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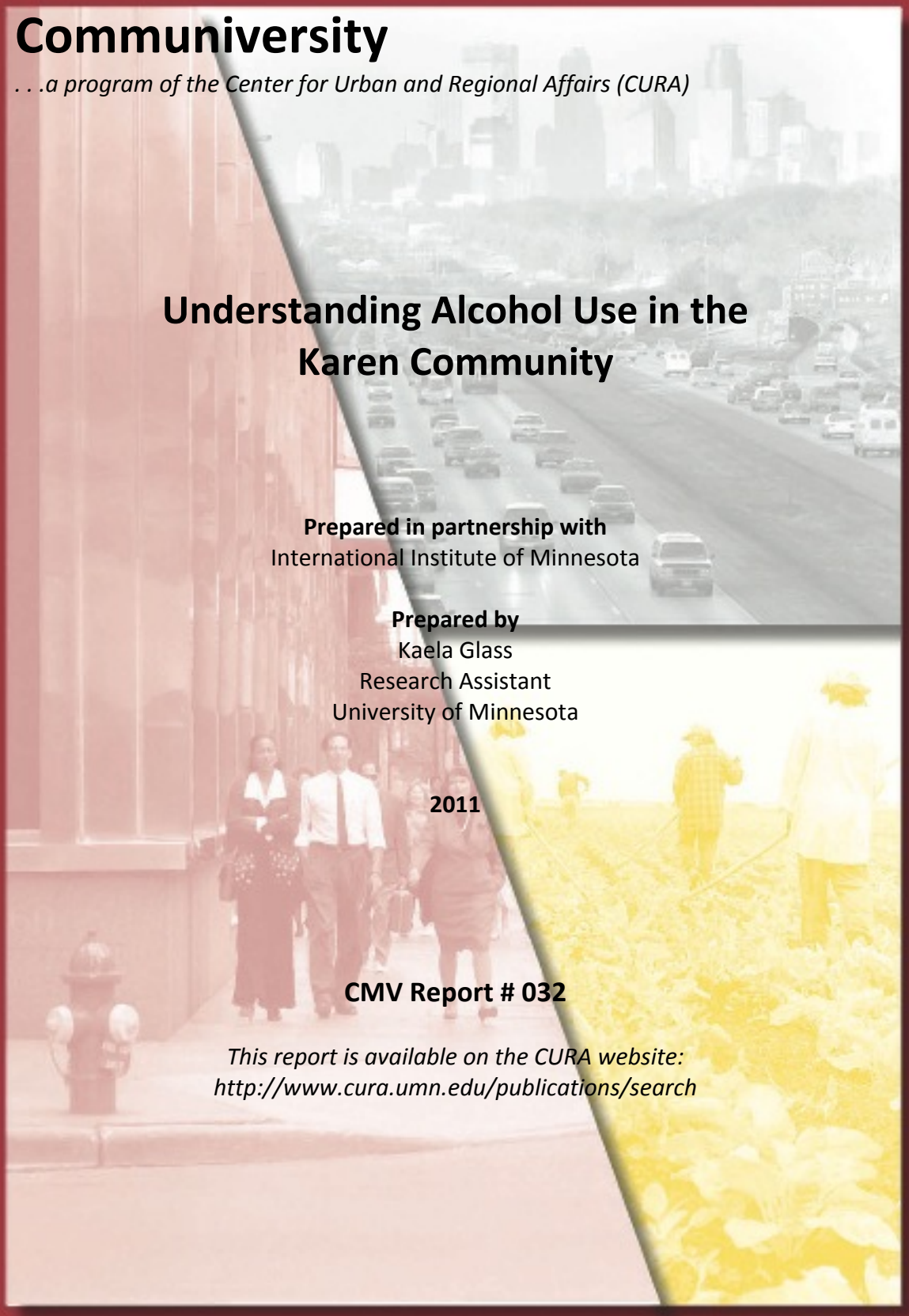

Understanding Alcohol Use in the Karen Community

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EXECUTIVE SUMMARY

Project Goals: This project sought to open up a discussion and dialogue around the emerging issue of alcohol use in the Karen community in the Twin Cities. The main goal was to gather insight into the scope of alcohol use in the Karen community, the cultural attitudes and beliefs surrounding alcohol use, and the problems and consequences stemming from overuse. After collecting this data, the study hoped to produce community-identified recommendations on how to address the problem.

Methods: The study consisted of 13 semi-structured, in-depth interviews with individuals or groups. Interviews were conducted with Karen community leaders, Karen community members, and service providers who work with the Karen community in an effort at triangulating emergent themes. The qualitative data that was collected was coded according to the methods of grounded theory to produce a conceptual understanding of alcohol use in the Karen community.

Findings: The data collected through this study highlighted and provided a better understanding of five main themes surrounding alcohol use in the Karen community: reasons for use; the hidden nature of the problem; differences between the Karen and U.S. social and cultural understanding of alcohol; consequences of alcohol use; and lack of access to resources, treatment and support programs. These themes were then used to guide recommendations targeting the areas, as identified by the community, that would be most important to address when planning programs or interventions around alcohol use. Possible options and recommendations include: convening a community forum around alcohol use for the Karen and service providers; education on the legal uses and consequences of alcohol in the U.S.; Alcoholics Anonymous and Al-Anon groups; Karen support groups for men and women; and a screening tool to detect alcohol use and prevent future alcohol related consequences.

