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Leveraging Family Values to Decrease Unhealthy Alcohol Use in Aging Latino Day Laborers

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Introduction

Heavy drinking in aging Latino day laborers creates conditions for negative health outcomes. “Day labor” is often characterized as work done primarily by men who congregate in street corners or in front of businesses like Home Depot.¹ In the United States, there are an estimated 117,647 day laborers on any given day, of whom 91% are immigrant Latinos.² Studies show that people who experience social disadvantage are likely to engage in unhealthy alcohol use behaviors and experience related health problems.³ Day laborers are largely socially disadvantaged: among 479 day laborers surveyed in Los Angeles in 2001, 95% were undocumented; 85% had less than a high school education; and 84% had limited English proficiency;⁴ and a 2010 survey of 1,815 Latino day laborers in Los Angeles found that almost 30% of the workers experienced violations of minimum wage laws in the workweek preceding the survey.⁵ Also, some day laborers engage in heavy drinking: among day laborers in Los Angeles, 20% reported ever being an excessive drinker, with 15% reporting drinking more than 7 drinks daily and 26% reporting drinking a fifth of liquor (25 oz.) in one day.⁶ This level of drinking is categorized as heavy drinking by the National Institute on Alcohol Abuse and Alcoholism: for men it is more than 4 drinks in one day or more than 14 in one week.⁷

Heavy drinking persists in Latinos until they are in their 60s,^{8,9} while drinking, and particularly heavy drinking, declines with increasing age in Whites.¹⁰ Although Whites have higher rates of alcohol abuse and dependency than Latinos,¹¹ compared to other ethnic groups, Latinos have higher rates of health conditions associated with alcohol abuse: cancer, unintentional injuries, and chronic liver disease/cirrhosis,¹² which are often comorbid with depression and anxiety.¹³ Latinos often engage in a pattern of low frequency, high levels of

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drinking per occasion, unlike Latinas who are usually abstinent or low-level drinkers¹⁴ and U.S.-born Latinos have higher rates of alcohol abuse than foreign-born Latinos.¹⁵

Yet, to our knowledge, there have been no studies testing interventions to reduce heavy drinking among aging Latinos, particularly aging day laborers. Of the more than 40 randomized trials examining interventions to reduce heavy drinking among younger adults in primary care sites,¹⁶ only one targeted Mexican-Americans,¹⁷ and three targeted older, primarily White adults.^{18,19,20}

We conducted semi-structured interviews to understand unhealthy alcohol use behaviors in socially disadvantaged, middle-aged and older Latino day laborers. We asked questions to explore their beliefs about the consequences of their alcohol use and what, if anything, would motivate them to change their drinking habits in order to identify elements for a culturally- and age-appropriate intervention.

Methods

This study used a grounded theory approach to explore how views of drinking behaviors were socially constructed by Latino day laborers. We used semi-structured interviews which can be especially effective in revealing the emotional and the symbolic meanings of drinking and its consequences that are not detected in typical survey approaches.²¹

Participants

We recruited participants from a job center operated by the *Instituto de Educación Popular del Sur de California* (IDEPSCA), a community-based organization that operates job centers and has a Workers Health Project to address the health needs of day laborers in Los Angeles. The research team distributed flyers and presented at the job center to recruit participants. Some participants referred their friends. The inclusion criteria were being: (1) Latino; (2) a day laborer; (3) age 50 years or older; and (4) an unhealthy drinker (defined as someone who reported having had at least two alcoholic drinks daily or almost daily). The interviews were conducted at locations convenient for participants, like the job center or a nearby coffee shop. Interviewers obtained participants' permission to audio-record the interviews, which were conducted in Spanish and translated into English by a transcription service. Participants each received a \$25 gift card for participating in the study.

Data Collection

The Institutional Review Board at the University of California, Los Angeles approved all study materials and procedures. Between January 20, 2009 and April 2, 2009, trained Spanish-speaking interviewers conducted semi-structured, face-to-face interviews lasting approximately one hour. Interviewers asked participants about (1) their perceptions of the health consequences of drinking alcohol (e.g., What do you think happens to your body when you drink alcohol?); (2) facilitators and barriers for changing their drinking behaviors (e.g., Would anything make you want to change your drinking habits?); and (3) their feelings about talking with health educators about their drinking habits (e.g., How comfortable would you be talking about your drinking behavior with a health educator?). Participants also completed a questionnaire with information on demographic characteristics (age, birth country, marital status) and health (family history of diabetes mellitus, high blood pressure). Alcohol use was measured using the Comorbidity-Alcohol Risk Evaluation Tool (CARET),^{22,23} which is used to identify adults who are unhealthy drinkers by assessing amount of alcohol use, comorbidity, symptoms and medication use.²⁴⁻²⁶

