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Understanding Alcohol Use in the Karen Refugee Community: A Qualitative Study

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Abstract

A recent study suggests refugee populations may be at greatest risk for alcohol abuse (Ezard, 2011). Concern is growing for the Karen refugee community in St. Paul, Minnesota in regards to alcohol use and misuse. This qualitative study assessed the perspectives of community members and providers related to alcohol use in the Karen community. The study also assessed the quality of alcohol-related educational and treatment opportunities for Karen community members. Ten Karen community members, seven providers of Karen descent, and eight non-Karen providers were interviewed. The interviews were transcribed and coded and themes were identified. *Alcohol abuse, lack of educational and treatment resources, and alcohol-related domestic violence* were the three themes consistent across participant groups. Karen community members also identified *pre-arrival drinking as a reason for alcohol misuse* and *alcohol-related violent behavior* as major themes. Karen providers identified two additional major themes: *alcohol-related illegal activity* and *cultural beliefs as an explanation for alcohol abuse*. Additionally, non-Karen providers identified *deficiency in identifying alcohol abuse* and *alcohol-related difficulty resettling*. Alcohol abuse was acknowledged as a problem within the Karen refugee community, with few educational resources to prevent and reduce alcohol abuse, as well as few treatment resources to alleviate alcohol abuse. Alcohol-related domestic violence and illegal activity themes demonstrate a need for alcohol abuse education, and also education about the laws pertaining to alcohol use. A culturally appropriate screening tool to screen for alcohol abuse is needed, in addition to culturally appropriate and language appropriate education and treatment opportunities.

Background

Global Alcohol Use and Misuse

Excessive drinking is associated with several short-term and long-term health risks in both men and women, including intentional and unintentional injuries, liver disease, cardiovascular disease and cancer (CDC, 2010). The World Health Organization estimates approximately 2.5 million individuals die due to the harmful use of alcohol worldwide each year (WHO, 2011). The significant number of deaths due to alcohol use contributes to 3.8% of deaths globally each year, and to the loss of 4.6% of disability-adjusted life-years (Rehm, 2009). A recent global study determined that the highest prevalence of alcohol-use disorders were in Southeast Asia, the Americas and the western

Pacific region, raising concerns for these regions as high risk regions for alcohol-related injury and disease (Rehm, 2009).

In addition to lives lost and increased morbidity, alcohol use contributes to increased health-care and other economic costs in developing and high-income countries. In 1998, the United States contributed 12.7% of health-care costs to managing health issues attributed to alcohol (Rehm, 2009). The Centers for Disease Control and Prevention (CDC) estimated that the costs of excessive drinking in the United States were as high as 223.5 billion dollars in 2006. Seventy-two percent of the costs resulted from losses in productivity in the workplace, 11% of the costs were due to health care expenses, 9% were attributed to criminal justice and law enforcement expenses, and 6% were due to motor-vehicle crashes (CDC, 2011). The CDC estimated that the cost of excessive drinking was \$746 per person in 2006. Trends show that typically men from ages 18-34 binge drink more than other ages or genders, and individuals with an income above \$75,000 are more likely to binge drink than those with lower incomes each year.

Alcohol Use and Misuse in the United States

Alcohol consumption and negative health effects associated with drinking alcohol are common in the United States and make up a significant proportion of the burden of disease. In 2011, approximately 65% of individuals drank in the past year, and 7.5% of the United States reported having an alcohol use disorder (WHO, 2011). In recent national surveys, 92% of individuals who drink excessively reported binge drinking (5 or more drinks in two hours for men, and 4 or more drinks in two hours for women) in the past 30 days (CDC, 2010). Seventy-five percent of alcohol consumed in the United States is consumed in the form of binge drinking. Binge drinkers are 14 times more

likely to report driving while under the influence of alcohol and are also at higher risk for many other alcohol-related injuries and diseases (CDC, 2010).