Key words: Karen refugees, alcohol use, social and cultural understanding of alcohol, Minnesota, qualitative research

BACKGROUND

KAREN REFUGEES FROM BURMA

Source: U.S. Department of State, Bureau of East Asian and Pacific Affairs, 2010.

Burma[1], a small country in Southeast Asia currently governed by an oppressive military regime, is the site of one of the longest-running civil wars in the world today. Throughout the civil war the Karen, one ethnic group of over 100 within Burma, have faced extreme persecution by the Burmese military causing massive dislocation and high numbers of political and economic refugees (Nieman, Soh, & Sutan, 2008). Ethnic nationalities, including the Karen, have been in constant armed conflict with the Burmese military for many years. As the government army continues its campaign to bring the country under its strict control and subject minority ethnic groups to numerous human rights abuses, internal displacement from forced migration and refugee outflows are widespread (Ramchandani, 2006). A substantial number of these refugees have fled into neighboring Thailand, with more than 150,000 people inhabiting more than nine refugee camps along the Thai-Burma border (U.S. State Department, 2003). Additionally, Thailand hosts an estimated one million people from Burma who live outside of the country's refugee camps.

[1] Two names, Burma and Myanmar, are used to refer to the same country. The name Myanmar comes from the Burmese language and has been criticized for reflecting the marginalization of ethnic minorities by the Burmese military junta. In this report, the country is referred to as Burma, the title used by the U.S. government as well as the majority of the Karen people (Power, et al., 2010).

Ethnic minorities in the refugee camps in Thailand (and other camps in Malaysia) are primarily categorized under the Priority 2 refugee status. This designation, given by the United Nations High Commissioner for Refugees (UNHCR), identifies specific groups as being in special need of resettlement. Recognizing Burmese and Karen refugees as Priority 2 means these groups are of great humanitarian concern due to past persecution and the high possibility of future mistreatment and oppression. In fiscal year 2008, the U.S. resettled 18,139 people from Burma, making up 30.14% of all refugees resettled that year (United States Department of State, 2010).

Of the refugees from Burma that are resettled in the U.S., the Karen ethnic group makes up the majority of this population. They also represent the vast majority of Burmese refugees resettled in Minnesota, and more specifically in the Twin Cities Metro area. Currently, some refugee resettlement agencies that accept refugees from Burma are only accepting people of Karen ethnicity, playing a large role in increasing this group's overall representation in the area.

THE KAREN IN MINNESOTA

According to the Minnesota Department of Health, from January 1979 through March of 2011, Minnesota resettled 3,319 primary refugees from Burma (Minnesota Department of Health, 2011) (see appendix I). Additionally, when you add the number of secondary arrivals (refugees who have moved to MN from another state) the total number of Karen is between 5,000 and 6,000 people. Although there are people from many different Burmese ethnic groups, it is estimated that 75% to 95% of the Burmese in Minnesota are Karen; of which 90% are settled in Ramsey County (Power, et al., 2010). Minnesota has seen the Karen refugee population increase dramatically in the past few years. In 2009 there was a total of 1,265 refugees resettled in Minnesota, 440 of which were from Burma (representing 34.8% of the total resettled population). Of these 440 Burmese refugees, 434 were resettled in Ramsey County. Looking at the International Institute of Minnesota (IIMN) in 2010 the organization resettled a total of 525 refugees. Of these 525, 180 were from Burma, making up 34% of IIMN's resettled population (see appendix II).

PROJECT PURPOSE

As identified above, large numbers of Karen refugees resettling in the Twin Cities has prompted service providers and refugee resettlement agencies and caseworkers to assess the resettlement experience of this growing population. Because the goal of IIMN and other resettlement agencies is to help refugee clients achieve "self-sufficiency", one of their top priorities is decreasing the barriers that inhibit clients from achieving this goal.

Concerned that alcohol use is a possible barrier to self-sufficiency, many service providers have identified high alcohol use within the Karen community as negatively impacting the stability of their clients. Clients already struggling to meet the financial demands of paying for rent, groceries, childcare and transportation find it difficult to remain self-sufficient when a high percentage of limited disposable income is spent on alcohol. Although many providers have informally communicated about alcohol use within this community and identified it as an area of concern, there isn't any information available that describes the scope of the problem or how to address it in a culturally appropriate manner. This project seeks to fill part of this gap in information by gathering insight into the scope of the problem, the cultural attitudes and beliefs surrounding alcohol use, problems stemming from overuse, and community-identified recommendations on how to address it.

RELATED LITERATURE

The relationship between alcohol use and refugee status has been correlated in many studies with different refugee groups. In her article, "Are refugees at increased risk of substance misuse?" Sowey explains that "stressors experienced by refugees in the areas of trauma, loss, adjustment and disadvantage" place refugees at an increased risk for mental health problems, which in turn increases their risk for substance misuse (2005). Not only do refugees face difficulties associated with a major life change and the struggle to adapt to life in a new country, they must also confront the additional burden of coming to terms with their forced relocation. When settling into the host country, "refugees may feel uprooted, homesick and acutely aware of the loss of social networks". In this situation it can be difficult to maintain traditions and rituals from the home culture, resulting in the loss of traditional social controls like those surrounding the acceptable use of alcohol (Sowey, 2005).

Loss of status is another change often undergone by Southeast Asian refugees that resettle in the U.S. Oftentimes men lose the ability to be the sole supporter of the family, potentially causing disruption of family relationships and leading to substance use or abuse. Differences in family roles and family structures, redefinition of the family unit and responsibility to family also add to the stress of resettlement, possibly heightening the risk of substance use (Hickey, 2005).