Data Analysis

We calculated descriptive statistics for the quantitative data. Transcripts were entered into Atlas.ti, a data management program for qualitative data. Interviews were interpreted through an inductive and data-driven, grounded theory approach^{27,28} that involved an iterative process of taxonomic organization, content analyses, and code mapping. Transcripts were coded during repeated examinations of the text by the multidisciplinary research team. The text was first broken down into fragments and “clustered” around single words or phrases. Clusters of text were coded and organized into a hierarchy of categories at consecutively higher levels of abstraction to build thematic content. We employed a constructivist paradigm in which the findings were “created” by exploiting the “variable and personal” nature of social constructs to refine individual constructs by comparing and contrasting them.²⁹ We used pseudonyms to de-identify the data.

Results

Sample Characteristics

Fourteen day laborers completed interviews. Table 1 shows that the respondents ranged in age between 50 to 64 years; the majority was from Mexico, lived with people other than their family members, and had less than a high school level education. All worked part-time and all but one reported earning less than \$5,000 each year. Most had lived in the US for at least 10 years, reported understanding or speaking English, and few reported being able to read English at any level. Almost all the participants reported a family history of alcohol abuse and rated their current health status as fair or poor. Thirteen of the 14 participants completed the CARET, and all reported drinking 4–7 or more drinks per occasion in frequencies ranging from 2–4 times per month to 6–7 times per week (Table 2). Participants reported multiple symptoms and conditions that could be caused or worsened by alcohol, including feeling sad or blue, trouble sleeping, and hypertension.

Thematic Analysis

In our analysis of the participants’ answers, three primary themes emerged: (1) perceived consequences of unhealthy alcohol use on physical and mental health, (2) the impact of unhealthy alcohol use on family relationships, and (3) the family as a key factor in efforts to change behavior (Table 3).

Consequences of Unhealthy Alcohol Use on Physical Health—Participants reported negative consequences of unhealthy alcohol use, including blackouts, accidents, job loss, falling due to loss of balance, cerebral hemorrhages, and epileptic convulsions. Respondents reported concerns with dying or aging faster. Two participants illustrated these concerns and the normalcy of heavy drinking. Diego, a 56 year-old diabetic Mexican who consumed one to two beers with dinner and 10 to 15 beers on Saturdays, claimed that being a heavy drinker was hereditary. “[Alcoholism] runs in the family. My father died of cirrhosis.... It’s in us. We like [alcohol]. We can’t stay away.”

Similarly, Gabriel, a 50 year-old Mexican, reported depressive symptoms and numerous falls in the past 12 months. He consumed 7 or more drinks daily. He had been warned of his risk for cirrhosis, yet indicated that he needed to drink to start his day, because “...I get palpitations in my stomach, like ulcers, and it prevents me from eating. I have to drink one [beer] to eat; otherwise I can’t eat. [Eating] makes me vomit.” He talked about friends that died because of excessive drinking and not eating enough:

“[Many] would go for 15 days drinking without eating. Then they would die; they would have a heart attack.... A lot of them had cirrhosis also. They would vomit their liver and would bleed...”

Excerpts from two other interviews also illustrated the concern with premature death:

“As long as I don’t get any help... I’m not going to make it and I’ll end up dead.”

“Alcohol is one of those things that shortens everyone’s lives.”

These passages suggest that perceptions of the consequences of drinking were reinforced either by their own experiences or those of heavy drinkers they knew.

The Consequences of Unhealthy Alcohol Use on Mental Health—Many participants attributed their alcohol use to loneliness, depression, or lack of self-love. Andrés was 50 years old, had a history of epileptic convulsions, drank 4 drinks two to three days per week. He admitted that his “number 1 reason” for drinking was because his family was very far away and he “lives like a lonely dog in the street.” Andrés shared that

“...[I’m] facing depression, which is not a justification but the root of the problem... you want to get rid of your depression and you decide to go for a beer or 3 or 4... I have emotional problems and depression and precisely because of that [I] look for those vices in order not to feel it so much...”

Other study participants indicated that, “depression is something to fight everyday,” and “... the alcoholic uses because nobody loves him...”

The Impact of Unhealthy Alcohol Use on Family Relationships—For most participants, prolonged and heavy alcohol use had strained their immediate and extended family relationships and interfered with their ability to send money to their families still living in their native countries. Oscar, a 51 year-old Guatemalan, consumed 4 drinks, 2 to 3 times per week, and was homeless. His right hand had been amputated following a car accident in which he was drinking and driving. He reported that

... the family suffers the most and the kids suffer too, they all suffer more than us... but there’s also an extended family, cousins, nephews, brothers, all of them... we’re taking the family down with us.

