



**PREVALENCE AND FACTORS ASSOCIATED WITH
POST TRAUMATIC STRESS DISORDER (PTSD)
AMONG MYANMAR MIGRANTS
IN MAE SOT, TAK PROVINCE**

ARKAR MANN KYAW

**MASTER OF PUBLIC HEALTH
IN
BORDER HEALTH MANAGEMENT**

**SCHOOL OF HEALTH SCIENCE
MAE FAH LUANG UNIVERSITY**

2025

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**THIS THESIS IS A PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
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THESIS APPROVAL
MAE FAH LUANG UNIVERSITY
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IN
BORDER HEALTH MANAGEMENT

Thesis Title: Prevalence and Factors Associated with Post Traumatic Stress Disorder
(PTSD) among Myanmar Migrants in Mae Sot, Tak

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Arkar Mann Kyaw



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ABSTRACT

Mental disorders such as Post-Traumatic Stress Disorder (PTSD) are highly prevalent among displaced populations, however, evidence remains limited among Myanmar migrant in Thailand, despite their heightened exposure to conflict, displacement, and post-migrant stressors. This study aimed to estimate the prevalence of PTSD and determine associated factors among Myanmar migrants living in Mae Sot district, Tak province, Thailand.

A cross-sectional study was conducted among Myanmar migrants residing in Mae Sot, Mae Tao, and Tha Sai Luad sub-districts. Data were collected using a self-developed, validated questionnaire. PTSD symptoms were assessed using the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5), with a cut-off score of 33 or higher indicating PTSD. Chi-square tests were conducted for preliminary analyses, and logistic regression was performed to determine factors independently associated with PTSD.

A total of 360 Myanmar migrants participated; 64.2% were female. The prevalence of PTSD was 31.7%. After adjustment for potential confounders, higher odds of PTSD were observed among females, younger migrants, those originating from conflict-affected areas, and individuals who were unemployed or engaged in professional/freelance work. Social structural vulnerabilities-including living apart from family, shorter duration of residence in Thailand, language difficulty, perceived discrimination, and perceived social exclusion were also independently associated with PTSD. In addition, substance use (tobacco and other substances) was strongly associated with PTSD.

A substantial proportion of Myanmar migrants in Mae Sot experience PTSD, reflecting significant unmet mental health needs. These findings highlight the urgent necessity for inclusive public health responses, including the integration of mental health services into health insurance benefit packages and the development of culturally adapted, accessible mental health

interventions. Addressing post-migration stressors and structural exclusion is essential to mitigating the invisible wounds experienced by migrant communities.

Keywords: Post-traumatic Stress Disorder, Myanmar Migrants, Border Health, Migrant Mental Health, Prevalence, Associated Factors



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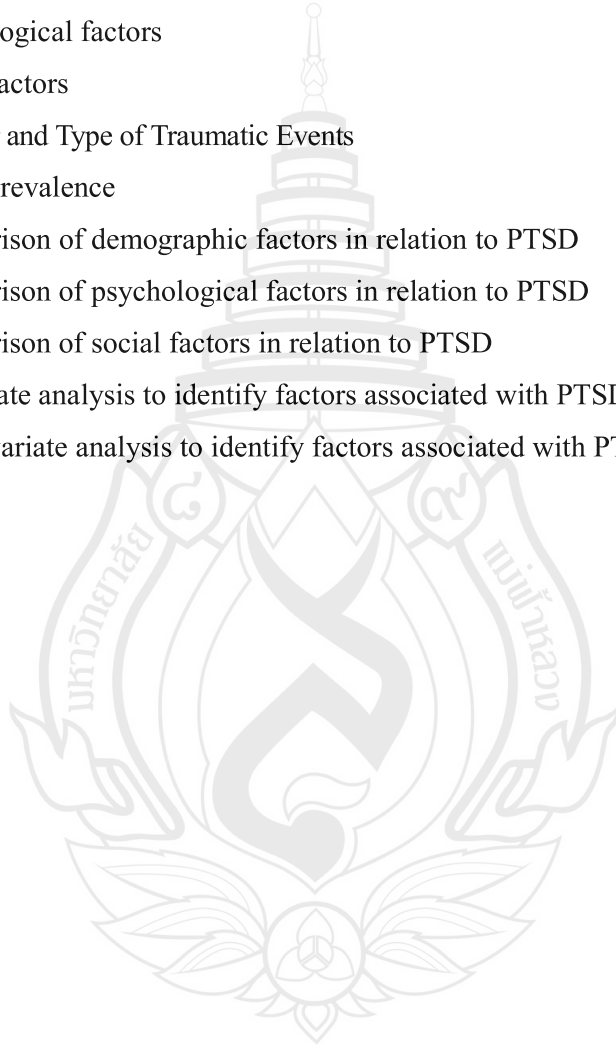
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ABBREVIATIONS AND SYMBOLS

