79*, 57–65.

Yee, B. W., & Nguyen, D. T. (1987). Correlates of drug use and abuse among Indochinese refugees: Mental health implications. *Journal of Psychoactive Drugs*, *19*(1), 77.

Zaw, A. (June 2008). *Operation delta.* Irrawaddy Delta Newspaper. Available at http://www.irrawaddy.org/print_article.php?art_id=12595.

Appendices

Appendix A: Consent Form for Focus Groups: Minnesota

INTRODUCTION
The purpose of this document is to invite you to participate in a research study developed by Jennifer Simmelink, and to tell you about the possible benefits and risks if you decide to participate. This documentation of your consent to participate in this study is required by law.

PURPOSE OF THIS RESEARCH
You are invited to participate in a study to help understand how Karen refugees talk about, think about, and experience the use of drugs and alcohol in their community. The purpose of the study is to learn more about what Karen refugees think are the causes, effects, benefits and problems associated with drugs and alcohol in the Karen community. This information will help to develop ways of helping individuals and their families so that they may experience a more successful resettlement in this country. The principal investigator of this study is Jennifer Simmelink. Jennifer is a doctoral student in the Department of Social Work at the University of Minnesota and is conducting this research as a student researcher.

DESCRIPTION OF THE RESEARCH
If you agree to be in this study, you will be asked to participate in a one to two hour focus group with 5 to 7 other Karen refugees of your similar age and gender. A focus group is a group of people of similar backgrounds who meet together to discuss a specific topic. If the group agrees, the focus group will be tape recorded to better document what you are saying.

CONFIDENTIALITY
The records of this study will be kept private. In any report that might be published, you will not be identified. Records will be stored securely and only the researcher will be able to see them. Papers with your name on them will be kept in a locked file cabinet. The interpreters for this group have agreed to keep everything you say confidential and not tell it outside of this group. It is important that participants in the group agree to keep everything said in the group confidential, but it is impossible to prevent other people in the group from disclosing personal information outside of the group.

BENEFITS AND RISKS
The questions you will be asked might be personal. As a result you may have painful memories. For example, as you start to talk about these things you may feel sad. It is not likely that this will be too distressing but if it is, the focus group will be stopped and you will be provided with necessary help. You are welcome to review the questions if you wish. It is impossible to completely prevent the possible disclosure of personal information outside the group.

MANDATED REPORTING

There is a possibility that your answers would require the researcher to break confidentiality. This would happen if it appears you are a danger to yourself or someone else. If needed, immediate action will be taken to assure your safety by referring you to someone who can help. Child abuse or elder abuse must be reported to state authorities.

COMPENSATION/COST

You will be given a $10 gift card to a grocery or other store for completion of this focus group.

CONTACT PERSONS

The primary researcher conducting this study is: Jennifer Simmelink at the University of Minnesota. You may ask any questions you have now. If you have questions later, you may contact Jennifer by phone at 612-625-1220. You can also contact Jennifer's advisors, Elizabeth Lightfoot at 612-624-4710 or Liz Wieling at 612-625-8106.

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, contact the Research Subjects' Advocate, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; or by telephone at (612) 624-1650. You may make any inquiries or report complaints about this study to the University of Minnesota's Human Subjects and Protection Board.

VOLUNTARY PARTICIPATION

You are volunteering to be in this study. You may choose not to be in this study or you may choose to start and then decide to stop at any time. If you choose not to be in this study, it will not affect your relationship with any Karen or other social service agencies or with others involved with the research project.

CONSENT

I have read all of the above information, asked questions, and received answers to things I did not understand. I willingly give my consent to participate in this study. Upon signing, I will receive a copy of this consent form.

_____

Name of Participant

_____ _____

Signature of Participant Date

I confirm that I have personally explained the nature, purpose, duration, and foreseeable benefits and risks of the trial to the participant (or if applicable, the participant's legal representative) named above.

_____

Name of person who administered consent

_____ _____

Signature Date

Appendix B: Interview Guide for Focus Groups: Minnesota

Thank you for agreeing to participate in this focus group. Today I want to ask you questions about how your community thinks and feels about drugs and alcohol, your thoughts about why people use drugs and alcohol in your community, and possible impacts on family and community relationships. You do not have to talk about your own or your family's drug and alcohol use. Rather, I am interested in learning about drug and alcohol use in the community as a whole. I want to learn about these things so that I can help Karen people in the United States be healthy and improve resettlement experiences.

