Factors Influencing Alcohol Use Among Myanmar Young Migrant Workers in Thailand

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Abstract: Young migrant workers depict both vulnerability and resilience toward negative health outcomes. A deeper understanding of their needs provides healthcare providers the opportunities to help increase their positive health and well-being. This cross-sectional study examined alcohol use in documented young Myanmar migrants working in Thailand and the factors associated with alcohol consumption. Cooper's Four-factor Model of Drinking Motives and the Transactional Model of Stress and Coping were used as guiding frameworks. The participants were 186 young migrant workers from migrant communities in a coastal province near Bangkok, Thailand. Interviews were used for data collection using demographic questionnaire and standardized measures of alcohol use, acculturative stress, depressive symptoms and self-esteem. Data analysis included descriptive statistics and logistic regression.

Results indicated that participants perceived themselves as having positive self-esteem, not currently experiencing discrimination or acculturative stress, and motivated to consume alcohol mainly for positive social interaction rather than for coping or enhancement of positive affect. Almost two thirds of participants reported consuming at least 1 alcoholic drink in the past 12 months. However, 92.5% of those were classified as low risk drinkers. Gender, length of stay, and drinking history predicted alcohol use. Our findings add further evidence that the significant differences across studies regarding migrants working in Thailand arise from differences in age, types of work, region in Thailand, registration status, length of stay, peer and community supports. As such, public health policies and programs and health services provided by community nurses related to alcohol use need to be tailored to specific regions within the country and to specific populations of migrant workers based on information from local empirical studies.

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Introduction

Increasing alcohol consumption and potential health-related problems as they relate to migrant workers are considered areas of concern in Thailand for governmental agencies, employers and healthcare providers. Thailand is the primary hub for migrant workers in Asia and the number of migrant workers

needed to support Thailand's labor force is predicted to increase, considering the country's declining birth rate, aging population, and the establishment of the Association of Southeast Asian Nations (ASEAN) Economic Community (AEC) in 2015. Myanmar is the largest source country of migrant workers in Thailand. Indeed, the Thai Ministry of Labour reported that in 2016, approximately 1.6 million documented migrant workers had come from Myanmar and up to 30% were aged 15-24 years.[1]

Alcohol use and misuse in young people (defined as adolescents and young adults) has been a longstanding global concern.[2] The WHO report on global use of alcohol (in those ages 15 to 19) by region indicated that in the South East Asia region (SEAR) (a region of 11 countries including Thailand and Myanmar) the prevalence rate of ever consuming alcohol was 14.2%.[3] However, this reflects aggregate data for the whole region and did not include data specific to young migrants. Young people's well-known propensity to engage in risky behaviors increases their vulnerability to the negative physical and mental health consequences of alcohol misuse may establish heavy alcohol use patterns that persist into adulthood.[4] Thus, it is imperative to monitor alcohol use patterns in young migrant workers, to identify those with high risk alcohol use and to gain information about current factors that influence alcohol use.

Review of Literature

Research into understanding alcohol consumption in young people and related factors has generally followed two broad theoretical frames. Social learning theory and socioecological frameworks have underpinned much of the explorations into various aspects of peer and/or family dynamics that may influence the initiation of alcohol consumption and the frequency and characteristics of drinking-related behaviors in adolescents.[5-7] Alternatively, stress and coping theories have been used to explain the relationship among various life stressors and the use of alcohol as a stress management strategy.[8-10] Cooper[11] integrated elements of both of these broad theoretical frames and posited a four-factor model of alcohol drinking motives in young people. These were defined as social (the anticipation of favorable social outcomes), conformity (gaining acceptance by peers), coping (attenuating negative affect) and enhancement (increased positive affect). This four-factor model has been validated in numerous studies. In a recent survey of 33,813 students in 13 European countries, Kuntsche et al.[12] validated the four-factor model and reported consistent findings across the participating countries that favorable social outcomes was the dominant motive followed by enhancement, coping and conformity. These authors also found enhancement motive was more associated with risky alcohol intake in boys and coping as a motive was more associated with risky intake with girls. In a recent American study, dominant motives varied by race and ethnic background, by age and by consumption patterns.[13] It is difficult to generalize data from previous studies on young people's alcohol use to young migrants from Myanmar working in Thailand as most of the studies focused on immigrant populations, high school or college students and/or bicultural populations (Hispanic or African-American).[12,14] In addition, prevalence rates of lifetime alcohol use reported in American studies (86.4% of those 18 or older)[15] are much higher than are reported in both Thailand (37% of those 12 to 65 years)[16] and Myanmar (29.5% of males age 20 or older)[17], which may reflect differing sociocultural beliefs and values that define acceptable alcohol-related behaviors.

