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Understanding Alcohol Use among U.S. Cambodians: How Useful Is the Concept of Cultural Norms?

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Abstract

Observed differences in substance use are frequently attributed to cultural norms, which in turn are often interpreted as fixed properties of ethnically defined groups. During a CBPR study (2009–11), US Cambodian women identified community-specific drinking behaviors and beliefs. To test how widely other US Cambodians shared their views, we formulated them into a series of normative statements and surveyed local community members (N=172). We identified few consensed norms, which we argue indicates that A) norms may not be reducible to normative statements; and/or B) norms may not be shared by all group members; and C) if neither A nor B holds, then the attribution of observed drinking patterns to cultural norms lacks internal validity.

Keywords

culture; norms; drinking; alcohol; immigrant; Southeast Asian; Cambodian

INTRODUCTION

Cross-cultural studies of substance use behaviors have demonstrated considerable variation in the types of substances most commonly consumed, as well as the social and physical contexts in which they are consumed (Gureje, Mavreas, Vasquez-Barquero, & Janca, 1997; MacAndrew & Edgerton, 1969; M. Marshall, 1979; Pittman & Snyder, 1962; Room, Janca, Bennett, Schmidt, & Sartorius, 1996; Room & Mäkelä, 2000; Schmidt & Room, 1999). Such observed differences in drinking across ethnically defined groups are often attributed to “cultural norms.” For example, a 2002 review article on minority women and drinking opened with the statement that “Women’s drinking patterns are influenced by the cultural norms and practices of the ethnic groups to which they belong, in addition to other environmental and biological factors,” (Collins & McNair, 2002). We find this use of the concept of cultural norms, published in NIAAA’s practitioner-directed journal *Alcohol Research & Health*, to be fairly typical of the literature in our field.

The term “cultural norms” was not defined in this article. However, further on the authors specified:

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Over time, as new immigrants adapt to U.S. culture, they tend to drop or modify the norms of their countries of origin and adopt patterns of behavior that are more representative of the general U.S. population. In cases where women either did not drink or drank small amounts of alcohol in their countries of origin, adopting the drinking norms of the general population of U.S. women translates into consuming more alcohol. (p. 254)

This model implies a one-to-one correlation between a specific group and a specific norm or set of norms. Anthropologists have called this the “bounded social wholes” model of culture. This model, in which all cultural difference is “distributed into discrete and autonomous units,” has been critiqued in recent decades as obscuring “contingency, hybridity, and historicalness” (Handler & Segal, 1999, p. xiv), depicting social groups as internally homogeneous, despite empirical evidence to the contrary. However, following the logic of bounded wholes, if cultural norms are indeed associated with internally homogenous groups, then cultural norms should be held by all, or at least most, of the group's members.

In this paper, we critically examine this usage of the idea of “cultural norms” by describing results of community-based participatory research on alcohol use among U.S. Cambodians. We invited a group of U.S. Cambodian women to analyze health issues in their community. The group selected problematic drinking as a key issue, and they identified numerous aspects of this problematic drinking. To test how widely their views were shared by other U.S. Cambodians, we formulated these views into a series of norms statements and asked a sample of U.S. Cambodians to what degree they agreed or disagreed with these statements. We present these results here.

BACKGROUND

U.S. Cambodians provide a useful case with which to test the utility of a “bounded wholes” model of cultural norms. Compared to most ethnically defined groups residing in the U.S., Cambodians arrived to the U.S. in relatively homogenous modes. The vast majority entered the U.S. within just a few years (mid-1980s to mid-1990s) as refugees, and with remarkably similar characteristics due to the tragic events that preceded their arrival, namely the genocidal civil war under the Khmer Rouge. Because the Khmer Rouge targeted city dwellers, white collar workers and intellectuals for execution, the majority of Cambodians who survived to arrive as refugees came from rural villages; spoke no English; had little to no formal education; brought practically no wealth with them; and had practically no means to sustain themselves and their families in the U.S. Unlike other immigrant groups, there were very few Cambodians established in the U.S. who could help newcomers get settled, adjust and make lives in the new country. Unlike other immigrants and even unlike other refugees from Southeast Asia, nearly all Cambodian refugees had suffered and have continued to suffer both mentally and physically from extensive and profound traumatic experiences from years of genocide, forced labor, flight, and transit in refugee camps (Chung & Kagawa-Singer, 1993; Rumbaut, 1989). U.S. Cambodians, then, would appear to represent a bounded social whole.