Foreign-born United States Residents and Alcohol Use

Foreign-born immigrants and refugees are a population within the United States that may be particularly vulnerable to alcohol use and misuse. Recent studies show that individuals of various ethnic backgrounds who were displaced due to conflict may be at a greater risk for harmful patterns of substance use, including alcohol use, compared to American-born residents (Ezrad, 2011). In one study, external and internal factors, such as displacement, difficulty assimilating to a new culture, and livelihood restriction, were identified as influencing alcohol use. Additionally, limited access to health services was recognized as a determinant of substance and alcohol misuse (Ezrad, 2011).

Evidence of excessive alcohol use and alcohol disorders is seen in a number of refugee populations relocated to the United States. Ugandan refugees reported more alcohol abuse in one qualitative study when compared to U.S.-born residents (Muhwezi, 2011). D'Avanzo and associates (1997) found that Cambodian refugee women living in Massachusetts and California reported using alcohol to deal with nervousness, stress, pain and insomnia. Additionally, men were found to be more likely to abuse alcohol or have an alcohol disorder than women in the same population (D'Avanzo, 1997).

However, the research findings of alcohol use among refugees are not consistent across different refugee populations. A recent study found that Cambodian refugee participants reported a low level of alcohol use and reported less frequent drinking than American-born residents (D'Amico, 2007). Similar findings were observed in a study of

Arab Americans, showing that Arab Americans were less likely to have issues with alcohol abuse and less likely to consume alcohol than U.S.-born residents (Arfken, 2011).

These findings demonstrate there may be differences in issues of alcohol use across different refugee and immigrants groups, supporting the need for further research on alcohol use in refugee communities and on the risk of alcohol use in certain refugee populations. Furthermore, the social issues and health concerns related to alcohol use may also vary across refugee populations, so further studies are needed to appropriately diagnose the level of alcohol use and related problems in particular refugee populations.

New arrival health screenings are recommended by the Centers for Disease Control and Prevention to appropriately screen and diagnose refugees for various health concerns upon their arrival to the United States. New arrival screenings are federally funded health physicals available to all new arrival refugees entering the United States. The new arrival screening guidelines currently have no tool to screen for alcohol use, although it is encouraged in the mental health screening guidelines to ask about alcohol use (CDC, 2011). Recent studies suggest that refugees who have special health concerns, such as alcohol abuse, often lack adequate and culturally appropriate resources for these health concerns (Weinstein, 2000). As a result, further research is necessary to determine whether or not alcohol use and misuse is being detected in newly arriving refugee populations, and if the associated health concerns are being addressed.

Theoretical Framework

According to the Acculturation Model of substance use, as foreign individuals become assimilated to the culture of their new country, they adopt the social norms of that culture (Johnson, 1996). If the cultural norms surrounding alcohol or substance use

are more lenient in their new home, there is a greater potential for substance misuse by the immigrant populations, including refugee populations (Johnson, 1996).

The Acculturative Stress Model supports a similar concern for displaced and immigrant individuals (Ausebel, 1960). The Acculturative Stress theoretical model suggests that the stress of acculturation, especially when coping resources are difficult to access or are unavailable, contributes to the increased misuse of substances (Ausebel, 1960)

Both of these theoretical models emphasize the potential risk for alcohol abuse among displaced individuals, especially refugees who arrive to the United States after living in significantly different conditions. Additionally, refugees endure a significant number of stressors prior to United States arrival, such as witnessing traumatic events and torture, which amplify stressors associated with acculturation to a new culture and way of living (Gonsalves, 1992).

Karen Burmese Refugees

The Karen people are one of eight main ethnicities in Burma and make up 5-10% of Burma's diverse population. Karen ethnic cleansing and oppression by the Burmese government began when Burma declared independence from Great Britain after World War II, on January 4th, 1948. The Karen people felt abandoned by their former British allies, so the Karen people sought to gain ethnic autonomy from the Burmese government (Dwe, 2009). During this civil war, Karen men and women were internally displaced and often forced to escape to the jungles of Burma, engaged in combat, and were tortured.