Studies that have looked at life stressors and motives for alcohol use in different minority subpopulations have focused mainly on acculturative stress and discrimination.[13] However, it is important to note that the majority of the studies that have examined acculturative stress and discrimination involve immigrant populations[18,19] or ethnically diverse Americans (Hispanic, African-Americans

and Asian).[7,20] These groups may be of similar age to our population of interest but were studying in a post-secondary institution, not working full time, were citizen sub-populations, not foreign workers and/or had made the decision to immigrate, not in the country on work visas. As such, these data cannot serve as direct comparators.

Migrant workers are at increased risk for being marginalized and exploited by their employers, for poor access to health services and low sense of community belonging, all of which can affect their mental and physical health.[21] In keeping with these risks and the potential for these workers to experience acculturative stress and discrimination the study was also guided by the Transactional Model of Stress and Coping by Lazarus and Folkman,[22] chosen for its emphasis on perception and appraisal. The major concepts included in this model are stress, cognitive appraisal, coping resources, and adaptational outcomes, with the stressor under consideration as acculturative stress based on being young adults away from family supports, language barriers, potential work and financial insecurity, lowered sense of belonging and being subject to potential discrimination in the workplace and community. The potential maladaptive outcomes are lowered self-esteem, increased depressive symptoms and increased use of alcohol as a coping strategy or to enhance positive affect.

There is a paucity of studies with migrant workers in the Pacific Rim and Southeast Asian countries and previously published work often focused on adult workers. Examples include Tse and colleagues[23] who found that enhancement and coping motives based on discrimination explained hazardous alcohol use in migrant workers in China. Studies completed in Thailand with adult migrant workers report marginalization & discrimination,[24] increased alcohol and other substance use,[25] and increased depression symptoms.[26] Very high prevalence rates of lifetime alcohol use (87%) and 12-month use (84.7%) were reported in adult Myanmar workers in a province near Bangkok, Thailand.[27] Sub-group analysis revealed that 41% of the participants ages 18-29 had consumed alcohol in the past 12 months, compared with the age groups 26-35 and >35, who had 12-month consumption rates of 61.35 and 72.3%, respectively.

Thai studies related to young migrant workers are very limited and are relatively dated. An older Thai study with young Myanmar migrant workers from a coastal province in Thailand (N=177) reported current alcohol use in the past 30 days in 25.4% of the male workers (0% in females), with marital status, job stress and working in jobs other than the seafood processing industry as predictors of alcohol use.[28] A more recent study with Myanmar migrants working in a different Thai province (N=300) reported even higher current alcohol use.[29] However, in this study over 70% of the young workers were undocumented workers, which may have influenced the findings, in particular alcohol use (36.7%), moderate to high job stress (reported by 87%) and financial problems (reported by 95%). Interestingly, only 2.7% of the participants had alcohol use as a single health-risk behavior, the remaining had combinations of betel-quid chewing, alcohol use and tobacco smoking.

Despite concerns voiced by various governmental and health agencies regarding alcohol use in young migrant workers, gaps remain in our understanding about alcohol use patterns in young migrant workers from Myanmar and factors that influence alcohol consumption across provinces, types of work, gender and employment status. This lack of in-depth information creates significant challenges to national and provincial policy development and plans for the provision of social and health services specific to young migrant workers. In addition, understanding factors related to young migrant alcohol use can support social policies and programs to decrease continued risky alcohol use into adulthood.

Study Aims

The aims of this study were to examine the percentage and risk levels of alcohol use and identify the predictive ability of selected variables (gender, length of stay, history of drinking in Myanmar, family history of alcohol use, acculturative stress, depressive symptoms, and self-esteem) on the likelihood of alcohol use among Myanmar young migrant workers in a coastal province near Bangkok, Thailand

Methods

Design

A descriptive, cross-sectional study design was used.