The data presented here were collected and analyzed within a two-year pilot community-based participatory research project. Community-engaged research methods have been

increasingly lauded for health disparities research (Wallerstein & Duran, 2006). Community-based participatory research (CBPR) is sometimes considered the purest form of community engagement. In CBPR, researchers and community members work together to select the research aims and methods, collect and analyze data, and sometimes identify and implement a course of action based on the results of the collaborative research (Cornwall & Jewkes, 1995; Israel, Schulz, Parker, & Becker, 2001). Because community members are engaged in all stages of the research and because the research is grounded in the lived experiences of community members, methods and measures developed within CBPR projects may be said to have high relevance and validity (Minkler & Baden, 2008). Our study engaged U.S. Cambodians as co-researchers using extended qualitative methods to identify research questions and develop measures, as described below.

METHODS

The project was formed around a core group of grassroots community members, called the Community Work Group (later, Cambodian Women's Group) or CWG. The CWG represented a diverse group of women who ranged in age from 21 to 60, and included recently arrived and long-time immigrants as well as U.S.-born women. CWG members had education/literacy levels ranging from none to college-level; possessed varying degrees of fluency in Khmer (Cambodian language) and English; and included both heterosexual and LGBT women. In the first year of the project, the CWG was tasked with identifying critical health issues for Cambodian women and their families. They conducted this formative research through an extended focus group format, which we have described in detail elsewhere (Lee et al., in review).

The group identified excessive drinking as a significant health problem among many community members. In a subsequent series of group activities, CWG women discussed their beliefs about Cambodian Americans' drinking behaviors. The women focused their inquiry on a set of research questions which were distilled, through an iterative process with the scientific staff, into a 13-item survey (see Table 1). Possible responses were in the form of a 4-level Likert scale: Strongly Agree, Agree, Disagree, and Strongly Disagree. The project team fielded this survey at a community-wide Cambodian New Year's event organized by the CWG. The objective of the study was to "test" the local generalizability of the CWG's articulated drinking norms by measuring the degree to which a larger community sample agreed or disagreed with them.

The survey was administered in English or Khmer by a team of 10 trained volunteers. These volunteers included participants in a Cambodian youth development program; students enrolled in Asian American studies and pre-medical studies at local colleges and universities; and staff at Cambodian stakeholder agencies. Volunteers offered to administer the surveys orally or to provide paper forms in Khmer or English for respondents to complete themselves. Two volunteers were able to administer the survey orally in Khmer. Survey respondents received a raffle ticket to win a gift card. Supervised by the scientific staff, volunteers from the youth group reviewed the completed survey forms, entered and cleaned the data, and conducted preliminary analyses in Microsoft Excel (Microsoft, 2010)

and SPSS (IBM, 2011). All protocols were approved by our institutional ethics review board.

Due to the dynamic nature of the event, we used an opportunistic sample, although the volunteers attempted to recruit both younger and older respondents to capture first- and second-generation immigrants. The total of 172 respondents (out of an estimated 500 persons who attended the event) included females (64.1%) and males, and second-generation youth and young adults (30.1%, ages 18–24) as well as first-generation adults (58.3%, ages 25–59) and seniors (11.7%, ages 60–85) (see Table 2). Children under 18 years old were excluded due to the challenges of obtaining parental consent at the event. Because we could not guarantee confidentiality due to the public nature of the event and the possibility that some surveys might be administered orally, we did not include items assessing respondents' own alcohol use.

To determine whether independent variables measuring demographic characteristics (age, gender, and Khmer proficiency) were differently associated with individual survey responses, the first author conducted chi-square tests using SPSS (see Table 3). Prior to analysis, survey responses were recoded as a binary variable consisting of “Agree” (Strongly Agree + Agree) and “Disagree” (Strongly Disagree + Disagree). Age, originally a scale variable, was recoded into a binary variable consisting of “25 and under” and “over 25.” The measure of survey respondents' Khmer proficiency, which originally consisted of three possible responses (“none,” “a little” and “well”) was recoded into “low/none” and “high.” Finally, we maintained the binary variable of nativity, e.g., “born in the U.S.” and “not born in the U.S.,” in its original form as recorded on the survey.

FINDINGS

Survey respondents disagreed with many of the normative statements developed by the CWG members. For example, 91.7% of respondents disagreed with the statement: “It's OK for kids to drink a little alcohol sometimes” (see Table 1). Another item that reflected a large gap between CWG members' perceived alcohol norms and survey responses was: “It is OK for young people to get drunk sometimes” – a notable 84.1% of survey respondents disagreed with this statement. 80.8% of respondents disagreed that Cambodians drink more than other ethnic groups.