Another participant explained that “little by little you don’t belong to society or to your family.” These selections were illustrative of the emotional pain experienced by both the families and the participants.

The Family as a Key Factor in Efforts to Change Behavior—The third theme that emerged was that family relationships are perceived as a source of motivation to stop or reduce drinking. Oscar, discussed earlier, described his alcoholism as “a nightmare that’s never going to end” until he’s dead, but, “I’d like to continue living because I still love my children and I... need this help, otherwise I’m going to [die].” He said that professional help would motivate him to reduce his drinking, but “most importantly, my family... [I don’t want to] make my children suffer.” Similarly, 50 year-old Juan, who reported having 12 drinks every Saturday and as well as trouble sleeping, memory problems, and feeling sad, believed that his family could motivate him to change his drinking behavior: “I [once] stopped doing cocaine because of my mother.”

We also found that health educators perceived as fictive kin could also motivate participants to reduce their drinking. Participants reported being willing to meet with a health educator once a week or once a month and they often used language employed in the context of talking about their families. Andrés, discussed earlier, said, “[We must be] made to feel like

family. I'm [health educator] here to help you, not to turn you in to immigration. I'm your ally." Believing that health educators cared "...is something you need [so] you don't feel so alone." Ramón, a 64 years old Mexican with diabetes and problems falling asleep, reported that he consumed 7 or more drinks per day, four to five times per week. He also saw the health educators as fictive kin:

[The health educators are] [w]onderful because only someone who loves you a lot or someone in your family would [help you]... It makes you feel good that someone is worried about you... especially not having our family here ... the support of someone else that worries about you... is a good stimulus.

Discussion

Our study of Latino day laborers has three main findings: (1) economic and social disadvantages; (2) unhealthy alcohol use and cumulative risk of heavy drinking and aging; and (3) strained family relationships and the perception that one's family could motivate behavior change. The study sample was socially disadvantaged, impoverished, poorly educated and virtually illiterate in English. They reported high levels of alcohol consumption; alcohol-related symptoms and conditions exacerbated by alcohol use; and framed the consequences of their drinking in the severest of terms—death. We found that drinking escalated in response to the pressures of immigrating and being away from family, which suggests they may need additional support. All the participants reported negative experiences with their families due to their alcohol use. Participants also reported being open to meeting regularly with a health educator.

Although the average age of the participants was 54 years, their drinking patterns and comorbidities are consistent with studies showing that heavy drinking in Latino men does not decrease until they are in their 60s.^{8, 9} Research shows that older men with comorbidities and unhealthy alcohol use have a higher mortality rate than those who do not engage in unhealthy alcohol use, hence a lower threshold for what is considered unhealthy alcohol use may be appropriate for this population to reduce their mortality risk.³⁰ We infer from participants' concerns with premature aging and death that an intervention should increase their knowledge of alcohol use and comorbidities.

Further, the strain on family relationships caused by drinking may affect older laborers more acutely than younger ones. Physically, those with strained family ties may be less likely to have family members care for them as they age. Emotionally, negative feelings associated with failing to fulfill their expected social roles, like the provider for the family, might exacerbate feelings of guilt and shame and fuel drinking. Chronic access-to-care challenges or no health insurance, and physically demanding and dangerous jobs, make it likely that they will rely on informal care from the very family they alienated.

The most striking findings was the salience and motivational power the participants attributed to their families. The men believed that their families could help them more than a professional could. Every respondent prioritized their families over themselves when they discussed the consequences of alcohol use. Their answers were consistent with research demonstrating that Latinos often choose health behaviors in order to "do right" by the family;³¹ that feelings of obligation to family influence behavior regardless of how long a person has resided in the United States;³² and that there is a high reliance on family for emotional support.³³ This finding is also consistent with research showing that families play a greater role in men's decision to become sober as they age.³⁴ Alcohol abuse interventions based on family relationships have been developed already for Latino adolescents,^{35,36} but not for middle-aged or older men. For men separated from their families, we suggest incorporating how they describe their families into the training of staff. Training program

staff, like community health workers, can increase the success of an alcohol intervention program. Studies have demonstrated that health interventions that included community health workers were successful, including a program for Latinos with diabetes mellitus that had an 80% completion rate;³⁷ culturally responsive curricula for farm workers,³⁸ and reaching immigrant communities to enhance disease prevention and health promotion activities, as well as to improve access to healthcare services.^{39,40} Incorporating family values into the training of staff has the potential to offset the disruptions in family networks associated with substance use disorders in Latino men.⁴¹ In addition, better understanding of Latino day laborers' family values can help to develop programmatic and social support networks that function as family proxies.⁴²

Limitations

The limitations of this study, like for all qualitative studies, include the small sample size, convenience sampling from one location, and its exclusive focus on males. Thus, the results may not capture the perspectives of other groups. Still, the findings provide a new way to think about Latinos' family values as constituents for an intervention.