Sample and Setting

The sample included young migrant workers from Myanmar who were living and working in a coastal province near Bangkok, that had the largest Myanmar migrant population in Thailand.[28] Inclusion criteria were young migrants aged 18-24, born in Myanmar and legally working in Thailand with a valid work permit. Using the Probability Proportion to Size (PPS) sampling method, 10 migrant communities were randomly selected from 40 migrant communities of different sizes in 18 sub-districts. Accessibility, availability of young migrants, and safety were also considered in the final list of migrant communities. The sample size was calculated using GPOWER version 3.1.9.2 based on an odds ratio of 2.66, an alpha level of 0.05. A minimum sample size of 155 is needed to reach the desired power analysis of .80. After considering the possibility for drop-out and incomplete responses, 20% additional participants were included in this study resulting in a final total of 186 young migrant workers.

Ethical Considerations

Ethical approval from the Institutional Review Board of the Faculty of Nursing, Mahidol University, was obtained prior to data collection, with the approval number IRB-NS20163922112. The consent form given to the respondents included voluntary participation, confidentiality, and the freedom to withdraw. Respondents were de-identified through the use of codes on questionnaires and their rights protected throughout the study.

Instruments

Five instruments used in this study were the: Demographic form, Acculturative Stress (AS) scale, the Center for Epidemiological Studies-Depression (CES-D) scale, the Rosenberg Self-esteem Scale, and the Alcohol Use Disorders Identification Test (AUDIT). The last four instruments were originally written in English. Thus, they were translated with permission from English to the Myanmar language according to the process of translation and adaptation of instruments recommended by the World Health Organization.[30] This translation consisted of the following steps: forward translation, expert panel back-translation, pre-testing and cognitive interviewing. Indicators of translation revealed satisfactory outcomes at each stage. Instrument content validity was reviewed by a panel of four experts in the mental health field. The reliability of each instrument was tested with 30 Myanmar young migrant workers living in the same province who were similar to the eligible sample of the study but were not included in the main study. Pre-testing reliability coefficients of 0.80, 0.70, 0.85, and 0.75 were attained for Acculturative Stress (AS) Scale, Center for Epidemiologic Studies Depression (CES-D) Scale, Rosenberg Self-Esteem Scale, and Alcohol Use Disorders Identification Test (AUDIT), respectively.

A demographic form was created to collect information on gender, age, marital status, ethnicity, educational background, length of stay in Thailand in years, occupation, history of drinking alcohol in Myanmar, family history of alcohol use, and for

those who drank alcohol, and the primary reason why they drank alcohol.

The Acculturative Stress (AS) Scale was modified to fit the context of young migrant workers in Thailand. Out of 30 items, six items were adapted from the Everyday Discrimination Scale[31] and five items from the Social, Attitudinal, Familial, and Environmental (SAFE) scale.[32] Other items were constructed based on previous studies about the most commonly identified acculturative stressors among migrants in general, and as experienced by Myanmar migrant workers in Thailand. The AS consisted of six subscales: perceived discrimination (six items); culture, food, language (three items); financial stress (three items); migration-related stress (five items); occupation-related stress (five items); family and social stress (eight items). Responses are given on a 6-point Likert-type scale from 0=I have not experienced the event at all to 5= extremely stressful. Possible scores range from 0 to 150. Higher scores indicated higher levels of acculturative stress. Using the mean as cut-off point, AS scores are further categorized into two levels: less stressed and more stressed. An item example is "I feel I am treated with less courtesy and respect than other people are". After the content validation process by a panel of experts in the mental health field, the AS had a scale-content validity index of 0.86. In the present study, the reliability coefficient alpha was 0.89.

The Center for Epidemiologic Studies Depression (CES-D) Scale[33] was used to measure the severity of depressive symptoms. This instrument is a 20-item, 4-point rating scale ranging from 0=rarely or none of the time to 3= most or all of the time. Total scores range from 0 to 60, with higher scores indicating greater depressive symptoms. A cut-off score of 16 is used to identify those at risk for clinical depression. An item example is " I was bothered by things that usually don't bother me". This instrument has been used in international studies on alcohol drinking among young migrants and the reliability across different populations ranged from 0.77 to 0.94.[14] In the present study, CES-D had an acceptable reliability coefficient alpha of 0.70.