PTSD	Post Traumatic Stress Disorder
COVID-19	Coronavirus Disease 2019
IOM	International Organization for Migration
WHO	World Health Organization
HIV	Human Immunodeficiency Virus
NCD	Non-Communicable Diseases
CBT	Cognitive Behavioral Therapy
EDMR	Eye Movement Desensitization and Reprocessing
SDH	Social Determinants of Health
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
PCL-5	Posttraumatic Stress Disorder Checklist for DSM-5
DSM IV TR	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
cOR	Crude odds ratio
adjOR	Adjusted odds ratio
CI	Confidence interval
IOC	Item Objective Congruence
FMDWS	Female migrant domestic worker
CAPS-5	Clinician-Administered PTSD Scale for DSM-5
PSS-I-5	PTSD Symptom Scale Interview for DSM-5
MSPSS	The multidimensional scale of perceived social support
NGOs	Non-Governmental Organizations
CSOs	Community-Service Organizations

CHAPTER 1

INTRODUCTION

1.1 Background and Rationale

Mental health refers to how we feel, think, and cope with life's challenges, which is crucial to our overall well-being (1). Poor mental health can affect various aspects of life, such as relationships, work, and longevity, while increasing risks such as suicide and human rights violations, all with significant economic implications (2). In 2019, approximately 1 in 8 people worldwide, or 970 million individuals, were affected by mental disorders, a number that rose significantly during the COVID-19 pandemic (3). In 2010, mental disorders cost the global economy \$2.5 trillion, with indirect costs (\$1.7 trillion) exceeding direct costs (\$0.8 trillion). These costs, which are higher in proportion to those of other major diseases, are expected to double by 2030 (4). Those who are exposed to traumatic events, such as warfare, accidents, natural disasters, or sexual violence, can endure conditions like posttraumatic stress disorder (PTSD), depression, anxiety, or substance use disorders that persist for months or years in some individuals. Around 70% of people worldwide will face a potentially traumatic event in their lives, but only about 5.6% will develop post-traumatic stress disorder (PTSD) (5).

Posttraumatic Stress Disorder (PTSD) is a serious mental health condition characterized by symptoms that involve re-experiencing the traumatic event, avoidance, changes in beliefs and emotions, and heightened physiological arousal following the event. Like other mental health disorders, PTSD arises from a combination of biological, psychological, and social factors including personality traits, previous mental health issues, female gender, sociodemographic characteristics, and specific alterations in gene expression. The characteristics of the traumatic event also influence the likelihood of developing PTSD; for instance, experiencing prolonged or repeated traumatic events, sustaining a serious physical injury, or witnessing harm to others can all heighten the risk (5-7).

The prevalence of PTSD commonly differs depending on the geographical location, across different populations, and context, which reflects the impact of trauma exposure. The established prevalence was 3.4 to 57.6% in adult irregular immigrants (IMs) to Europe (8), 31% in adult Syrian refugees resettled in high-income Western countries (9), 19.8% to 94% among refugees, asylum seekers, and migrants from African countries (10), 3.8% to 42.37% in Serving Military and Veteran Populations (11), 48.4% in the Ethiopian population dwelling in war-affected communities (12), and 40.8 % for of migrants living in limbo(13). Recent studies show a significantly high prevalence of PTSD among military personnel, veterans, migrants, refugees, and communities affected by war. Most of these studies focus on personal information and social factors. However, this study emphasizes psychosocial factors, as PTSD can also stem from psychological elements.

The psychosocial model of mental health emphasizes the interplay between an individual's psychological state and social environment, focusing on socio-economic conditions, relationships, and life experiences rather than biological causes. It addresses social determinants like poverty, trauma, and social exclusion, providing a holistic framework that spans emotional, social, cognitive, and spiritual dimensions. Key features include prioritizing therapy, peer support, and community involvement while promoting human rights and reducing stigma. Widely applied across healthcare, education, and community services, it informs practices such as trauma-informed care and mental health education. This model is well-suited to the study as it integrates psychological and social factors, such as trauma exposure, housing, and discrimination, to explore PTSD among Myanmar migrants and guide community-level interventions (14, 15).