1. What do people in the Karen community think about drug and alcohol use? How do people in the Karen community feel about drug and alcohol use?
    a. How do men, women and youth think differently?
    b. Do people think/feel differently in Burma, in the camps and in Minnesota?

2. How (in what ways, for what purpose) do people in the Karen community use drugs and alcohol? What kinds of drugs and alcohol do people use? When do they use it?
    a. Do men, women and youth use drugs and alcohol the same or differently?
    b. Do people in Burma, the camps and Minnesota use drugs and alcohol differently? What are the differences?

3. Why do people in your community use drugs and alcohol? (probing questions include asking about factors like trauma, resettlement stress, and acculturation and meaning of use related to these different factors)
    a. Do men, women and youth use drugs and alcohol for different reasons?
    b. Do people in Burma, the camps and Minnesota use drugs and alcohol for different reasons?

4. What happens when people in your community use drugs or alcohol? What are the problems or benefits of using drugs or alcohol?
    a. Do men, women and youth have different problems or benefits?
    b. Do people in Burma, the camps and Minnesota have different problems or benefits?

5. How does drug and alcohol use affect families and other relationships in the community?

6. What influences people to use or not use drugs or alcohol?

7. What would help people stop using drugs or alcohol?

Appendix C: Consent Script for Thailand

INTRODUCTION
I would like to invite you to participate in a research study developed by me, Jennifer Simmelink, and to tell you about the possible benefits and risks of participating. After I tell you all of this information, I will ask you if you want to participate in this study.

PURPOSE OF THIS RESEARCH
The purpose of this study is to help understand how Karen refugees talk about, think about, and perceive the use of drugs and alcohol in their communities. The purpose of this study is to learn more about what Karen refugees think are the causes, effects, benefits and problems associated with drugs and alcohol in the Karen community. This information will help to develop ways of helping individuals and their families address drug and alcohol use.

DESCRIPTION OF THE RESEARCH
If you agree to be in this study, you will be asked to participate a one to two hour interview or in a one to two hour focus group with 5 to 7 other Karen refugees of your similar age and gender. A focus group is a group of people of similar backgrounds who meet together to discuss a specific topic. If you agree, the interview will be tape recorded to better document what you are saying.

BENEFITS AND RISKS
The questions you will be asked might be personal. As a result you may have painful memories. For example, as you start to talk about these things you may feel sad. It is not likely that this will be too distressing, but if it is, the interview will be stopped and you will be provided with the necessary help. You are welcome to review the questions if you wish.

CONFIDENTIALITY
The records of this study will be kept private. In report that might be published, you will not be identified. Records will be stored securely and only the researcher will be able to see them. Papers with your name on them will be kept in a locked file cabinet. The interpreters for this interview/group have agreed to keep everything you say confidential and not tell it outside of this group. It is important that participants in the group agree to keep everything said in the group confidential, but it is impossible to prevent other people in the group from telling information outside of the group.

CONTACT PERSONS
The primary person doing this study is Jennifer Simmelink. You may ask any questions you have now. If you have questions later, you may contact Jennifer by email at simm0055@umn.edu. You can also contact Jennifer's advisor, Elizabeth Lightfoot by email at elightfo@umn.edu.

VOLUNTARY PARTICIPATION

You are volunteering to be in this study. You may choose not to be in this study or you may choose to start and then decide to stop at any time. If you choose not to be in this study, it will not affect your relationship with any social service agencies or NGOs involved with the research project.

Appendix D: Interview Guide for All Interviews: Thailand

Thank you for agreeing to participate in this conversation. Today I want to ask you questions about how your community thinks and feels about drugs and alcohol, your thoughts about why people use drugs and alcohol in your community, and possible impacts on family and community relationships.

1. Please tell me a little bit about yourself—where you are from, your family background,

2. How do you think drugs and alcohol are affecting the refugee community? Individuals, families and communities?

3. What do people in the refugee and migrant communities think and feel about drug and alcohol use? How do people talk about it?

4. What are the reasons that people use drugs and alcohol? What reasons prevent people from being able to stop or make it difficult to stop?