Similarly, due to difficulties in accessing health care in the home and resettlement countries, refugee communities may turn to traditional health methods and healing techniques that include using alcohol or other substances. It is also important to note that alcohol use is influenced by "how individuals approach and grapple with differences between the cultural beliefs and traditions represented by the birth culture and those encountered in the host society" (Hickey, 2005).

In terms of responding to alcohol use within refugee communities, the literature suggests that service providers play a vital role in assisting refugees to: decrease alcohol abuse and dependence; decrease alcohol-related problems; and find better coping strategies to address the stress of migration and acculturation (NIAAA, 2004). As far as treatment options Sowey states, "Treatments needs to address four factors: "failure in personal adaptation, family disintegration, environmental isolation, and existential crisis" (2005).

This general review of alcohol use in refugee communities highlights many of the same issues uncovered by this study with the Karen. When examining alcohol use and forming possible solutions to address it, it will be important to keep this literature in mind, yet the unique cultural and traditional beliefs of the Karen refugee community paired with their distinct experience in the Twin Cities will be the underlying foundation that informs any intervention or treatment.

METHODOLOGY

This study used grounded theory methodology to gather and analyze qualitative data to identify themes and patterns of Karen alcohol use and generate a conceptual understanding of the issue. It was most appropriate to use a non-representative convenience sample, employing the snowball sampling technique to identify a broader base of participants. Key community leaders, identified by staff at IIMN, were the initial participants of this study. Other participants, including service providers, other community leaders and community members, were referred by study participants or

identified through the author's research of community resource databases. All study participants were voluntary and signed written informed consent forms.

The author conducted 13 scheduled, in-person, semi-structured interviews either with individuals or groups of two. Interviews were conducted between January 22 and April 7, 2011. The interviews were recorded and transcribed verbatim with the signed permission of study participants. The comparative data analysis method used to code transcriptions was consistent with the methods used for discovering grounded theory. This method pulls out emerging categories and constructs by finding cause, context, dimensions, correlations, consequences and relationships among categories (Glaser & Strauss, 1967). Level 1 codes were formed using the exact words of participants, preventing preconceived impressions from influencing the data. After the level 1 coding process, data was reorganized into coding tables and marked with level 2 codes. Level 2 codes elevated and condensed level 1 codes into a smaller set of categories. Finally, level 2 codes were organized and grouped into level 3 codes to identify overall themes and patterns.

LIMITATIONS

Based on the small sample size and non-random sampling method used for this project, the results and findings cannot be extrapolated or generalized to represent the views and experiences of all Karen refugees resettled in the U.S. or Minnesota, or all refugee resettlement service providers. Furthermore, the author did not develop broad theoretical guidelines behind the phenomenon as it was outside the scope of the project. What the research and project does provide is the beginning of a dialogue that can identify: trends in alcohol use; the Karen community's perception and identification of the problems associated with alcohol use; and thoughtful recommendations on how to address this problem using a community-centered approach. Throughout the interview process every participant, both Karen community leaders and service providers, identified the need for community-wide conversations around this issue. This study represents an initial step of this larger process.

FINDINGS

RECOGNITION OF A PROBLEM

After hearing multiple instances of the negative consequences of alcohol use within the Karen community, yet not finding any resources, materials or literature offering insight or knowledge on this issue, the project supervisor formulated this study as a means of filling the gap in information. Interviewing service providers, Karen community leaders and Karen community members, reaffirmed that alcohol use is a concern for the Karen community that doesn't currently have an adequate response. One provider, who used to work primarily with other refugee groups but estimates that 70% of her current clients are Karen, stated that it seemed unusual that so many cases of Karen using alcohol had come up in her short time working with the community. Her self-described "first reaction" when asked to be interviewed for our project was, "Thank goodness. I'm glad you are looking at it." Similarly, another provider stated, "I realize that there are a lot of folk in the Karen community that are dependent upon alcohol to a greater and lesser extent." A third participant said she believes the Karen have a "serious drinking problem here in this country." Based on these responses, it became clear that the gap in knowledge and information was deeper than the study had originally anticipated, making it all the more relevant and timely.

THEMES

The author of this report and the research supervisor used a systematic coding analysis to determine five major themes that best encompassed the vast amount of qualitative data that was collected. Readers should note that although the data is split into themes, each theme does not represent a discrete category. Many of the issues identified below cut across themes and are woven together so tightly that teasing them apart can hide their compounding impact. The purpose of creating themes was to guide recommendations on the most pertinent areas, as identified by the community, which would need to be addressed when planning programs or interventions around alcohol use.

I. REASONS FOR USE

Many participants pointed to alcohol use in the Karen community in the U.S. as being partly dictated and influenced by experiences in the home country and the environment of the refugee camps. It is important to understand that Karen refugees that are resettled in the U.S. have typically spent many years (one participant was in a refugee camp for 19 years) in Thai refugee camps before resettlement. Within the camps, alcohol is very accessible and oftentimes made by the refugees themselves. One participant explained that many Karen children grow up in the camps where, contrary to the Karen State in Burma, alcohol becomes "familiar" to children at a very young age. He explained that in this context, "Alcohol is like a social treatment for the Karen community in refugee camps in Thailand," and is a large part of the culture of the camps.

Multiple participants also shared that it is common for the Karen in Burma to use smaller amounts of alcohol to improve physical health.