For other survey items, we found ambiguity in community members' responses. For example, the respondents were divided (50% of respondents agreed) regarding the statement: “Cambodian kids get alcohol problems because their parents cannot control them.” Respondents were also somewhat divided in their response to the statements: “It's easy for kids to get alcohol at stores” (51.6% disagreed) and “In the U.S., successful Cambodians drink less alcohol” (53% agreed).

Table 3 shows associations between survey responses and the following demographic characteristics: gender, age, Khmer proficiency, and nativity. Gender was significantly related to responses to three survey items. Men were significantly more likely than women to agree with the statements, “It's OK for men to get drunk sometimes” ($p=.034$) and “In the U.S., successful Cambodians drink less alcohol” ($p=.038$). Conversely, women were

significantly more likely than men to agree with the statement, “Cambodians get problems with alcohol because they have too many worries” ($p=.031$).

We also found significant associations between younger age (25 years and under) and support for the statements “It’s OK for men to get drunk sometimes” ($p=.033$) and “Cambodians get problems with alcohol because they have too many worries” ($p=.044$).

Preferred language and nativity were also significantly associated with response patterns for a few survey items. Having little to no speaking proficiency in Khmer was moderately associated with support for the statement, “It’s OK for women to get drunk sometimes” ($p=.045$). Respondents born in the U.S. were significantly more likely than those born outside the U.S. to endorse the statements, “It’s OK for women to get drunk sometimes” ($p=.004$); “It’s easy for kids to get alcohol at stores” ($p=.024$); and “Cambodians get problems with alcohol because they have too many worries” ($p=.038$).

DISCUSSION

In that our survey utilized measures developed through intensive community-engaged qualitative research, and we made every attempt to field the survey within a diverse group of individuals who nevertheless may be said to represent a cultural group, our study represents a reasonable attempt to assess the utility of the “bounded wholes” conception of cultural norms. That, across the entire group of respondents, we found little agreement with the normative statements developed by the CWG indicates that A) norms may not be reducible to normative statements; and/or B) norms may not be held by all group members. That we were able to identify significant agreement with some norms statements in disaggregated analyses indicates that these normative statements might be more relevant within groups more narrowly defined as opposed to ethnically defined “cultural” groups. In considering why this may be, we need to examine the ways in which we use and operationalize the concepts of norms and culture, particularly in terms of research on problem drinking and other forms of substance use and misuse.

For us, the general idea that norms might link culture to drinking is not problematic. “Norms” are defined as rules for behavior that are shared within a specified group. Cultural norms would therefore be rules for behaviors that are shared by people who share culture. When used too narrowly, however, the concept of cultural norms may lose important and fundamentally transitive elements.

The transitive nature of norms may be readily grasped. Norms may be understood to change due to conditions both internal to a group (changing membership; changing characteristics of on-going members) and external to the group (changing societal values and conditions). A classic example of changing external conditions is Prohibition in the United States, when norms related to drinking changed massively after the alcohol ban was implemented, and once again after it was repealed. An example of internal change is the phenomenon of “maturing out” of problematic drinking—as adolescents transition into adult roles and statuses, their drinking norms also change (Bachman et al., 2001; Bachman, Wadsworth, O'Malley, & Johnston, 1997). Cultural norms, therefore, might be assumed to be similarly

contingent and transitive. However, we find in substance use research that when combined with “culture,” the concept of “norms” acquires a static character. This we attribute in turn to outdated notions of “culture.”

We find that “culture” is frequently cited as a variable or condition in substance use research, but rarely defined. When researchers do provide a definition, frequently it is along the lines of Tylor's classic definition of culture:

Culture, or civilization, taken in its broad, ethnographic sense, is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society. (Tylor, 1871, p. 1)

This definition is useful in that its breadth allows researchers to attribute to culture all manner of heretofore-undefined causality. However, in this sense this holistic definition also represents something of a black box. Equally problematic is the fact that Tylor's definition of culture is now nearly one and a half centuries old, and social theory has advanced substantially since that time. Recent theory in anthropology has focused on the contingent nature of culture: culture as process, incorporating and responding to global trends and forces. Appadurai (2006, p. 62) asserts that “...no culture, past or present, is a conceptual island unto itself, except in the imagination of the observer.”