New Contribution to the Literature

This study attempts to bridge the gap in research on unhealthy drinking among aging Latino day laborers. Our findings suggest participants' family values can be leveraged in an intervention. We also identified areas for further research: (1) exploring how family relationships motivate behavior change; (2) learning to integrate participants' family values into staff trainings; and (3) developing novel ways to disseminate information on unhealthy alcohol use, aging, and comorbidities within the context of immigrant and work experiences. Knowledge in these areas is needed to create elements for an intervention to reduce the burden of alcohol-related physical, emotional, and social consequences in this vulnerable population.

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Table 1

Socio-demographic and health-related characteristics (n =14)

Characteristics	Total n (%)^a
<i>Age in years, mean (range)</i>	53.6 (50–65)
<i>Where were you born?</i>	
Guatemala	2 (14.3)
Mexico	12 (85.7)
<i>Marital Status</i>	
Married	4 (28.6)
Divorced/Separated	6 (42.9)
Never Married	4 (28.6)
<i>Living Situation</i>	
Living with spouse	1 (7.1)
Living with partner	5 (35.7)
Living with relatives or friends	2 (14.3)
Living with others, not relatives or friends	5 (35.7)
Live alone	1 (7.1)
<i>Education^b</i>	
=< 8 th Grade	5 (38.5)
Some High School	6 (46.2)
High School graduate/GED ^c	1 (7.7)
Technical/Trade School	1 (7.7)
<i>Employment</i>	
Working part-time	14 (100)
<i>Annual Income</i>	
< \$5,000	13 (92.9)
\$5,000 – \$14,999	1 (7.1)
<i>Year moved to the United States</i>	
Before 2000	12 (85.7)
2000 and thereafter	2 (14.3)
<i>Understand English</i>	
Very well	2 (14.3)
Not too well	7 (50)
Not at all	3 (21.4)
Don't know	2 (14.3)
<i>Speak English</i>	
Very well	2 (14.3)
Not too well	6 (40.0)
Not at all	3 (21.4)
Don't know	3 (21.4)
<i>Read English</i>	
Very well	2 (14.3)

Characteristics	Total n (%) ^a
Not too well	2 (14.3)
Not at all	5 (35.7)
Don't know	4 (28.6)
<i>Family history of...</i>	
Depression	6 (42.9)
Alcohol problems	12 (85.7)
<i>Current Health Status</i>	
Excellent	0 (0)
Good	2 (14.3)
Fair	8 (57.14)
Poor	4 (28.57)
<i>Quality of Life (scale 0–10)</i>	
0–6 (worse)	8 (57.1)
7–10	6 (42.9)

^aTotal may not add up to 100% due to rounding.

^bOne response is missing for education.

^cGeneral Educational Development Test

Table 2Alcohol use, symptoms and conditions (n=13)^a

Items	Total n (%) ^b
<i>Frequency of drinking</i>	
6–7 times per week	1 (7.7)
4–5 times per week	3 (23.0)
2–3 times per week	5 (38.5)
Once a week	2 (15.4)
2–4 times per month	2 (15.4)
<i>Quantity of drinking per occasion</i>	
7 or more drinks	8 (61.5)
4 or more drinks	5 (38.5)
<i>Sometimes or often have the following symptoms:</i>	
Feeling sad or blue	9 (69.2)
Trouble sleeping	6 (46.2)
Gastrointestinal complaints	5 (38.5)
Memory problems	5 (38.5)
<i>Conditions</i>	
Hypertension	5 (38.5)
Diabetes mellitus	2 (15.4)
Depression	3 (23.1)
Gout	2 (15.4)

^aOne response is missing.^bTotal may not add up to 100% due to rounding

Table 3**Themes Regarding Consequences and Impact of Unhealthy Alcohol Use**

1. <i>Perceived Consequences of Unhealthy Alcohol Use on...</i>
Physical Health
Alcohol use will lead to new disease or death in the future
Alcohol impacts health today
Mental Health
Alcohol seen as a way to cope with depression and loneliness
Will come to believe that no one loves him
2. <i>Impact of Alcohol on Family Relationships</i>
Children and extended family suffer more than the alcohol user realizes
Family has cut-off the alcohol user
3. <i>Family Values and Assistance for Behavior Change</i>
Restoring relationships with spouses and children most important
Health educators that treated men like family, e.g., caring, worrying about safety