Migrants are individuals who move to a foreign country to live or work, and are also known as immigrants who have arrived from abroad by the hosts (16). Approximately 1 billion people live outside their country of birth, including 281 million international migrants and 82.4 million forcibly displaced individuals (17,18). Migration is a complex, ongoing process influenced by social, political, and personal factors, and the experience differs depending on whether it is forced or voluntary (19). Migrants, particularly refugees, are often exposed to adversity and show higher rates of mental health disorders compared to host populations (18). These risks are exacerbated by traumatic events, which can be experienced at various stages of migration: pre-migration (e.g., conflict, violence), during

migration (e.g., dangerous journeys), and after migration (e.g., socio-economic challenges) (16).

Thailand has a long history of hosting hundreds of thousands of people from neighboring countries fleeing from war, internal conflict, or national instability, while also successfully promoting and deploying many workers abroad, especially from Cambodia, Lao PDR, and Myanmar.(20). According to the IOM data from October 2023, Mae Sot in Tak province, Thailand, hosts 81,000 Myanmar migrants (21), but the number is still underestimated for many reasons. Following Myanmar's coup in February 2021, there has been a significant increase in migrants at the Thai border, including laborers, displaced persons, political refugees, and vulnerable groups (22). Previous studies on migrants have highlighted trends in PTSD prevalence. A 2015 study in Uganda found that the prevalence of PTSD was 11.8% seven years after the conflict, indicating that the effects of trauma can persist for years (23). Additionally, a five-year longitudinal study in Canada revealed that the PTSD rate among visible minority immigrants was 7.5%, which is double that of the host population (24). Furthermore, a meta-analysis of communities affected by the Ethiopian war reported an alarmingly high PTSD prevalence of 48.5% (12). However, research on the PTSD prevalence of PTSD within the Myanmar migrant community in Thailand remains limited.

PTSD, categorized as a mental disorder, has not been widely studied among Myanmar migrants, even though the high prevalence of mental health issues (like anxiety and depression) exists. A few studies have explored their mental health. A 2021 cross-sectional study conducted among Myanmar migrants in the Samut Sakhon district, Bangkok, revealed that 11.9% of participants reported symptoms of depression and/or anxiety (25). Another recent study in the Samut Prakan district, Bangkok, found that 47.9% of young Myanmar migrant workers experienced depressive symptoms, which were associated with workplace, security, and living stressors, as well as self-esteem issues (26). It is crucial to have information about PTSD among Myanmar migrants, as Mae Sot is the most populated migrant area with a high-risk population.

Untreated PTSD in migrants has significant impacts across various levels. At the individual level, it can lead to chronic psychological distress, depression, anxiety, substance abuse, and an increased risk of self-harm or suicide. This not only affects the individuals but also strains family relationships, as emotional withdrawal, irritability, and aggression

often arise. In communities, individuals with untreated PTSD may withdraw from social engagement, further isolating themselves. On a societal scale, the rising demand for mental health care due to untreated PTSD can strain healthcare resources. Economically, untreated mental health conditions, including PTSD, cost economies billions of dollars annually in lost productivity and healthcare expenditures, which also affects the mental well-being of the host population.(27).

The context of PTSD and migrants' health issues is complex and still under debate. However, research demonstrates that post-migration living conditions significantly influence migrants' mental health. This study utilizes the psychosocial model to comprehensively address the social, personal, and psychological needs of individuals while also promoting the prevention of mental health issues.

The study aimed to identify significant risk factors contributing to PTSD, including psychological factors (substance use, alcohol consumption, and number of traumatic events), social factors (housing stability, neighborhood safety, social support, discrimination, and legal status), and demographic factors (gender, age, marital status, and employment). Demographic factors can be used to identify higher-risk groups, while associated factors can help modify existing interventions and implement new effective health promotions. Furthermore, this study aimed to address the mental health challenges faced by Myanmar migrants by providing data-driven insights that can inform public health policies and interventions in border regions such as Mae Sot. The actionable insights from this study will help policymakers, NGOs (non-governmental organizations), and healthcare providers prioritize mental health within migrant programs. It also advocates for increased funding and enhanced access to mental health services in areas like Mae Sot.

Additionally, the findings offer evidence-based recommendations for mental health interventions tailored to the unique needs of Myanmar migrants, aiming to enhance mental health outcomes. Furthermore, the study proposes strategies for community-level support systems, emphasizing improved social inclusion, reduced discrimination, and better access to healthcare services.