The Karen National Union (KNU) recently found peace in their home country of Burma after enduring torture and ethnic cleansing for over 60 years (BBC, 2012). The

Burmese government signed a ceasefire with KNU in January 2012. However, prior to this agreement, 451,000 Karen individuals were internally displaced in Burma, and nearly 135,000 of the displaced Karen resided in refugee camps in Thailand along the Thai-Burmese border (IRC, 2009).

In June of 2009, the number of resettled Burmese refugees, a large portion of those Karen, reached the 50,000 mark, making the Burmese refugee resettlement program the current largest resettlement program in the world (UNHCR, 2009). Karen refugees started to arrive in St. Paul, Minnesota in 2000, and a large influx of Karen refugee resettlement began in 2004 (Power, 2010). Since 2000, nearly 5000 to 6000 Karen refugees have resettled in Minnesota, with the highest concentration in the city of St. Paul. It is estimated that 90% of Karen refugees in Minnesota now reside in Ramsey County (Minnesota World Relief, 2011). Approximately 835 Karen refugees resettled in Minnesota in 2010, 36% of all new arrival refugees in Minnesota, making Karen refugees the largest refugee population that resettled in Minnesota that year (MDH, 2012). An unknown number of Karen refugees have arrived from other states within the United States, known as secondary refugees, adding to the 5000 to 6000 refugees who have resettled in Minnesota (Power, 2010).

Evidence of Alcohol Misuse Among Karen Refugees

A recent report on Thailand refugee camps housing thousands of Burmese refugees showed that alcohol negatively impacts the incidence of domestic violence, and violent behavior and aggression within this population. The report also showed that alcohol is a growing concern for adolescent refugees (UNHCR, 2007). Another study found that alcohol was the most important public health and social concern in Thailand

refugee camps (Ezard, 2011). Most men were suspected of drinking alcohol, and alcohol use was described as culturally appropriate and accepted within the camps. Screening and a brief pilot program addressing detected alcohol misuse was shown to be effective in one of the Karen refugee camps, Mae La refugee camp, in Thailand (Ezard, 2010). However, the level of alcohol use in the Karen population living in the United States is not well documented. New arrival screenings do not require screening for alcohol use, and there is not a known resource for the Karen population if an individual within that community is identified as having an alcohol dependence disorder.

In Minnesota, a recent study found that Karen refugees view alcohol use as a private activity, making it difficult to know the level of alcohol use occurring in the Karen population (Glass, 2011). Researchers estimate that 25% of resettled Karen adults in St. Paul drink alcohol, but the number may actually be higher due to under-reporting (Power, 2010). Furthermore, the level of alcohol abuse and the extent of alcohol use for each individual within the community are unknown (Glass, 2011). These findings suggest that a lack of screening and a deficiency in culturally appropriate alcohol screening tools have not been effective in identifying alcohol misuse in the Karen community, and that further research is needed to identify the level of alcohol use.

The International Institute of Minnesota, which dedicates federal funding and services for Karen refugee health and resettlement, was the first to investigate the occurrence of and reasons behind alcohol abuse in the Karen community. The Institute's recent study identified potential predictive determinants for alcohol abuse through in-depth interviews with leaders in the Karen community. Poor mental health, loss of identity, and alcohol consumption norms in Thai refugee camps were suggested to be

potential mediators for alcohol abuse in the target population (Glass, 2011). These findings support the Acculturation and Assimilation Models of alcohol misuse as a result of stressors in transitioning in resettlement, as well as a change in cultural norms regarding alcohol use as a mediator for alcohol abuse. The evidence suggests alcohol abuse is a recent and undocumented health concern for the Karen community, and there is a need to further investigate the potential mediators of alcohol use in the community.