Another important consideration is the degree to which individuals identify with the norms of “their” group. Oetting (1997) argued that cultural identification is so unevenly distributed among group members that cultural norms theory has little value for explaining group patterns in alcohol and drug use and misuse. Furthermore, individuals can and do identify with subcultures that may subscribe to different alcohol and drug norms than the wider group. Immigrants, in particular, may demonstrate considerable hybridity in adopting norms from both origin and host societies, notwithstanding the elements that may already have been common to both societies due to, for example, globalized youth norms regarding substance use (Moloney, Hunt, & Evans, 2008).

It is also important to remember that ethnicity is only one dimension of culture, and that ethnicity itself is a slippery concept. As Phinney (1996, p. 922) observes: “Ethnic cultures, rather than unified structures to which one belongs, can be thought of as clusters of dimensions along which individuals or samples vary. Although these dimensions are typically correlated in the group as a whole, individuals differ in the extent to which they adhere to any given value or attitude.” Individuals may find that norms embedded in, for example, their workplace or religious community resonate more closely with their personal values than the norms espoused by members of their ascribed ethnic community. Further, recognizing that substance use behaviors may be contingent on social interactions at specific moments and in specific contexts (Zinberg, 1984), some researchers have recommended studying social networks rather than cultural or societal norms writ large (Abel & Plumridge, 2004).

While cross-cultural studies of substance use behaviors may seek to address important public health issues, generalizing problematic behaviors to an entire community—and attributing them to culture—can pathologize populations. As Glick Schiller (1992) has

argued, blanket characterizations of cultural groups as “at risk” may reinforce the image of these populations as “contagious cultural others” (p. 239). Ong (2003) made a similar argument in her study of Cambodian refugees in the San Francisco Bay Area. This process of “medicalization,” as it is called in anthropology and other social science fields, transforms an obvious but diffuse social problem into a pathology located in the body of an individual patient. Lock & Scheper-Hughes (1996) argued that medicalization individualizes and shifts perception away from social and political processes and onto the individual body. Medicalization can also have important repercussions for research endeavors. As Green & Mercer (2001) have pointed out, decades of being associated with these types of characterizations, together with lack of tangible benefits, may result in some communities being unwilling to participate in research studies.

CONCLUSION

Prior research on Asian Americans and other U.S. ethnic groups has suggested a strong link between cultural norms around alcohol, on the one hand, and drinking behaviors within these communities, on the other (Sue, Zane, & Ito, 1979). Like other Southeast Asian cultures, Cambodian culture has been described as “wet,” (Amodeo, Robb, Peou, & Tran, 1997) i.e., promoting or at least having permissive norms regarding drinking. We wish to complicate this depiction by invoking historical and social contextual factors as well as important variation among U.S. Cambodians that may impact observed drinking patterns. Substance abuse among Cambodian refugees has been linked with poor mental health stemming from their war and refugee traumas together with poor living conditions in the U.S. (Amodeo et al., 1997; D'Avanzo, 1997; D'Avanzo, Frye, & Froman, 1994).

Recent studies have identified persistent poor mental health among U.S. Southeast Asians even many decades after these experiences (Hinton, Rasmussen, Nou, Pollack, & Good, 2009; G. N. Marshall, Schell, Elliott, Berthold, & Chun, 2005; Palmieri, Marshall, & Schell, 2007). Researchers have noted a tendency among Southeast Asian immigrants to self-medicate with alcohol in response to posttraumatic stress disorder (PTSD) and anxiety deriving from their traumatic experiences of war, genocide and flight (Amodeo et al., 1997; D'Avanzo, 1997; O'Hare & Tran, 1998). Although there have been fewer studies involving the second (and now third) generation of Southeast Asian Americans, there is evidence to suggest heavy episodic drinking among youth in some settings (Lee, Battle, Antin, & Lipton, 2008). Ethnographic studies have shown that the life experiences of young Cambodians are radically different from those of their parents (Jeung, 2002; Ly, 2010) in ways that may impact health behaviors, including problem drinking.

The difficulty in locating Cambodian Americans in our study area precluded us from collecting a random sample, or one large enough to produce ideal statistical power, within this pilot study. Also, despite our efforts to recruit a range of participants, our sample of survey respondents may have been biased in terms of who attended the event and who chose to respond to the survey. It is also possible that the CWG women were idiosyncratic in having more personal experiences with problematic drinking within their families and social circles.