1.2 Objectives

The study has two objectives:

1. To estimate the prevalence of PTSD among Myanmar migrants living in Mae Sot, Tak province, Thailand.
2. To identify the factors associated with PTSD among Myanmar migrants living in Mae Sot, Tak province, Thailand.

1.3 Operational Definitions

1.3.1 Gender is about the roles, behaviors, expressions, and identities that society assigns to people based on their perceived or assigned sex. It differs from biological sex, which refers to physical and physiological traits. Cultural, social, and personal factors influence gender. However, gender will be recorded as a nominal variable with options for male and female,

1.3.2 Age is defined as the length of time an individual has lived, typically calculated in years from their birth date to the data collection date. Age will be collected as continuous data and later categorized into age groups.

1.3.3 Marital status refers to a person's legal relationship and includes various categories based on their current situation. Marital status categories include single, married, widowed, divorced, and separated.

1.3.4 Religion is the belief system or faith practice that a person identifies with. It includes spiritual beliefs, rituals, and traditions that can affect how they cope with challenges, interact with others, and maintain their mental health. Religion will be categorized into commonly observed options such as Buddhism, Christianity, Islam, and others.

1.3.5 Ethnicity is how participants identify their cultural, language, or ancestral group. It shows their shared heritage, traditions, and social identity. Ethnicity will include groups like Karen, Mon, Burmese, Shan, Kachin, and others.

1.3.6 Place of origin means the last place where the participant lived or was part of a community in Myanmar before moving to Thailand. This indicates their geographical and

cultural background. Region of origin will be open-ended, and later categorized into Myanmar states or regions.

1.3.7 Education is the highest level of formal schooling the participant has completed when they took the survey. This level of education can impact their awareness, coping strategies, and access to resources. Education levels will be grouped into illiterate, primary school, middle school, high school, and graduate and higher. Income will be collected as continuous data and categorized during analysis

1.3.8 Employment Status shows the participant's current work situation. It tells whether they are employed, unemployed, or doing informal work. Employment status will have options such as employed and unemployed. Data will be collected primarily through binary (yes/no) or multiple-choice questions, with options for further details where applicable.

1.3.9 Occupation means the main job or activity a participant does to earn money during the survey. This can affect their economic status, stress levels, and access to resources... while occupation will reflect common migrant jobs like factory labor, domestic work, agriculture, shopfront selling, construction, and others.

1.3.10 Income is the total money a participant earns from all sources, such as wages, self-employment, or remittances, over a specific period, like a month. This total can influence their access to resources and overall well-being.

1.3.11 Housing means having a secure and permanent place to live. It looks at whether a person has adequate shelter or is facing housing instability, which can include frequent moves, homelessness, or overcrowding. Housing conditions will be assessed by identifying participants' places of residence, categorized as rented dormitories, work compounds, shared housing, or others, to determine stability.

1.3.12 The number of family members living together is the total count of family members, like parents, children, or close relatives, who share the same home as the participant. This number can affect the participant's social support and emotional well-being.

1.3.13 Length of stay in Thailand means how long the participant has lived in Thailand since arriving, measured in years or months. This duration can impact how well they adapt, integrate socially, and maintain their mental health. The duration of stay will be open-ended and recorded as continuous data.

1.3.14 A language barrier is people's difficulty communicating in languages while seeking health services.

1.3.15 Legal status means how a person is officially classified in the country where they live. This classification affects their access to rights, services, and legal protections. For migrants, legal status can include being an asylum seeker, refugee, undocumented migrant, or legal resident. Legal status will be categorized into documented or undocumented.

1.3.16 Ability to access health services refers to the participant's actual ability to obtain healthcare in their current living environment.

1.3.17 Health insurance card refers to the official documentation that entitles an individual to access health care services, including medical treatment, either through a public or private health insurance. Having a health insurance card can significantly influence an individual's ability to receive necessary care, especially regarding financial support and accessibility. Information about health insurance will be collected through a binary question (yes/no), with further categorization into schemes such as the Social Security Scheme, Migrant Health Insurance Scheme, M-Fund (widely used in Mae Sot), or others.

1.3.18 Smoking means that participants report using tobacco products, like cigarettes, chewing tobacco, cigars, etc., which can affect their physical and mental health.

1.3.19 Alcohol drinking refers to how much alcohol (beer, wine, spirits, etc.) the participant reports drinking in the past month

1.3.20 Substance use refers to the participant's self-reported use of cannabis, cocaine, amphetamine, inhalants, sedatives or sleeping pills, hallucinogens, or opioids within the past month.