> We can use alcohol like medicine; it's good for our health. We can use alcohol to help health, but if we use a lot it's not so good. Sometimes they [Karen in Burma] use it for health, for pain. If they use drugs they don't get any pain.

Similarly, another participant stated that the Karen used alcohol as medicine in "the genocide in Burma". "[We use alcohol] because we don't have Western medicine. So when you feel cold, you can drink a little bit to make yourself hot. Another use is when you have dysentery you can drink a little bit, not too much, to make the body warm." Examining alcohol use from this perspective, as a matter of health and medicine, provides insight into one of the reasons why some Karen refugees may show high rates of alcohol use even when resettled in the U.S.

Many participants also responded that alcohol is used to feel less stress and less emotional pain. "Some of the people they use [alcohol] when they have stress; they use alcohol and then they feel less…Like release their body." This participant went on to say that alcohol is used in Karen society and the Karen community to forget painful past experiences. "If you get stressed or depression, [alcohol gives you] the chance to forget the past." Another participant noted similar reasons for using alcohol. "Some people died in the genocide. That means they [those that have survived] have a lot of strain. They kind of feel nothing; just use alcohol to relax the mind."

Service providers and mental health professionals understand this connection to stress and tend to agree with the assessment that alcohol use can stem from trauma. One participant explained,

> There is a lot of pain in those transitions. All the people that are coming, whether they realize it or not, are victims of torture and have been forcibly removed from their homes. Some of them have witnessed or experienced terrible things that would be very understandable causes to begin drinking or continue drinking.

Furthermore, as another participant pointed out, Karen refugees experience a triple trauma. Trying to resettle in a new country has come after leaving homes and family members behind and living in refugee camps for ten, fifteen or twenty years. She explained, "From a mental health perspective, traumatic events change the nervous system and keep people at a higher level of arousal. And alcohol is used across all cultures to medicate that stress response." Another participant shared a similar idea. "When we did the focus groups for a mental health project, I heard that because Karen people have a long history of war and a lot of people get stressed, that's why they drink a lot of alcohol."

Consistent with the literature on alcohol use in refugee communities, these responses show the complex physical, cultural, and emotional interaction that play a role in determining alcohol use. It also reiterates the need for treatments and responses to address these Karen specific uses and understanding of alcohol.

II. A HIDDEN PROBLEM

Alcohol use in all communities is a multifaceted, sensitive and dynamic issue that often surfaces as something else, if it surfaces at all. Alcohol use is a problem that often remains hidden and secret, is highly stigmatized and difficult to address appropriately. Presently it seems as if using alcohol is an unacceptable behavior among the Karen, influencing people to keep it hidden and not talk openly about it.

> In Karen culture in Burma, if the family, either of the parents or the father, the husband, uses alcohol, the community will look down on them. You know culturally and in Karen society and in Burma, it's kind of like a stigma. In Burma people who use alcohol, society [and] the community will push people away from that person.

One provider anecdotally described this phenomenon of hiding alcohol use by talking about one of the first community health gatherings that she planned for the Karen. She said she can distinctly remember a man who spoke for five or seven minutes, weaving alcohol use into all sorts of other issues.

> Again it's woven in; it's always woven in. It's never talked about up front, it's always woven into another issue or a broader issue. So either the broad issue of mental health, or it's woven into the youth situation…just all of these different concerns. It's never really talked about. It either comes up, like I say, hidden or woven in…sort of like a bullet point under a larger problem.

Other participants agreed with this idea that alcohol is a hidden problem, one that you only "hear about" but can never confirm. One person said, "They don't talk about it. It is more like a secret." Another participant described it as "more of a non-spoken theme" throughout the community. Another person recounted that even in informal social situations, there was a strong stigma around those who use alcohol. "It was clear that [using alcohol] was not acceptable under any circumstances, and we were in a very informal situation. They may have shame related to even social use." This participant added that if the community had a more open approach to alcohol it would be healthier, allowing the problem to be addressed and treated rather than kept as a secret taboo.

> It's a changing dynamic. A lot of the younger folks are different than the very very traditional. And a lot of the younger folks in any community don't have the same definition anymore of what it means [to use alcohol]. And I think they [other refugee communities] see it as much healthier to be open and that it would be harder to be closed off about it; like it's a healthier thing to be able to maybe have a glass of wine in a social setting and at weddings and things.

Another participant agreed that it is the strong community stigma that keeps alcohol use hidden.

> Everyone knows about it, but it is an unspoken but very well known secret. There is a lot of shaking of heads and it is this kind of open shameful secret that continues to be perpetuated. Some of what I perceive is a sense of judgment: it's bad, it's wrong, it's not what our culture teachers, it's not what our faith teaches.

His sense is that the prevailing attitude in the Karen community is not one of the disease model, but still has more to do with moral failing. "There is a lot of shame and guilt around it. I think we are dealing with a problem that one, is very shame based, and two, it is seen as a moral failing

rather than as a physical disease." Perhaps it is the shameful, guilty and moral underpinnings that keep alcohol use secret, forcing it to remain under the surface rather than be addressed. This participant went on to say, "If we can reduce somewhat the stigma attached to it" the community would be more open about the problem and individuals would be more likely to get help when necessary.