Overall, our findings support continuing investigation into the complex concepts of cultural norms and community representation within community-based health research and studies of “cultural” differences in substance use more generally.

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Table 1*Summary of Survey Responses (N=172)*

Survey Item	Disagree (%)	Agree (%)
Cambodians can't party without alcohol.	61.8	38.2
Cambodians drink more than other ethnic groups.	80.8	19.2
It's OK for kids to drink a little sometimes.	91.7	8.3
Younger Cambodians drink more than older Cambodians.	66.5	33.5
It's OK for young people to get drunk sometimes.	84.1	15.9
It's OK for men to get drunk sometimes.	51.6	48.4
It's OK for women to get drunk sometimes.	65.4	34.6
Cambodian kids get alcohol problems because their parents cannot control them.	50.0	50.0
It's easy for kids to get alcohol at stores.	51.6	48.4
Cambodians in the U.S. drink more alcohol than in Cambodia.	62.7	37.3
Cambodian women in the U.S. drink more alcohol than in Cambodia.	61.3	38.7
In the U.S., successful Cambodians drink less alcohol.	47.0	53.0
Cambodians get problems with alcohol because they have too many worries.	33.5	66.5

Table 2*Descriptive Statistics (N = 172)*

Measure	Variable	%
Gender	Female	64.1
	Male	35.9
Age Group	18–24	30.1
	25–59	58.3
	60–85	11.7
US-Born	Yes	34.5
	No	65.5
Year of Immigration to U.S. (non US-born)	1960–1980	9.1
	1981–1990	64.5
	1991–2010	26.2

Table 3

Crosstabulation of "Agree" Responses to Survey Items by Age, Gender, Khmer Proficiency, and Nativity

Survey Item	Gender (%)		Age Group (%)		Khmer prof. (%)		Nativity	
	Females (n=109)	Males (n=61)	25 and under (n=51)	Over 25 (n=112)	Low/none (n=53)	High (n=117)	U.S. (n=59)	Non-U.S. (n=112)
			χ^2	χ^2	χ^2	χ^2	χ^2	χ^2
<i>Cambodians can't party without alcohol.</i>	35.4	42.1	46.9	36.4	42.9	36.4	41.1	37.0
<i>Cambodians drink more than other ethnic groups.</i>	18.4	19.3	18.0	19.6	20.8	17.8	21.4	18.2
<i>It's OK for kids to drink a little sometimes.</i>	8.0	7.1	7.8	9.2	8.3	7.4	7.1	9.0
<i>Younger Cambodians drink more than older Cambodians.</i>	38.1	24.6	33.3	34.7	41.7	30.2	36.8	32.0
<i>It's OK for young people to get drunk sometimes.</i>	14.1	19.0	23.5	11.3	18.0	15.1	17.5	15.2
<i>It's OK for men to get drunk sometimes.</i>	42.2	59.6	60.8	42.4	53.1	46.8	57.9	43.6
<i>It's OK for women to get drunk sometimes.</i>	29.7	43.9	42.0	30.0	46.0	29.6	49.1	26.5
<i>Cambodian kids get alcohol problems because their parents cannot control them.</i>	48.5	53.6	52.0	48.5	55.1	47.2	45.6	53.1
<i>It's easy for kids to get alcohol at stores.</i>	49.0	47.4	54.0	43.8	60.0	43.3	60.7	41.8
<i>Cambodians in the U.S. drink more alcohol</i>	32.6	45.5	41.7	36.2	32.6	39.8	42.6	34.7

Survey Item	Gender (%)		χ^2	Age Group (%)		χ^2	Khmer prof. (%)		χ^2	Nativity		χ^2
	Females (n=109)	Males (n=61)		25 and under (n=51)	Over 25 (n=112)		Low/none (n=53)	High (n=117)		U.S. (n=59)	Non-U.S. (n=112)	
<i>than in Cambodia.</i>												
<i>Cambodian women in the U.S. drink more alcohol than in Cambodia.</i>	37.1	42.1		38.8	40.2		29.2	43.4		35.7	40.8	
<i>In the U.S., successful Cambodians drink less alcohol.</i>	46.8	64.3	4.31 *	49.0	57.0		44.7	56.3		44.6	57.4	
<i>Cambodians get problems with alcohol because they have too many worries.</i>	73.0	56.1	4.66 *	77.6	61.0	4.04 *	76.0	61.7		77.2	61.0	4.30 *

Note. Only significant chi-square results are shown in the table.

* $p < .05$