1.3.21 Perceived neighborhood safety is about how safe and secure people feel in their homes and surrounding areas, and will be collected as binary responses (yes/no). This includes their awareness of crime, violence, and other dangers nearby. Feeling unsafe can lead to stress and trauma, which can worsen mental health issues like PTSD.

1.3.22 Perceived social exclusion is when a person does not receive enough emotional, practical, or informational support from their social network, which includes family, friends, and community members. Perceived social exclusion will be collected as binary responses (yes/no).

1.3.23 Perceived discrimination means maltreating people based on their race, ethnicity, nationality, religion, gender, or legal status. Migrants often face discrimination in

places like work, healthcare, schools, and daily interactions in their communities. This unfair treatment can harm their mental health and lead to symptoms of discrimination. Discrimination will be collected as binary responses (yes/no).

1.3.24 Perceived social support refers to the individual's perception from 3 sources: family, friends, and a significant Other, which is assessed by the Multidimensional Scale of Perceived Social Support (MSPSS) with a mean score of 1-7.

1.3.25 Post Traumatic Stress Disorder (PTSD) refers to a mental disorder classified under stress and trauma-related disorders in the DSM-5 [33,34], which is assessed by the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) with a score of 33 or higher plus at least one traumatic event in life.

1.3.26 The number and type of traumatic event exposures count how many different traumatic events a person has experienced. It doesn't matter if the events are similar or different. This count helps show the total trauma someone has faced, which can affect how severe their PTSD symptoms might be. Traumatic events range from large-scale crises (war, terrorism, natural disasters) to personal tragedies (violent assault, chronic illness, or the death of a loved one).

1.3.27 Myanmar migrants are people who have moved from Myanmar to another country, like Thailand. They may stay temporarily or permanently. They migrate for different reasons, including seeking better job opportunities or escaping political and social problems. This group includes refugees, asylum seekers, labor migrants, and other Myanmar nationals who leave due to various challenges in their home country.

1.4 Conceptual Framework

This study adopted a psychosocial framework to estimate the prevalence of PTSD and investigate the factors associated with it among Myanmar migrants in the Mae Sot district of Tak province. The research focuses on the interaction of psychological and social factors, including pre-migration trauma, post-migration stressors, and demographic characteristics, to understand how they influence PTSD.