Previous studies have not only shown that Southeast Asian refugees are at higher risk for abusing alcohol in order to cope with the stress and mental unease of their past in refugee camps, but they also show that alcohol is seen as a substance with healing properties rather than as a harmful drug (D'Avanzo, 1997; Makimoto, 1998). Therefore, it is imperative to assess the level of alcohol abuse amongst Karen refugees, as well as determine community beliefs regarding alcohol use.

Purpose of Current Study

The purpose of this study was to assess awareness and perspectives related to alcohol use in the Karen refugee population in St. Paul, Minnesota. This study sought to understand the community beliefs regarding alcohol use and the understanding of alcohol misuse and the health consequences of alcohol misuse. The study also sought to better understand the extent of alcohol use identified by Glass and associates (2011) by determining the perceptions of the amount of alcohol use in the Karen community.

As previously mentioned, Ezard and associates (2011) found that decreased access to health services was a determinant of alcohol abuse in refugee communities. Another purpose of this study was to assess the availability of resources for alcohol abuse and alcohol use education in order to understand if decreased access to these resources

may be contributing to alcohol abuse in the Karen community. This study also examined the quality and appropriateness of available services and educational resources for the Karen community.

Upon arrival to the United States, Karen refugees undergo several new arrival health screenings by providers at clinics. Despite the recommended new arrival health screenings by the CDC, a past study suggests that there is still a need for a tool to clinically identify and assess substance abuse in Southeast Asians (O' Hare, 1998). Due to the growing numbers of Southeast Asians, particularly Karen refugees, in St. Paul, Minnesota, it is necessary to evaluate the extent to which providers are aware of alcohol use in the Karen community and how they become aware of alcohol use. It is also important to determine what is being used to educate the Karen community if alcohol abuse is identified. This study assessed whether providers are aware of alcohol use in the Karen community and how providers become aware of this use.

This study focused on assessing these objectives:

1. Assess awareness and perspectives about alcohol use in the Karen refugee population in St. Paul, Minnesota.
2. Understand the perceptions of alcohol abuse and dependency in the Karen community.
3. Examine the quality and cultural appropriateness of alcohol education and informational resources provided and available to the Karen refugee population in St. Paul, Minnesota.
4. Examine health care provider perspectives and awareness of alcohol use in the Karen refugee population of St. Paul, Minnesota.

Methods

Participants

Health care and service providers were recruited from clinics and organizations that provided direct health and human services to new arrival refugees. Once clinics and service organizations were identified as organizations that work closely with the Karen community, the organization directors were contacted for permission to recruit provider participants. Clinic and social service directors either permitted contact directly with providers for recruitment, or directors contacted providers themselves to find providers willing to participate. A snowball sampling technique was used after initial provider interviews. Interviewed providers gave recommendations for other providers who work with the Karen community and who might be willing to participate.

Fifteen health care and social service providers were interviewed: six primary care physicians, two licensed social workers, a Ramsey County home care visitor, two social service providers, and four clinical interpreters. Of the 15 providers, seven were Karen and the other eight providers were not of the Karen ethnicity. Three of the seven Karen providers were Karen community leaders. The Karen community leaders were identified as individuals who are members of the Karen community and are recognized and respected as community members who provide guidance, knowledge and assistance the Karen community. Seven of the health care and service providers were women and the remaining eight provider participants were men. Recruitment for provider interviews was terminated when saturation was reached for Karen community health care and service providers. Saturation was determined as the point when multiple participants repeated interview content and responses.

Karen community members were recruited from English as a Second Language (ESL) classes at Vietnamese Social Services (VSS). A Vietnamese Social Services director was contacted prior to recruitment in order to receive permission to recruit community members. Karen community members were recruited using convenience sampling. The director of the ESL program at VSS recruited participants over the legal drinking age of 21 from classrooms over several weeks until saturation was reached. Participants were selected based on their willingness to participate in a recorded interview regarding alcohol use in the community. Ten Karen community participants were interviewed. The three men and seven women who were interviewed were between the ages of 21 and 65. The Karen refugee participants varied in the length of time they had lived in the United States ranging from nine months to four years.