The Rosenberg Self-Esteem (RSE) Scale[34] was used to measure the level of self-esteem. This instrument is a 10-item, four-point Likert scale ranging from 0= strongly agree to 3= strongly disagree. The total possible score of this scale can range from 10 to 30. The higher the score, the higher the self-esteem. Total scores are further categorized into three levels: low self-esteem (0-14 scores), normal self-esteem (15-25 scores), and high self-esteem (26-30 scores). An example of an item is "On the whole, I am satisfied with myself." Reliability for the Thai version in a previous study was 0.85[35]and its test-retest correlations ranged from 0.82 to 0.88.[36] In the present study, the Cronbach's alpha for this questionnaire was 0.80.

The Alcohol Use Disorders Identification Test (AUDIT) was used to measure past year's alcohol consumpton. This instrument, developed by the World Health Organization[37], is a 10-item 5-point Likert scale ranging from 0= never to 4= daily or almost daily, except for items 9 and 10 which has only three options, and scored as 0, 2, and 4. A score on the AUDIT is further categorized into three risk levels: 0-7 = low risk, 8-15 = hazardous drinking; 16-19 = harmful drinking; and 20 and above = alcohol dependence. Scores are categorized mainly into two: those who answer "0" to all items are considered non-alcohol users while those who answer 1, 2, 3 or 4 in any of the item are considered alcohol users. An example item is " How often during the last year have you found that you were not able to stop drinking once you had started?" The Cronbach's alpha for AUDIT in the present study was 0.85.

Data Collection

The primary investigator (PI) coordinated with a local non-government organization (NGO) to

help recruit young migrant workers. As a foreigner in Thailand who cannot communicate in Thai or Myanmar languages, the PI worked with four research assistants (RAs) who were also migrant workers with good command of the Myanmar and English languages. They were experienced in field data collection, were well connected with the respondents in the community, and were trained in basic counseling. These RAs were trained regarding the objectives of the study and data collection procedures, the details of the questionnaires and strategies to manage any problems during the interview such as emotional distress in respondents. A snowball recruitment technique driven by chain referral was used to complete face-to-face interviews with 186 participants. The RAs helped identify and recruit eligible respondents who met the inclusion criteria and assisted the participants in completing the questionnaires. The PI was also present on site where the data collection occurred to provide assistance during data collection (January-May 2017).

Data Analysis

Demographic characteristics of the sample, frequencies and risk levels of alcohol use were analyzed using descriptive statistics. Acculturative stress, depressive symptoms, and self-esteem scores were further categorized according to the distribution of data for acculturative stress and the recommended cut-off scores for depresive symptoms and self-esteem. Univariate and multivariate logistic regression analyses were then performed to identify the predictors of alcohol use.

Results

Of the 186 participants, 54.8% were male (n = 102) and 45.2% were female (n=84). The mean age was 22 years. About half were single and from the Mon ethnic subpopulation of Myanmar. Forty percent of the participants had completed elementary level schooling, with 54% having completed some further education. The average length of stay in Thailand was 4 years (SD=2.34). The majority (73.7%) worked in the seafood processing industry. More than a third did not have a history of alcohol drinking in Myanmar (86%) and did not have a family history of alcohol use (88.2%). **Table 1** provides the overall rate of having consumed at least 1 alcoholic drink in the past 12 months (64.5%), as well as the AUDIT scale of classifying risk by alcohol drinking patterns. Among those who reported drinking in the past 12 months, majority (92.5%, N=172) were in the low risk category and reported peer bonding (54.5%) as the primary reason for alcohol use, with "feeling happy" and "during major celebrations" also being mentioned several times.

Table 1 Frequency and AUDIT classification by score among participants (N=186)

Alcohol Use and Risk Levels	Number	Percentage
Did not drink alcohol in Thailand	66	35.5
Drank alcohol in Thailand	120	64.5
AUDIT classification		
Low risk (0-7)	172	92.5
Hazardous drinking (8-15)	13	7.0
Harmful drinking (16-19)	0	0.0
Alcohol dependence (20-40)	1	0.5

Irrespective of alcohol use, **Table 2** shows that scores in acculturative stress and depressive symptoms were generally at low levels. Although almost 50% of participants were either less stressed or more stressed, the over-all mean of 25 showed low levels in both groups. While using the cut-off score of 16 on the CES-D as indicative of the risk for clinical depression, there were only eleven individuals (9.2%) from the drinking group and five (7.6%) from the non-drinking group. Self-esteem scores reflected normal levels in the majority of participants regardless of drinking status.