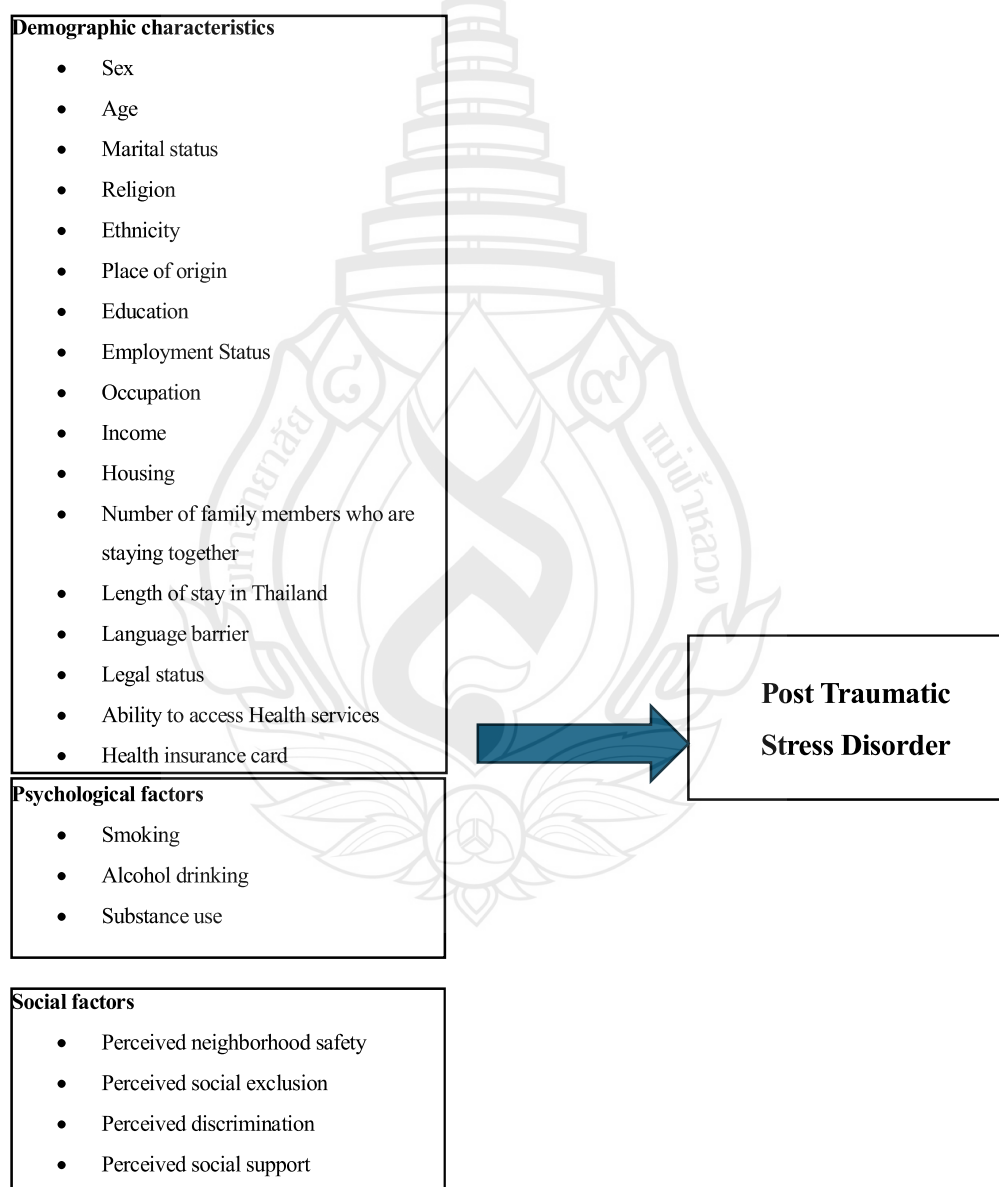


Figure 1.1 Conceptual Framework

CHAPTER 2

LITERATURE REVIEW

This chapter reviews existing theories and research related to post-traumatic stress disorder (PTSD) among migrant populations. It highlights the various factors that contribute to the prevalence of PTSD within this group. The section is organized under the following headings:

- 2.1 Concept of Human Migration and Health
- 2.2 Migration and Mental Health
- 2.3 Post-Traumatic Stress Disorder
- 2.4 Relevant research findings

2.1 Concept of Human Migration and Health

Migration is defined as the movement of individuals across the globe, typically to establish permanent or semi-permanent residency. This phenomenon has been a fundamental aspect of human civilization, dating back to early migrations from East Africa and remaining a defining feature throughout history. Migration occurs in various forms, ranging from short-distance movements within local areas to extensive relocations between countries (28, 29).

Migration involves various purposes, including everyday activities such as commuting, shopping, traveling, and longer-term relocations. While these short-term moves provide valuable insights, they differ from more permanent migrations, which are often motivated by economic, social, or personal factors. The potential for greater stability influences the decision to migrate, as do better job opportunities or improved living conditions, all contributing to the steady increase in migration rates worldwide (28).

2.1.1 Types of Migration

Migration manifests in several forms, each distinct based on its motives and characteristics:

1. Internal Migration: This occurs when individuals move within the borders of their own country, relocating from one city or region to another.
2. External Migration: Movement across national borders, known as external migration, includes both immigration and emigration, representing the departure from one country and settling in another.
3. Emigration and Immigration: Emigration involves leaving one country to reside in another, while immigration refers to entering a new country from abroad.
4. Forced Migration: Forced migration occurs when governments or authorities compel large populations to relocate, often due to race or religion, and is also known as population transfer or involuntary migration.
5. Impelled Migration: People leave their homeland due to adverse conditions, such as war, political instability, or religious persecution, although they are not directly forced.
6. Voluntary Migration: In voluntary migration, individuals choose to relocate, often motivated by prospects of better living conditions or job opportunities.
7. Refugees and Asylum Seekers: Refugees are those who flee their home country due to persecution, fear, or severe threats, and generally arrive in a new country with minimal belongings. Asylum seekers, similarly, leave their country to seek protection in another (28, 30).

This study will focus on Myanmar migrants living in the Mae Sot district for at least six months due to various reasons for migration.

2.1.2 Causes of Migration

Everett Lee's theory explains migration as a selective process influenced by push and pull factors. Push factors compel people to leave their homes due to unfavorable conditions, such as poor living standards, political instability, environmental hazards, or social and economic decline. In contrast, pull factors are attractive aspects of a new location that draw people in, such as improved living standards, better employment opportunities, and stable social conditions (29). Both push and pull factors encompass a variety of social, political, economic, and environmental influences.