Study Design

A cross-sectional, qualitative study was implemented to address the study objectives. This project was conducted through the International Institute of Minnesota, a refugee resettlement voluntary agency located in St. Paul, MN, in collaboration with the Center for Regional and Urban Affairs (CURA). The Institutional Review Board of the University of Minnesota approved the study and procedures.

Data Collection

Data were collected through recorded semi-structured interviews. Interviews with health care providers were recorded and transcribed for coding. Karen community interviews were facilitated by the principal investigator and translated by an interpreter. The facilitator asked the question in English for the recording and the interpreter translated the answers into English. The English portion of the recorded interviews was

transcribed for coding.

Analyses

Codes and themes were identified based on study objectives and what topics became evident throughout interview transcripts. Interviews with non-Karen health care and service providers were coded, and themes were identified separately from health care and service providers of Karen descent. Karen community member interview transcripts were coded and themed separately from provider transcripts as well. Coding and themes were conducted using Microsoft Office Word 2008. “Qualitative Methods in Public Health” was used to guide qualitative methodology and analysis (Ulin, 2005).

Codes and Themes

Key words and phrases identified as similar were combined into a code. Codes were identified by reading through transcripts several times and by searching key words and phrases in the transcripts. Themes emerged by combining similar or related codes. Codes were determined to be significant enough to be placed into themes semi-quantitatively. If a large proportion of participants in the respective groups mentioned the code in the interview, and if the code was mentioned a number of times within the interviews, the codes were kept to use for themes. Codes mentioned only a few times and within only a few interviews were not considered significant and were left out of further analysis.

Thirty-four codes were identified in the Karen community member transcripts, and five major themes emerged from these codes. Thirty-nine codes were identified for Karen health care and service providers. Of those thirty-nine codes, twenty-nine were kept for inclusion for the five major themes identified. Forty-four codes were identified

in the transcripts for non-Karen health care and service providers. Twenty-four codes were further analyzed to identify five major themes.

Results

Themes Identified by all Interview Groups

Three major themes were consistent across participant groups. *Alcohol abuse recognized as a health concern* in the Karen community; *lack of educational resources and treatment opportunities*; and *alcohol-related domestic violence and abuse* were the three themes identified by all three groups.

Alcohol Abuse Recognized as a Health Concern

Participants identified alcohol abuse in the Karen community as problematic and a health concern for the community. All but one of the Karen community members stated that they thought drinking is a problem in their community, primarily among adolescent and adult males. One woman described the Karen community's perspective on alcohol use in the following way:

People in our community see that drinking is bad because it affects people all around us....Usually people who drink I see most men drink more than women and I don't see women often and usually people start drinking age 20 or higher, but people start drinking at age 15 now.

Several participants described people they knew who had difficulty with quitting drinking. Karen health and service providers described the same concern. As indicated by one Karen provider, youth drinking is particularly a problem:

Like, adult, adult that is not over 70, and young teenagers are drink a lot too. Karen, now we do have a lot of populations are growing so alcohol is a big concern to our community because alcohol is everywhere. I think some of them cannot be without alcohol but I don't think they think it is a disease or that it is addicting to them.

Non-Karen providers identified similar concerns for alcohol use as an issue for

the Karen community based on their work with this population. They stated that alcohol contributes to alcohol-related problems in this community. As one of these participants indicated:

We've had difficulty putting our finger on how much an issue or problem, we haven't been able to quantify in any way, but anecdotally it's a problem. I think it ties in with family violence, and some domestic violence. Several of our patients have had legal issues mainly related to a DWI.