Table 2 Univariate logistic regression examining factors associated with alcohol use among participants (N=186)

Variables	Alcohol Use		Total	B	SE	OR	95% CI	p
	Yes (n=120)	No (n=66)						
	n (%)	n (%)	N (%)					
Gender								
Female	31 (25.8)	53 (80.3)	84 (45.2)	ref				
Male	89 (74.2)	13 (19.7)	102 (54.8%)	2.46	0.37	11.71	5.63,24.32	<.001
Length of stay (years)								
Less than 3 years	45 (37.5)	40 (60.6)	85 (45.7)	ref				
3 to 5 years	45 (37.5)	20 (30.3)	65 (34.9)	0.69	0.35	2.00	1.02, 3.94	.045
More than 5 years	30 (25.0)	6 (9.1)	36 (19.4)	1.49	0.50	4.44	1.678,11.78	.003
History of drinking in Myanmar								
No	95 (79.2)	65 (98.5)	160 (86.0)	ref				
Yes	25 (20.8)	1 (1.5)	26 (14.0)	2.84	1.03	17.11	2.26,129.40	.006
Family history of alcohol use								
No	104 (76.7)	60 (90.9)	164 (88.2)	ref				
Yes	16 (13.3)	6 (9.1)	22 (11.8)	0.43	0.51	1.54	0.57, 4.14	.394
Acculturative stress								
Less stressed (below 25)	62 (51.7)	36 (54.5)	98 (52.7)	ref				
More stressed (25 and above)	58 (48.3)	30 (45.5)	88 (47.3)	0.12	0.31	1.12	0.62, 2.05	.707
Depressive symptoms								
No depression	109 (90.8)	61 (92.4)	170 (91.4)	ref				
At-risk for clinical Depression	11 (9.2)	5 (7.6)	16 (8.6)	0.21	0.56	1.23	0.41, 3.71	.712
Self-esteem								
Low	3 (2.5)	2 (3.0)	5 (2.7)	ref				
Normal	115 (95.8)	64 (95.5)	178 (95.7)	0.20	0.93	1.22	0.20, 7.48	.832
High	2 (1.7)	1 (1.5)	3 (1.6)	0.29	1.53	1.33	0.07, 26.62	.851

ref = reference category

Table 2 also shows the univariate analysis performed to identify crude estimates of the variables on the likelihood of alcohol use. Significant factors associated with alcohol use were gender, length of stay, and history of drinking in Myanmar. Males were 11.71 times more likely to drink alcohol compared to females (OR= 11.71 , 95% CI: 5.63-24.32, p < .001). Those who have stayed in Thailand for 3 to 5 years and more than 5 years were more likely to drink alcohol compared to those who have stayed for less than 3 years [(OR= 2.00 , 95% CI: 1.02-3.94, p = .045) and (OR= 4.44, 95% CI:1.68-11.78, p = .003), respectively] . In addition, migrants who have had a history of alcohol drinking in Myanmar prior to working in Thailand were also more likely to drink alcohol than those who did not (OR= 17.11, 95% CI: 2.26-129.40, p=.006). On the other hand, non-significant variables were family history of alcohol use, acculturative stress, depressive symptoms, and self-esteem.

Multivariate regression analysis (stepwise forward selection) revealed that out of seven variables of interest, gender, length of stay, and history of drinking in Myanmar predicted alcohol use **(Table 3).** Specifically, the odds of drinking alcohol are 11.22 times greater for males as opposed to females (OR= 11.22, 95% CI: 5.02-25.05, p<.001). Those who have stayed longer in Thailand for 3 to 5 years and more than 5 years were more likely to drink than those who have stayed less than 3 years [(OR= 3.18, 95% CI: 1.35-7.44, p = .008) and (OR= 6.19, 95% CI: 1.98-19.38, p = .002), respectively]. Higher chances for alcohol use was also found among those who have had a history of alcohol drinking in Myanmar prior to coming to Thailand compared to those who did not have (OR= 14.36, 95% CI: 1.69-121.98, p = .015). These three variables together explained 34% (Cox & Snell R Square) of the variation in alcohol use among participants.