2.1.3 Effects of Migration on Health

Migration impacts both origin and destination locations, contributing to changes in population dynamics, resources, and healthcare needs. Generally, these moves are seen as helpful for the places that welcome migrants (31). Migration can simultaneously introduce challenges for migrants themselves, particularly regarding health. Migration and health are increasingly recognized as global public health priorities, as the scale and complexity of migration grow. Migrants, particularly those from conflict zones, war-torn regions, or areas facing environmental crises, often face a high risk of infectious diseases due to inadequate resources, crowded living conditions, and limited access to healthcare. In reception and settlement areas, factors like crowded shelters can lead to outbreaks of respiratory and gastrointestinal infections. Following resettlement, latent and untreated infections, such as tuberculosis, viral hepatitis, HIV, and parasitic diseases, may remain prevalent, leading to ongoing health challenges (32,33). Non-communicable diseases (NCDs) also vary based on migrant demographics, settlement countries, and types of conditions, including cardiovascular diseases, diabetes, and cancers (34).

2.2 Migration and Mental Health

In 1932, Odegaard studied the relationship between migration and mental health, showing that migration can be a precipitating factor for mental illness. Vulnerable individuals may experience increased risks of mental health issues post-migration due to the numerous barriers encountered during migration and post-migration adjustment. Migrants often face stressors such as discrimination, language barriers, social isolation, and cultural adjustment challenges, which can increase the likelihood of developing mental health disorders (30).

2.2.1 Mental Health

The Mental Health Foundation explains that mental health encompasses individuals' thoughts and feelings about themselves and their lives. It affects their ability to manage stress, adapt to adversity, and function effectively in family, work, and community settings. Mental health is closely tied to physical health, impacting the other in interconnected ways (35).

2.2.2 Common Mental Disorders and Migration

The World Health Organization and meta-analysis studies indicate that the most prevalent mental disorders among migrant populations are anxiety disorders, depressive disorders, and post-traumatic stress disorders.

1. **Anxiety Disorders:** Anxiety disorders are characterized by intense fear and worry that disrupt daily life. These disorders include generalized anxiety disorder, panic disorder, social anxiety disorder, and separation anxiety disorder. Globally, anxiety disorders affect approximately 4.05% of the population, with rates rising over the past three decades. They are more prevalent in high-income regions and are more common among women (3, 36).

2. **Depressive Disorders:** Depressive disorder goes beyond temporary mood changes, presenting as prolonged sadness or loss of interest in activities. It often includes symptoms like low self-esteem, suicidal thoughts, sleep disturbances, and appetite changes. Depression increases suicide risk, but effective treatments, including therapy and medication, are available based on severity and age. Major depressive disorder (MDD) and persistent depressive disorder (PDD) share similar symptoms and causes, influenced by genetics, neurotransmitter imbalances, and environmental factors such as work-related stress. Treatment mainly involves medication and cognitive therapy. (3, 37).

3. **PTSD:** PTSD may arise after exposure to traumatic events, with symptoms like intrusive memories, flashbacks, avoidance of reminders, and a constant sense of threat. These symptoms must persist for several weeks to impact functioning significantly, and effective psychological treatments are available (3).

2.2.3 Impact of mental disorders among migrant populations

Mental health disorders, including PTSD, have significant impacts on migrants at various levels

1. **Individual level:** Migrants are at a greater risk of developing post-traumatic stress disorder (PTSD) due to experiences such as conflict, persecution, and perilous journeys. Mental health disorders can result in symptoms like flashbacks, nightmares, and increased anxiety, all of which can disrupt their daily functioning and diminish their quality of life. If these issues go untreated, they may lead to significant problems such as substance abuse and suicidal thoughts (38, 39).

2. Family and community level: Stigma surrounding mental health is often heightened for migrants, who may already face discrimination in host communities. This stigma can prevent individuals from seeking support and strain relationships with family and community members, impacting their ability to form stable social networks (40, 41).

3. Economic Impact: The human capital approach measures the economic impact of mental disorders by separating costs into two categories: direct costs and indirect costs. Direct costs include visible expenses such as diagnosis, treatment, medication, and hospitalization. In contrast, indirect costs encompass invisible losses, such as decreased income due to mortality, disability, and absenteeism from work (4). Migrants with mental health disorders often struggle to maintain stable employment due to persistent symptoms, leading to economic instability. Despite this, migrant workers contribute to the host country's economy in the same way as local workers. This financial burden impacts not only the affected individuals but also strains the healthcare systems in host countries (42).