Lack of Educational Resources and Treatment Opportunities

The second major theme that emerged from the interviews across all groups was the desire for more educational and culturally appropriate resources about the harmful health and behavioral consequences of consuming alcohol, as well as education regarding the laws that pertain to alcohol use. Additionally, providers mentioned an insufficient number of treatment opportunities for individuals struggling with alcohol abuse or chemical dependence in the Karen community.

Each of the Karen community members interviewed stated that they were given no information on alcohol or alcohol use when asked what kind of information they received while living in the United States. Several interviewees did not understand basic laws related to drinking. One participant said:

[My husband's] friends say that its ok if you drinking and then you drive, it's no problem, but one time the police get [my husband] and tell him you can drink but you can't drive so the police put him in the jail for two days and nobody tell me about it so I didn't know where he was.

Karen providers felt a similar need for more resources in educating their community and new arrival refugees:

I think we should have more resources and more knowledge to the community. Then it's not just drinking but also how [drinking] is going to

affect their family about drinking. So I think if we have more resource and knowledge and classes that we can address to our community.

Non-Karen health care and service providers shared similar views on the need for more resources, as well as a lack of education regarding laws related to alcohol:

There also seems to perhaps be a lack of general understanding of even the basics, like it's not good to drive after you've been drinking or things like that. So there's a lot of issues we haven't been able to pinpoint or quantify very well. Also there are not resources out there, so we've sort of been looking for where's a resource that is culturally competent and language appropriate help for people and families struggling with alcohol.

Alcohol-related Domestic Violence and Abuse

Another theme that emerged across all sample groups is the problem of domestic abuse that occurs while men in the community have been drinking. One woman explained that domestic abuse was occurring in the Karen neighborhood she lives in as a result of drinking. She recounted two different instances where abuse occurred in her apartment building:

In my opinion if people limit drinking beer that would be good because some people, first of all in my apartment, one man when he drinking he abuse his wife. Where I live, [another] man often do that when he drinking he is fighting with his family.

Karen providers stated that domestic violence towards women is a concern. For example one participant stated:

I heard about the alcohol once from the woman and said that the husband is drinking, drunk and abuse—like he thought something wrong with the wife—and he hit her. When he drink he is very bad for his wife, throwed everything around and throwed everything at his wife.

Non-Karen providers explained that one of the major ways they heard about alcohol abuse in the Karen community was as a result of treating women who were victims of alcohol-related assault:

So there's been issues with domestic violence within the community. When we see the victim then, we learn that the perpetrator is under the influence of alcohol at the time of the assault or that there's an ongoing alcohol problem and things like that.

Themes Identified by Individual Interview Groups

Two additional themes were identified for each participant group. Additional major themes for the Karen community participant group were: *pre-arrival drinking as a reason for alcohol misuse* and *alcohol-related violent behavior*. Two additional major themes for the Karen health care and service provider group were: *alcohol-related illegal activity* and *cultural beliefs as reasons for alcohol abuse*. Finally, the two additional major themes for the non-Karen provider group were: *deficiency in identifying alcohol abuse* and *alcohol-related difficulty with resettlement*. Each of these is described below.

Karen Community Member Themes

Members of the Karen refugee community, who are not providers, identified two themes not identified by other interview groups. The Karen refugee community identified drinking prior to coming to the United States in the refugee camps in Thailand and drinking in their home country of Burma as a reason for the level of drinking after resettlement to the United States:

Back in the camp I see people drinking about two or three times a day. [The drinking] is the same in the United States but they do it in the apartment.

This group also identified physical fighting and violence as another theme. As described by one participant:

They drink too much so they don't notice themselves and they want to fight other people. Also a lot of the time people will ruin stuff in the apartments or anything that's in the house.

Karen Health and Service Provider Themes

Karen community members who provide health services to their own Karen refugee community mentioned alcohol-related illegal activity as an issue, which often involved law enforcement:

When they have problem [with drinking], sometimes the kids will call the police, sometimes the wife will call the police, or they drink and drive and the police will see them already. After that they have to involve with the police for a long time.