Table 3 Multivariate logistic regression examining significant factors associated with alcohol use among participants (N = 186)

Variable	B	SE	OR	95% CI	p
Gender					
Female	ref				
Male	2.42	0.41	11.22	5.02,25.05	<001.
Length of stay					
Less than 3 years	ref				
3 to 5 years	1.16	0.44	3.18	1.35,7.44	.008
More than 5 years	1.823	0.58	6.19	1.98,19.38	.002
History of drinking in Myanmar					
No	ref				
Yes	2.66	1.09	14.36	1.69,121.98	.015
2- Log likelihood	166.14				
Cox & Snell R Square	.34				

ref = reference category

Discussion

The findings revealed that the overall rate of having consumed at least one alcoholic beverage in the past 12 months was 64.5%. However, it is important to note that 92.5% of the participants were in the low risk AUDIT category. This indicated that the migrant population of young workers from Myanmar who mostly worked in the seafood processing industry perceived themselves at low risk for alcohol-related problems. Interestingly, the majority identified peer bonding and social activities as the main reasons for alcohol use. The alcohol use pattern and motivation appear more consistent with anticipated positive social outcomes and perhaps conformity during specific events,[11] rather than coping or enhancement of mood as primary motives for their drinking. Buddhism is also a common religion shared by both countries that may have contributed to the low levels of alcohol use in this population. In Buddhism, alcohol drinking is considered a poor behavior and needs to be avoided.[38] In a study among Israeli adolescent alcohol consumption, religiosity and religious education have been shown to decrease the prevalence of alcohol consumption.[39]

Findings of this study showed favorable results for the migrant communities and healthcare practitioners because aside from the low levels of risky alcohol use, acculturative stress and depressive symptoms scores were low and self-esteem, normal. The levels of these predictor variables may be due to the fact that the respondents were legal migrant workers with health and social benefits. In fact, the Myanmar migrant communities were conveniently located around markets, schools, temples, and hospitals. They also lived within the same communities as their families, relatives, and friends. Moreover, since Thailand and Myanmar share similar cultures, beliefs, and lifestyles, not many adjustments were needed in the host country to live comfortably.

Despite the evidence that migrant workers are at increased risk for acculturative stress and discrimination,[13] the participants appraised their experiences as not stressful enough to be a threat to their well-being. According to Lazarus and Folkman,[22] people can experience similar stressful events but appraise them differently depending on personal characteristics and perceived personal coping resources. Personal characteristics in this study that significantly influenced migrant workers' alcohol use included gender and history of drinking in Myanmar. The findings of this study were congruent with previous studies that among those who were more likely to use alcohol were males,[18] stayed longer in the host country,[19] and started drinking prior to migration.[9] The possible explanation to gender is that although alcohol drinking is unacceptable under Buddhist teachings, the attached social stigma and shame related to alcohol use is higher for females than males.[27,29] Thus, alcohol use is more accepted as a component of male-to-male social activities, despite the religious constraints.

The finding that length of stay predicted alcohol use is consistent with other research.[27] It is possible that the protective influence of Myanmar culture and religion that discouraged migrants from using alcohol dissipates with time spent in Thailand, thereby facilitating higher rates of alcohol use compared to those who had newly arrived. They may have greater opportunities for socialization and peer bonding, which was identified as the primary reason for drinking in this study. They may also feel more financially secure and confident that they are past the initial migration-related concerns regarding work and accommodation. Although length of stay in this study did predict alcohol consumption, there was no evidence to suggest that the amount consumed by individuals also increased—a key finding in terms of developing public health policy for this population.

The finding that a history of drinking in Myanmar predicts alcohol use may reflect that the participants had engaged in a pattern of socially-related alcohol use in Myanmar or had started drinking alcohol at a younger age. Early initiation of drinking as a factor

for increased risk of increased alcohol use is supported in previous studies.[9] However, the low amount of alcohol consumed by the majority of participants does not provide evidence of significantly increased alcohol use. It is also important to note that even if history of drinking was a significant predictor, there was a low number of cases for those with a history of drinking and not consume alcohol in the past 12 months, thereby making it a weaker estimator of the likelihood of alcohol use.