III. DIFFERENCES IN SOCIAL AND CULTURAL UNDERSTANDING OF ALCOHOL

Of the themes discovered within the qualitative data collected through this project, differences in Karen and US culture and laws was the widest reaching and most persistent. Participants repeatedly identified three areas of misunderstanding or need. First is adjusting to the U.S. laws governing alcohol use, which were described as being much stricter than in Burma and refugee camps. Second, participants overwhelmingly agreed that there is a general lack of understanding about appropriate alcohol use in the U.S. And third, participants unanimously agreed that the Karen community needed to be educated about U.S. laws to address this lack of understanding.

One participant talking about Karen traditional use of alcohol said that before his community came to the U.S. or were in refugee camps they lived free in the country-side where drinking alcohol didn't result in such negative consequences as it does here. Culturally, alcohol was used during festivals, ceremonies, and celebrations and was given to the whole family, "even to the baby they give alcohol; a little bit, little bit." Another participant echoing this idea, stated, "the problem is that over there [in Burma] they live free. In Burma, they drink…and if they feel dizzy they just stay home or lie down somewhere." These traditional uses and learned behaviors continue to influence use here in the U.S., even though they may be incompatible with the new environment.

Alcohol use is not only influenced by these cultural beliefs, but also by different societal understandings of use that guide perceptions of what is acceptable and allowable for different situations. Likewise, laws governing alcohol use in the US are much different, and in many cases stricter, than in Burma and the refugee camps in Thailand.

> The laws in the U.S. are different than Asian countries. I would say even Burma, and refugee camps, and Thailand the laws aren't the same. They are completely different than in America. You can drink alcohol everywhere in Asia, like Burma or Thailand or refugee camps, even under the tree or in the street. You don't get any disturbance unless you make trouble. But in America, it's hard. You have a lot of rules and regulations. It is completely different here.

When discussing frequency of alcohol use, some participants felt that use in the Karen community in the U.S. was the same as in Burma, the only difference being the laws. "It is different; if you drink here you cannot walk on the street. In our country, you can bring [alcohol with you] and you can walk on the street." Another participant seconded this idea. "We don't have .0 and .5. Whatever you want, you can drink. The alcohol you can buy easily from the villages or from Thailand. There is no limit."

As a natural problem stemming from different laws and social guidelines around alcohol use, there is also a lack of understanding and knowledge of the legal consequences. One participant said she believes people don't understand much about rules in the U.S. There is a "lack of knowledge and awareness about the law and the restrictions here in this country about drinking. They just go ahead and drink. They don't care. They don't know." Another participant stated that in addition to not understanding the rules and regulations, Karen people "don't understand the legal consequences" that go along with them.

This is especially true around driving. "In Thailand [and Burma] you drink, you drive. Nobody arrests you. They don't have any specific rules for drinking alcohol. But here people have to face rules, laws." Another participant expressed the opinion that some Karen think driving and drinking are rights and freedoms in the U.S., unaware that the two freedoms can have dangerous consequences when exercised in combination. "They think this is our right and they drink and drive. And that is why we try to help them, so they understand that when you drink you cannot drive. I think the other thing is they think this is a free country; that is why they drink a lot." Furthermore, driving isn't very common in Burma and even less so in the refugee camps, whereas in the U.S. driving is often necessary and an important part of the culture. "Here they [the U.S.] have a lot of laws. When they [the Karen] drink in Burma you don't have to drive, so you cannot get in accidents, which affect all of your family. And here, you will affect other people."

There is also some speculation about what types of drinks are identified as alcohol by newly resettled Karen. Two participants wondered whether the Karen see beer and wine as alcoholic drinks.

> One thing that has become particularly clear to me, particularly for new refugees, is that they don't identify wine and beer as alcohol. So when they are picked up for a DWI[2] and they have been drinking beer they don't understand. That tells me there is an education piece that needs to be addressed initially.

Another recurring theme was lack of understanding of the physiological impacts of alcohol. "There seems to be a huge ignorance about the effects of alcohol and the impact of alcohol on the body." Another participant echoed that concern, expressing that some Karen do not understand the idea of blood alcohol levels. Without the learned behavior or belief structure that understands the effects of alcohol on the body, it is understandable that some Karen don't understand the need to prohibit alcohol use while and before driving.

Lack of understanding and lack of education around alcohol are resulting in the Karen seeking help and services after they are in trouble or have experienced negative consequences. In many cases, people that are getting help and education around alcohol use are doing so to fulfill legal requirements.

> What we are experiencing here is that they are coming because they are court ordered. Most recently, there are some court ordered demands on some of these people and they need to get to some kind of meeting and they need to get some papers signed if they are ever going to get out from under this sentence.

Another participant related that it is only "when alcohol interferes with the law" that it comes to the surface and is addressed.

IV. CONSEQUENCES

One startling piece of evidence uncovered from these interviews was the negative consequences, personal, familial, and community, resulting from alcohol misuse. In most cases, it seems to be the Karen women bearing the highest burden and receiving the least amount of support.

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[2] Participants in this study did not distinguish between DUIs and DWIs. Therefore, quotations used throughout the report are verbatim. The author also did not distinguish between DUIs and DWIs.

Participants also expressed concern for the future of the community should these behaviors and their consequences continue.

Surprisingly, it seems to be Karen community members with jobs that are more likely to consume larger amounts of alcohol. "Some of the husbands they go outside and they work. When they get some money, they use [it on] alcohol." Another participant reiterated this thought. "The challenge is that most of the people who drink are working people because they have money." One participant said that typically, alcohol consumption is low when people first arrive, but increases after a short time in the U.S. "When they were here first they didn't drink because they didn't know where to buy. After they're here for like a month, they get a job so they can [pay] rent and then they start drinking because they know how to get it."