Another theme found in the data from the Karen providers was reasons why the Karen community uses alcohol. Several complex reasons were also mentioned, specifically related to cultural beliefs and the belief that drinking alcohol will help with the stress of resettlement. As stated by one participant:

They usually use alcohol when they have a dead body or a newborn. The other thing is traditional, they believe it is to cure the disease and prevent disease. They keep it and use it especially when they have pressure or a chronic disease—chronic pain—trouble sleeping, especially men they use alcohol when they have trouble with income or with family.

Non-Karen Health and Service Provider Themes

Each of the providers of non-Karen ethnicity indicated that there is a deficiency in identifying alcohol abuse in the Karen community because of a lack of effective, culturally appropriate screening tools and the overwhelming number of unmet basic health needs of new-arrival refugees:

We're not screening effectively for actual alcohol abuse. They arrive and we're just trying to deal with all their immediate problems, and then we could implement more screenings for [alcohol] if we had a [screening tool] that was validated and found to be effective.

Alcohol-related difficulty resettling emerged as a theme due to the comments and concerns for Karen community members who are drinking due to difficulties with

acculturation and transitioning from refugee camps to the United States:

Certainly when they arrive here, there is acculturation issues, and that's a huge understatement—it's culture shock beyond our understanding—of course that's going to play into [drinking], and then PTSD depression with self-medication through alcohol.

Discussion

A persistent theme across all of the participants and groups was that there is alcohol abuse and misuse within the Karen community in Minnesota. This theme is an indication that the Karen community is at risk for alcoholism and alcohol dependency. Karen community members stated they are well aware of alcohol abuse in their community. All individuals interviewed expressed a concern for their community, especially concern for the male adults and adolescents. Indications of alcohol abuse and misuse in the male Karen community supports similar findings that often men in refugee communities struggle with alcohol abuse upon resettlement in the United States (D'Avanzo, 1997).

Findings from this study also indicate the lack of culturally appropriate educational resources available to the Karen community regarding alcohol use and misuse. All Karen community members interviewed confirmed that during their time living in the United States they had not received any information on alcohol, the effects of alcohol use, or the concept of alcohol being addictive. Providers openly acknowledged the deficiency in resources and educational opportunities for this specific refugee population, specifically due to other unmet health needs and due to the fact that the Karen population is a new refugee community to the United States. Several providers expressed a desire for culturally appropriate educational literature or classes to educate

new-arrival Karen refugees.

Alcohol-related domestic violence was an unexpected theme that emerged from the interviews with providers and Karen community members. Almost every account given by a provider or Karen refugee described the perpetrator of domestic abuse being under the influence of alcohol, and all accounts described the husband abusing his wife or children. Domestic violence creates an unhealthy living environment for refugee families already struggling with alcohol abuse. One challenge is that alcohol abuse often only became evident to providers after treating a Karen woman who reported her husband hits her while intoxicated. Providers and community members also provided evidence of law enforcement involvement as a result of domestic violence in the Karen community, which makes acculturation even more difficult within the family, the Karen community, and the St. Paul community.

Providers and community members provided insight to help explain why alcohol abuse is occurring in the Karen community. Karen community members described that community members generally began drinking in Burma and the Thailand refugee camps due to the fact that there was little to do. Karen community members explained that this habit has persisted upon resettlement in the United States, and that community members tend to feel that there is more alcohol available and alcohol is more accessible.

Providers suggest that mental health issues and difficulty coping may be influencing alcohol misuse. This idea is supported by the study by D'Avanzo and associates (1997) that found that Cambodian refugees drank to cope with stress, pain and insomnia. These symptoms are often implications of underlying mental health issues such as depression and post-traumatic stress disorder, suggesting alcohol use may be a

means of coping for an underlying health issue (Lindstrand, 2006). These findings support the Acculturative Stress Model, which proposes that the stress of resettlement contributes to alcohol use and misuse (Ausebel, 1960).