The findings that the family history of alcohol problems, acculturative stress, depressive symptoms, and self-esteem were not predictors of alcohol use did not support the hypothesis.

One reason may be due to a measurement issue. In previous studies, the severity of alcoholism or the extent of alcohol use disorders was used as an outcome variable. In this study, alcohol use was categorized into whether the participants ever drank alcohol in the past year or not. Further, the strong link between family history and alcohol use was reported to be strongest amongst those with both parents having alcohol problems, those with existing comorbidities such as depression, and those exposed to family violence. The low level of depressive symptoms in this study may have weakened the link between family history and alcohol use.

Scores on the Acculturative Stress (AS) Scale and depressive symptoms did not predict alcohol use. As mentioned earlier, the participants in this study were legal migrant workers living with their families, relatives and friends in the same community, and with culture, lifestyle, and beliefs similar to the host country; thus, acculturative stress may not be an issue in this population; thereby not influencing alcohol consumption. Other potential contributors to the lack of association between acculturative stress or depressive symptoms and alcohol use may be the type of work and the stability of employment. The seafood processing industry may represent more stable employment opportunities than does construction and agricultural jobs.[28] Having a more stable income may also increase social activities and entertainment, which may involve social consumption of alcohol.

In addition, participants had positive self-esteem, which may make them more likely to appraise stressors as challenges to share and as opportunities for growth, rather than a threat to one's well-being. Although young migrant workers with normal levels of self-esteem may be less susceptible to peer pressure and have less need to conform, they may also feel comfortable in participating in occasional peer events that include the intake of alcohol within socially-acceptable limits. Thus, self-esteem could not predict alcohol use in this population.

Overall, the results were more consistent with Cooper's four-factor model of alcohol drinking motives among young people noting that the main reason for drinking was socially-motivated rather than stress-driven. Although outcomes did not support expectations within the Transactional Model of Stress and Coping—increased levels of acculturative stress and depression and lower self-esteem associated with alcohol use—the concept of resilience is addressed within this framework. Positive self-esteem, peer support (as indicated by peer bonding as a common motive for alcohol use) and sense of belonging are factors associated with higher resilience.[40] A future study focusing on resilience in young migrant workers may provide key protective indicators that can also help shape public policy.

Limitations

One limitation, in terms of tools, relates to the use of the CES-D. Some items of the CES-D proved to be confusing for the respondents. In Myanmar language there is no word for depression, only the more generic state kya yaw gar that directly translates to "feeling down". The concept of depression as an illness remains foreign to the majority of adolescents in Myanmar. This may account for the lower Cronbach's

alpha score obtained in this study. This study was limited to only one province near Bangkok, Thailand and included only legal or documented young migrant workers from Myanmar. Further studies that include both documented and undocumented migrant workers can be conducted in other regions of Thailand. Moreover, there is very little prior research related to factors influencing alcohol drinking in this population, thereby offering a wide opportunity for development in this area of study.

Conclusions and Implications for Nursing Practice

Important findings regarding this group of young migrant workers included higher prevalence of alcohol consumption in the past 12 months compared to national reports from either country, but low individual alcohol use patterns, low levels of acculturative stress and depression symptoms, and positive self-esteem. These data can help shape local public health policy, in terms of focusing services for young people within communities that are dominated by Myanmar migrant workers. Community nursing strategies to support health and wellness could include creating public recreational and meeting places where young people could interact outside of alcohol serving establishments or private homes.

The results also reflect more opportunity for nurses in the area of health promotion and disease prevention. In particular, nurses can provide health education on the harmful effects of alcohol misuse, implement mental health screening programs, obtain baseline health assessment for future follow-up and interventions, and provide opportunities for young people to engage in more productive community activities to support and maintain a desirable state of mental health. Furthermore, nurses could also focus on supporting individual resiliency factors, such as peer support and community belonging, as well as ongoing monitoring of individual alcohol use patterns to identify individuals who may move to higher risk consumption patterns with longer lengths of stay and to identify factors that may influence such changes.