Similarly, service providers and community members are seeing Karen families face financial hardships due in part to high amounts of income being used to purchase alcohol. One participant stated, "You get money and you don't use it for the family you use it for the alcohol." In an already resource-poor environment, in which self-sufficiency is incredibly difficult, alcohol misuse represents yet another barrier to a successful resettlement process.

> In terms of the financial consequences for the family, most of these families just have enough. A lot of times they don't even have enough. I mean if they are on MFIP, their MFIP grants often don't cover their rent even. If they are working, it's not like they still have a lot of room to maneuver. The other thing as it happened in one family was one of the men was picked up and taken to detox and there was a charge for that. Tickets, of course, if there are DWIs, which are not cheap, and missed workdays as a result of that.

Another participant said, "I've had a lot of [Karen] women tell me, well my food stamps aren't enough but my husband hasn't been giving me money for food because he is drinking it." One participant said people don't know how to check and balance their use of alcohol and the amount of money they spend on it. "They take advantage. I start seeing people after they arrive here, 2 years or 1 year, and they get a job. They don't give back money to their wives, and they are just drinking." Even when a family's main source of income is public assistance, it is often the man that controls the finances. Another participant, speaking of a client, said, "She felt that most of [the public assistance] was going towards his alcohol use and she wasn't getting enough for her and the kids and she had to kind of beg him to get any sort of income."

Additional concerns, particularly for women, are the longer-term consequences resulting from alcohol use that could cause future financial instability for the family.

> The women that I have talked to say, 'my husband is perfectly able to hold a job and go to work. But after they come back they do a whole lot of drinking and then they have these DWIs and then I'm afraid they are going to lose their jobs because they have to go to court and then they have to drive to go to work and they can't drive anymore'.

One of the most upsetting consequences revealed by participants, both men and women, service providers and community members, was the high correlation between alcohol use and domestic violence. Although they described it in different ways, every single participant said they were "hearing about it" within the community, and many expressed numerous pieces of anecdotal evidence to support and emphasize its prevalence.

One participant, tying domestic violence to alcohol use, said, "When we see a case like domestic violence, most of the violence is included with the alcohol. They hit their wives and they shout at their families. We have a lot of domestic violence." Another participant, also speaking of domestic violence and its tie to alcohol use, said, "Yeah, I think the majority of them [cases of domestic violence] are related to alcohol use. Their husbands are drinking. So yeah, very frequently that is what it is related to. Not always but frequently." One participant stated, "It's anecdotal, and it's sort of sporadic, it hasn't been with every case. Domestic violence is also one [issue] that is not talked about a lot; there is a huge amount of stigma around that."

Most participants agreed that violence and abuse to children was not happening in the Karen community, however some expressed concern about the potential for alcohol use and domestic abuse to lead to it. One participant also acknowledged that the domestic abuse between adults that is witnessed by children could have huge impacts on the children and the community as a whole.

Reinforcing the idea of women bearing the majority of the burden. One participant stated very clearly that some women have a deep desire for access to alcohol to be taken away completely.

> I know the women I have talked to wish there would be no alcohol available for the Karen. I just talked to an interpreter, a Karen interpreter, and she said if she were wealthy she would buy all the liquor stores in St. Paul and close them down. And she is

> a leader in her community and she must see way more than I do. I know it is something that is really hard for them and they are struggling quite a bit with it.

V. ACCESS TO COMMUNITY RESOURCES AND SUPPORT PROGRAMS

Based on the problems and needs identified by participants, it was troubling to hear that there are very few, if any, resources available to the Karen around alcohol use and its consequences. For the few services that do exist, many Karen and service providers don't know how to access them or what happens to clients once they are referred to a program.

Social service providers are feeling stuck without a referral system or even a single program to offer Karen clients experiencing problems with alcohol use. One participant said, "We don't have any money to serve people with alcohol [problems]." So instead, her organization tries to educate the community as best it can about using alcohol appropriately and hopes that treatment options will become more available in the near future. Another provider confirmed the idea of trying to provide education as a stopgap measure until more resources became available. Furthermore, existing organizations that serve the Karen community don't have the capacity to add yet another service into their already strained budgets. "We don't have a program to serve them about alcohol or something like that. We just focus on the next month…and just focus on how they [clients] can get a job. So we don't have the time and energy to focus on those kinds of their needs."

Another provider expressed distress and frustration about the lack of services available to his clients. "Where they can get help, they don't know. Where they can get treatment, they don't know." Having identified alcohol use as a problem, the community is beginning to feel overwhelmed that they lack the resources to address it.

> One of the issues is, so if problems are identified, what services are available? I think part of the struggle has been trying to find appropriate services and it's kind of overwhelming the system as it already is; not only for mental health services but then for substance abuse, culturally specific substance abuse programs.

Making it even more challenging are the other barriers that prevent the Karen from accessing culturally appropriate treatment options. "There is one particular client I tried to get into treatment, but it's really hard. It's difficult to get them in. There are many barriers, not only

language but transportation, whether they make it there on time, all of that stuff." This same provider when asked if she knew of any resources accessible to the Karen community that specifically addressed alcohol use responded, "No. None. No." In a more hopeful tone she went on to say, "It would be wonderful if there would be more resources." Echoing this thought, a second provider had hopes that this project would result in a concrete list of resources that could be given to the Karen and Karen service providers, as no such resource directory has yet been created. Again recalling her first community health forum, the provider described how a Karen man finished up his five-minute statement with a question.