5. What are the differences in the ways that men and women use alcohol and drugs? What are the differences in the ways that men and women feel or think about drugs and alcohol? If men and women are different, why is this?

6. What are the good things and bad things about using drugs and alcohol? What are the differences between a person who does not have problems using alcohol and a person who does? How are individuals, families and communities affected by drug and alcohol use?

7. What has been done in the past to help someone who has problems with alcohol or drugs? What is being done now?

8. How difficult or easy is it for someone to change? How difficult or easy is it for someone to stop using drugs or alcohol if they are having problems with it?

9. What types of things do you think would help people to stop using drugs and alcohol?

Appendix E: Data Analysis Steps

STEPS	ACTION
1	Read through all Minnesota transcripts of group interviews to get a sense of the whole
2	Read through all Minnesota field notes and memos to get a sense of the whole
3	Read through all Minnesota text again to develop codes and finalize a codebook
4	Coded all Minnesota text using codebook
5	Developed themes for Minnesota data, incorporating reflexive and theoretical memos and field notes to support thematic and categorical analysis
6	Ongoing consultation with academic advisor who also served as data content and process auditor
7	Read through all Thailand transcripts of group interviews to get a sense of the whole
8	Read through all Thailand individual interviews to get a sense of the whole
9	Read through all Thailand memos and field notes to get a sense of the whole
10	Read through Thailand group interviews again to develop codes
11	Read through Thailand individual interviews to further develop codebook
13	Coded all Thailand text using codebook
14	Developed themes for Thailand data, incorporating reflexive and theoretical memos and field notes to support thematic and categorical analysis
15	Ongoing consultation with academic advisor who also served as data content and process auditor
16	Compared Minnesota and Thailand categories and themes, noting similarities and differences
17	Integrated data—categories and themes—that appeared similar across geographic locations and added themes that were location-specific
18	Conducted member checking
19	Conducted peer review with cultural liaison
20	Assessed representational weight of themes with group interviews from both locations
21	Assessed representational weight with individual interviews, noting where individual interviews added depth and weight to focus group themes and/or areas of difference
22	Ongoing consultation with academic advisor who also served as data content and process auditor

Appendix F: Categories, Themes and Sub-themes

Domain: Karen Experiences and Perceptions of Alcohol Use after Conflict-Related Displacement		
Categories	**Themes**	**Sub-themes**
Reasons for Alcohol Use	Appropriate reasons for using alcohol	Drinking alcohol for health or medicine
		Drinking alcohol in the "old way"
	Inappropriate reasons	Drinking to forget loss and difficult emotions
		Drinking because they follow their heart
		Drinking to feel free
		Drinking just because they want to
		Men drink because they are men
		Drinking is caused by the Burmese government
		Drinking to deal with the Burmese government
		Drinking to get rid of fear
		Drinking because of friendship
		Drinking because of conditions in refugee camps
		Drinking because of resettlement stress
Consequences of Alcohol Use over the Limit	Fighting and violence are consequences of drinking too much	Family violence is a consequence of drinking too much
	Health problems are a consequence of drinking too much	
	Problems with laws and rules are a consequence of drinking too much	
	Addiction is a consequence of drinking too much	
Beliefs about Alcohol Use	Alcohol is good, but people choose to use it wrongly	
	Alcohol use changed after displacement because the culture was broken	
	People learn how to drink	
	There is a culturally appropriate limit to alcohol use	
	Some Alcohol Use is an Abuse of	

	Culture	
	Alcohol Use is a Serious Problem in the Karen Community	
Ways of Stopping Alcohol Use	It is a personal choice to stop drinking	
	People stop drinking because of health concerns	
	People stop drinking when they start thinking about other people	
	Education will help people to stop drinking	
	The community is responsible to help people stop drinking	
Women's Ways of Using Alcohol	Women do not use alcohol as much as men	
	Women's reasons for using alcohol	Women drink to feel equal to men
		Women drink to get revenge on their husbands for drinking
	Women's consequences of alcohol use	When women drink their children suffer
		When women drink they are at risk for sexual violence
	Women are hopeless that men will ever stop drinking	
Youth's Ways of Using Alcohol	Youth's reasons for using alcohol	Youth use alcohol to fight with each other
		Youth use alcohol to experiment with it
		Youth use alcohol because of broken hearts
	Youth have lost their culture	