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ปัจจัยที่มีอิทธิพลต่อการดื่มแอลกอฮอล์ของแรงงานข้ามชาติวัยหนุ่มสาวชาวพม่าในประเทศไทย

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บทคัดย่อ: แรงงานข้ามชาติวัยหนุ่มสาวเป็นกลุ่มที่มีทั้งความเปราะบางและความยืดหยุ่นต่อผลลัพธ์เชิงลบทางสุขภาพ ความเข้าใจที่ลึกซึ้งถึงความต้องการของคนกลุ่มนี้ทำให้บุคลากรสุขภาพเห็นโอกาสของการพัฒนาภาวะสุขภาพและความเป็นอยู่ที่ดีขึ้นของเขาได้ การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษาการดื่มแอลกอฮอล์ และปัจจัยทำนายการดื่มแอลกอฮอล์ของแรงงานข้ามชาติวัยหนุ่มสาวที่เข้าเมืองอย่างถูกกฎหมาย โดยใช้ Cooper's Four-factor Model of Drinking Motives และ Transactional Model of Stress and Coping เป็นกรอบแนวคิด กลุ่มตัวอย่างเป็นคนวัยหนุ่มสาวที่เป็นแรงงานข้ามชาติชาวพม่าที่ทำงานอยู่ในจังหวัดชายฝั่งทะเลใกล้กรุงเทพมหานครฯ แห่งหนึ่งจำนวน 186 คน เก็บรวมรวมข้อมูลด้วยวิธีสัมภาษณ์โดยใช้แบบสอบถามข้อมูลประชากร แบบสอบถามที่ได้มาตรฐานสำหรับใช้ในการประเมินการดื่มแอลกอฮอล์ ความเครียดที่เกิดจากความต่างทางวัฒนธรรม อารมณ์ซึมเศร้า และความรู้สึกมีคุณค่าในตนเอง วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา และการวิเคราะห์การถดถอยโลจิสติก

ผลการวิจัยพบว่ากลุ่มตัวอย่างมีความรู้สึกว่าตนเองมีคุณค่า ไม่ได้รู้สึกว่าตนเองถูกแบ่งแยกหรือมีความเครียดที่เกิดจากความต่างทางวัฒนธรรม แรงจูงใจหลักในการดื่มแอลกอฮอล์มาจากการปฏิสัมพันธ์ทางสังคมในเชิงบวกมากกว่าการเผชิญปัญหา พบว่าประมาณสองในสามของกลุ่มตัวอย่างดื่มแอลกอฮอล์อย่างน้อย 1 ครั้งในช่วง 12 เดือนที่ผ่านมา ซึ่งร้อยละ 92.5 ของผู้ดื่มแอลกอฮอล์กลุ่มนี้จัดเป็นนักดื่มที่มีความเสี่ยงต่ำ นอกจากนี้พบว่าเพศ ระยะเวลาที่อยู่ในประเทศไทย ประวัติการดื่มแอลกอฮอล์ในประเทศพม่า สามารถทำนายการดื่มแอลกอฮอล์ได้ ผลการศึกษานี้นับเป็นหลักฐานเชิงประจักษ์ที่แสดงถึงความแตกต่างของผลการศึกษาการดื่มแอลกอฮอล์ข้ามวัฒนธรรมว่าเกิดขึ้นจากความแตกต่างด้านอายุ ลักษณะงาน ภูมิภาค การขึ้นทะเบียน ระยะเวลาทำงานในประเทศไทย การสนับสนุนจากเพื่อนและชุมชน ดังนั้น การพัฒนานโยบายสุขภาพและการจัดบริการการป้องกันการดื่มสุราของแรงงานข้ามชาติของพยาบาลชุมชนจำเป็นต้องออกแบบให้มีความเหมาะสมและเฉพาะเจาะจงกับภูมิภาคและลักษณะของชนชาติแรงงานข้ามชาตินั้น ๆ ตามผลการวิจัยเชิงประจักษ์ในบริบทที่ศึกษา

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คำสำคัญ: ความเครียดที่เกิดจากความต่างทางวัฒนธรรม การดื่มแอลกอฮอล์ อารมณ์ซึมเศร้า พม่า ความรู้สึกมีคุณค่าในตนเอง แรงงานข้ามชาติวัยหนุ่มสาว

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