> The alcohol specific question was sort of woven into this very long story about all sorts of other issues, but alcohol was the pervasive theme. And he was asking the same question: What can you do if you have this problem? And I remember feeling the impact of that question. And it was one of the questions that I'd say was, in my mind, one of the most serious and one of the ones I thought we didn't have a good answer for.

OPTIONS AND RECOMMENDATIONS

The five themes detailed in this report represent the largest barriers the Karen community is facing around addressing the reasons and consequences of alcohol use. Mentioned earlier, these themes will be the most important areas to address when planning a response or intervention. All of the specific recommendations offered come directly from the community and address the needs as identified by the community. Whereas alcohol use is impacting different members of the Karen community in different ways, one thing is abundantly clear: services to prevent, educate, address, and treat alcohol use are necessary and desired. When one participant was asked if services or programs to address alcohol use would useful to and used by the community, he responded, "Yes, definitely. That would be wonderful. This is the first time I have heard about an agency or community [that] wants to help [Karen] families about alcohol."

COMMUNITY FORUM

One common response when talking about what would need to happen to address alcohol use and its consequences was that the answer would have to come from the community. Programs and services imposed from outside, without the support and backing of the Karen, would be

ineffective and unsustainable. "It's got to be a Karen owned idea. This is what I am showing my people and this is what I am showing the leaders, and this is what has to happen." Resonating the need for a culturally appropriate response, another participant stated,

> I would go back to the idea of trying to draw the community together and really take a look at not just imposing, 'well here's what Americans think works with chemical dependency,' but to say culturally, how would you like to deal with this. If you can talk to the community as a whole and say, this is how families within the community are being affected and that this isn't okay. How are you as a community going to intervene with individuals within your community around these issues?

These responses attest to the strong sense of unity and responsibility that underlies the Karen community here in the Twin Cities.

> I don't think you can underestimate the power of the community with the Karen and that any solution has to come from and through the community. It is just so community oriented, this group. It's just hard for us to imagine a solution; the solution needs to be community wide. It's possible. I mean, I have seen it and I know how close the Karen are and how community oriented so many of the leaders are and self-sacrificing they are when they get behind something and when they understand it. I think this can be one of the things we make a difference on. It is going to have to be as a community [asking], 'What is going to be our attitude toward this and how are we going to deal with this?'

To gather ideas on how to pull the community together and engage people around these sensitive issues, one participant recommended a community forum.

> I think there somehow needs to be organized a community forum or some talk of drawing together various constituencies within the Karen community to talk about alcohol. I would like to see two. I would like to see one around chemical dependency, and I'd like to see one around domestic abuse. I am thinking about the Karen community itself. So pulling together leaders…to begin discussion [and] mostly to say, 'how can we call together the larger Karen community and what's an effective way to do that to educate and talk about these issues?'

She also mentioned the essentiality of involving a wide-array of community members, especially women. Gathering many community voices and hearing how this issue is impacting different people would strengthen the response and provide insight into a broader array of possible interventions. Furthermore, "a community forum would take into account cultural norms" of the community and allow the community itself to "actively make choices around these issues".

Another participant stated the need for the community to get beyond responding reactively, and instead focus on a proactive, preventive approach. "I'd rather it be proactive and get the community saying, 'we need to address this now because it is only going to get worse'." Another participant reiterated this thought. "The answer is going to be a change in the community and culture as much as individual conversion to saying I have to do something about this. That is going to take an attitude shift and a paradigm change in the whole community about what this is about."

Participants also expressed how important it would be for the Karen community to recognize the problem and express its intolerance based on the strong values and beliefs that unite them. "It is going to have to come from them saying that this is who we are, and this is who we are as a community, and this is our value and we're not going to tolerate it anymore." When the Karen community explicitly recognizes what it will accept and tolerate and what is unacceptable, community-wide change will be possible. "We don't want to see and deal with domestic violence. A lot of domestic violence happens. So that is the big issue we believe if you can do prevention then domestic violence will decrease and families will be happier." Similarly, as one participant suggested, if the community wants to look at family preservation, there will need to be some prevention that brings healing and treatment, especially to women, that will help the community adjust appropriately and successfully to life here in the U.S.

EDUCATION ON LEGAL USES AND CONSEQUENCES

Many participants in the study also recognized and emphasized the need for education. Rather than using what seems to be the more intuitive community health approach, participants thought that it would be most effective to begin with an education campaign around U.S. laws governing alcohol use and the corresponding legal consequences. This would prevent many of the negative consequences involving DWIs, and perhaps decrease the incidence of domestic violence, if people knew the possible legal consequences they pose. "Rather than interventions being really put upon them because of the consequences of DWIs and domestic abuse issues and all the other consequences there are," the intervention would focus on preventive education. Tying legal consequences to the process of becoming a permanent resident and legal citizen of the U.S.

would go far in addressing the "general sense of laxness" the community currently feels about preventing legal problems.

> What we are experiencing here is that they are coming because they are court ordered. So if you can find out what some of the legal ramifications are, or talk to somebody that says, 'Yes, I am interested in working with this group, just strictly from the law and the consequences of drinking.' So, maybe just something from the legal side of things.

Longer-term, resettlement agencies and their parent organizations must advocate for more education and screening to be done in refugee camps prior to resettlement. Providing education on the appropriate use and legal restrictions of alcohol in the U.S. would prevent many of the misunderstandings and legal trouble seen in the Karen community.