American-born providers indicated it is very difficult to identify and screen for alcohol abuse in the Karen community because of the overwhelming number of basic health needs among members of this community. Another complication is that even if individuals from the Karen community are identified as having an alcohol-related problem, there are no culturally competent resources available to help them. Without referral opportunities for chemical dependency or alcohol abuse, the providers struggle to provide adequate health care services and the Karen community members continue to struggle with alcohol abuse.

Recommendations for the Karen Community

As emphasized by providers and community members, there is a strong need for alcohol abuse prevention and control in the Karen community. Culturally appropriate educational materials are necessary to inform the Karen community about the harmful effects of alcohol consumption, the addictive qualities and dependency of drinking, as well as the laws regarding alcohol use. Several Karen providers described that Karen community members are often illiterate and do not speak English, so having multiple sources of information, written and oral, will help the community in understanding the laws, resources, and potential problems related to alcohol use.

Alcohol and chemical dependency programs are unavailable for the Karen community. Providers emphasized that chemical dependency programs and group therapy meetings are in English and do not allow interpreters into the meetings for

confidentiality purposes. As a result, there are minimal referral opportunities for the Karen community. Culturally and language-appropriate programs are needed for the Karen community for treatment of alcohol abuse and dependency. Providers also explained that churches and Karen community leaders are strong connections for Karen community members. Therefore, educational resources may be effectively disseminated in churches or through Karen community leaders.

Further research is needed to develop a culturally appropriate screening tool for health care and service providers to effectively identify alcohol abuse and misuse in the Karen community. The U.S. Preventive Services Task Force recommends screening assessments and surveys should be used in order to reduce and help to prevent alcohol abuse (U.S. Preventive Services Task Force, 2004). Providers of Karen descent explained that the Karen language does not have words for “alcohol”, “alcoholism”, “chemical dependency”, or words pertaining to mental health issues. Community members also do not quantify drinking in the same way, and often used two fingers to describe the volume of beer or hard alcohol consumed. Tools created to screen for alcohol abuse should take into account differences in language, quantification, as well as cultural beliefs of drinking alcohol.

Limitations

This study has a few limitations. A recommendation for qualitative research is to present study findings with study participants. Study participants remained anonymous throughout the study, making it difficult to present the study findings with participants to confirm accuracy of the findings. Credibility is defined as the confidence in the truth of the findings, and is strengthened by confirming findings with the participants. Thus, the

credibility of this study may be weakened.

Another limitation is that because of limited resources, only one person identified codes and themes. Multiple coders are used to crosscheck findings and are important for establishing dependability, defined as reliability of qualitative research findings and the ability to replicate the results of the study (Ulin, 2005). However, an advantage is that only one person conducted the interviews, ensuring more consistency across data collection.

The transferability of this study is limited due to convenience and snowball sampling being used as sampling methods. Transferability denotes the generalizeability of the qualitative findings to the entire Karen population and other refugee populations (Ulin, 2005). Transferability may have been improved if Karen community members interviewed were not all from the same ESL course at the same adult learning center.

Conclusion

Despite a few study limitations, the findings of this study are significant for identifying the needs of the community in regards to alcohol use. The study results confirmed a suspected alcohol abuse problem within the Karen refugee community, and a need for resources and treatments. Alcohol-related domestic violence and other alcohol-related problems like drinking and driving are major concerns consistently identified throughout the study. It is important that alcohol abuse and related problems are addressed in a culturally appropriate way and as quickly as possible to decrease further distress and difficulties for the Karen community, and to alleviate health, social, and financial issues related to alcohol abuse. To effectively address the problems, culturally appropriate educational materials, screening instruments, and intervention and treatment

programs need to be identified or developed. In order for the Karen refugee community to effectively transition from the difficult lifestyle in the refugee camps to the United States, alcohol use must be considered as a pertinent health concern in addition to other typical health issues affecting refugee populations.

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