ALCOHOLICS ANONYMOUS AND AL-ANON

Five participants specifically mentioned the need and desire to provide the Karen community with a recovery program like Alcoholics Anonymous (AA). Moreover, there was a strong feeling that attaching an AA group to existing community organizations serving the Karen would provide the trusting and supportive safe-space necessary for participants to feel comfortable with the program.

During the interview period, one interviewee identified a single fledgling AA group in St. Paul specifically for the Karen. "It's not an AA group, but its kind of an orientation to and exposure to the principles of AA." Most other participants had not heard of this group or of any others in the community, and cited the need for more programs like this, as well as program materials, to be available in the Karen language. "Because of limited English, I think it would be ideal to have, whether you are having an AA group or some treatment, options for just Karen. First of all, if there was some money available to get AA materials in Karen. That is basic." One participant suggested applying for a grant to translate materials into Karen. Or, for those community organizations already providing services to the Karen, applying for a grant to add an AA program could be incredibly beneficial.

To complement the Alcoholics Anonymous programs, interviewees also recognized the need for support programs for family members and others that are not users themselves but are impacted by alcohol use. "Services like Al-Anon for the women, or for the men if it's a woman, or any other dependents, or relatives, or caregivers, is extremely critical. So at the same time the [AA] meeting might be going on, you need to have a meeting for the people that are going to have to support those folks. You need the dual model."

SUPPORT GROUPS

In addition to programs like Alcoholics Anonymous, organizing Karen specific support groups would address some of the resettlement related issues that may be correlated with alcohol use. "I think support groups work well in refugee communities. They do want to talk about it because talking about it really, really helps." Having the opportunity to normalize many of the feelings associated with resettlement and learn about the emotional cycles of the resettlement process might address some of the loss of self and loss of purpose that many participants said is leading to alcohol use. "I think it would be good to have a men's group and I think it could have a positive effect on the community, particularly if it's facilitated in a way that helps them learn some of the things they need to know about life here and [they] have a chance to talk about the issues of resettling."

When asked if Karen women would like a women's support group, one participant responded, "Yes, I think so because if someone can support them it is okay. We have a lot of women that feel like this, so if someone can support them, yeah it's okay."

SCREENING

Another proactive approach to addressing alcohol use would be the systematic screening of new arrivals.

> I think resettlement staff, job counselors, people who work with refugees in the initial year they are here, if they were trained to ask questions, to screen to look for certain things, I think it would be really helpful because I think they could step in sooner and it may be less damaging to the family.

One step in this direction is the work being done by a professor from the University of Minnesota's School of Social Work and professionals from the Center for Victims of Torture. These organizations are in the process of developing a culturally appropriate mental health screening for various refugee communities in the Twin Cities, including the Karen. One participant expressed the positive impact this could have on recognizing and treating alcohol use. "I think things such as alcohol use and addiction, substance abuse, would come out in that [mental health screening] more regularly as part of a clinical practice if that were to be woven in systemically into the health exam."

FURTHER RESEARCH

Beyond the recommendations identified by this study, it is clear that further research is needed to more deeply triangulate and understand this issue and its solutions. A quantitative study to find out the scope of alcohol use in the Karen community would add more context to this project and support and strengthen this qualitative data. Unfortunately, the focus groups that were planned could not be carried out as they relied heavily on a community organization already overwhelmed providing direct services to their Karen clients. As this is often the case with community-based organizations, providing funding for a qualitative study to conduct focus groups is recommended to complement the information collected by this study. Focus groups would provide more background information about cultural uses of alcohol, expand the study's participant base, and further open up dialogue around the hidden issue of alcohol use.

Further research could also include a broader examination of alcohol use in various Karen refugee communities resettled in other parts of the U.S. It's possible that other states are farther along in their dialogue on this issue and have begun to develop and tailor referral, treatment and support options for the Karen. Connecting with refugee resettlement agencies and service providers across the U.S. to create a collaborative approach to addressing alcohol use in the Karen community would be a powerful and innovative response.

Mentioned earlier in this report, funding to translate Alcoholics Anonymous or similar program materials into Karen is also one of the fundamental first steps that must happen prior to providing these programs to the Karen community. After this, future research opportunities

could include pilot programs for treatment and intervention, support programs for others impacted by alcohol use, and education campaigns.

Overall, recognizing and understanding this issue and how to address it are only in the beginning phases. Dialogue must continue within and around the Karen community to truly surface and address alcohol use and find sustainable solutions that best meet the needs of the community.

APPENDIX

APPENDIX I

Refugee Health Assessment Report
***Primary Refugee Arrivals By Country**
Refugees arriving from 01/01/1979 through 03/28/2011

Region Covered in Report:
ALL COUNTIES / BURMA / ALL CLINICS

DEMOGRAPHIC - AGE

Country	Total		< 5		5-14		15-24		25-44		45-64		>65	
BURMA	3319	100%	441	13.2%	831	25%	759	22.8%	900	27.1%	332	10%	56	1.6%
Total / % of Total	**3319**		**441**	**13.2%**	**831**	**25.0%**	**759**	**22.8%**	**900**	**27.1%**	**332**	**10.0%**	**56**	**1.6%**

APPENDIX II

International Institute of Minnesota: Refugee Arrivals from Burma

Year	Burma	% of total
2004	1	0.04%
2005	57	6%
2006	54	4%
2007	152	23%
2008	88	44%
2009	31	27%
2010	180	34%
2011	109	86%

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