The high prevalence of mental health disorders among migrants has highlighted the urgent need for specialized mental health services. Effective interventions are essential, as untreated mental health issues can exacerbate illness, deepen existing health inequalities within migrant populations, and result in significant indirect costs.

2.3 Post-traumatic Stress Disorder (PTSD)

The impact of trauma on mental health has been noted throughout history, especially among soldiers. In the 18th century, Joseph Auenbrugger described PTSD-like symptoms such as exhaustion and depression in homesick troops. Terms like “irritable heart” in the Civil War and “shell shock” in the World Wars reflect early attempts to understand trauma responses. However, they weren't yet unified under a single diagnosis. Today, PTSD is formally recognized as a unique disorder, classified under "Stress and Trauma-Related Disorders" in the DSM-5, not as an anxiety disorder. Civilian PTSD is common, with triggers like accidents and assault, especially among adolescents, where trauma exposure is high (43, 44).

Post-traumatic stress disorder (PTSD) is a complex condition triggered by exposure to traumatic events, whether single or repeated, such as war, terrorism, natural disasters,

violent assaults, and serious accidents. People with PTSD often experience intense, persistent fear memories and may feel emotionally numb, especially when untreated, which can lead to severe consequences like substance abuse and depression, posing risks to their well-being (1, 45). Symptoms of PTSD must persist for several weeks to significantly impact daily functioning. Fortunately, effective psychological treatments are available to help manage these symptoms (1, 46).

2.3.1 Signs and Symptoms

PTSD is a complex condition often triggered by traumatic events. Its symptoms are divided into distinct clusters: re-experiencing, avoidance and numbing, and arousal. Re-experiencing involves the involuntary reliving of trauma through flashbacks and nightmares, often triggered unexpectedly. Avoidance and numbing refer to behaviors aimed at avoiding trauma-related thoughts or places, as well as emotional detachment, which can impair relationships. Arousal symptoms reflect a heightened state of alertness, manifesting as hypervigilance, irritability, and insomnia (45, 46).

The DSM-5 refined PTSD's classification, relocating it from anxiety disorders to Trauma and Stressor-Related Disorders, grouping it with conditions like Acute Stress Disorder and Adjustment Disorders. This update also removed the requirement for immediate emotional responses, such as fear or helplessness, in diagnosing PTSD. The DSM-5 expanded the symptom criteria from three to four clusters: intrusion (flashbacks and unwanted memories), avoidance (of trauma-related reminders), negative changes in mood and cognition (emotional numbness and detachment), and hyperarousal (insomnia and hypervigilance) (43).

These symptoms disrupt daily functioning, with emotional numbness often straining relationships, while insomnia and hypervigilance lead to chronic exhaustion and anxiety. This revised understanding of PTSD's symptomology highlights the disorder's wide-reaching impact on mental and physical well-being, emphasizing the importance of accurate diagnosis and tailored treatment approaches (43, 45, 46).

2.3.2 Comorbidity

PTSD frequently coexists with other mental health conditions, making its diagnosis and treatment more complex. Depression, anxiety, and substance abuse are the most common comorbid disorders. Studies reveal that more than half of men with PTSD also struggle with alcohol misuse, followed by depression and conduct disorders. At the same time,

women with PTSD most often experience depression, specific phobias, and social anxiety. Nearly half of women with PTSD also report issues with alcohol, though the prevalence is lower than in men. PTSD's comorbidities can significantly impair individuals' ability to function, leading to greater risks of unemployment, divorce, social isolation, and a higher chance of involvement in domestic issues, all of which underscore the need for comprehensive treatment strategies that address the full range of comorbidities (43, 46).

2.3.3 Etiology and Causes of PTSD

Post-traumatic stress disorder (PTSD) is increasingly understood as a complex psychological condition that arises from a failure of recovery following traumatic experiences. Understanding altered fear learning is crucial. This term describes the difficulty in stopping reactions to things that remind a person of their trauma. This struggle can lead to ongoing and distressing symptoms that affect individuals in many ways (43). Following exposure to trauma, it is common for individuals to experience PTSD symptoms, indicating that these reactions are almost universal among those who have faced such events (45).

Research suggests that around 60% of men and 50% of women will encounter a traumatic experience in their lifetime. Although most individuals exposed to trauma may exhibit some symptoms of PTSD in the immediate after-effects, the severity and duration of these symptoms can vary significantly. For some, symptoms may resolve quickly, while others may face more persistent challenges (40).

The reasons behind the development of PTSD are complex and multifaceted, with ongoing research exploring the biological, psychological, and social factors that contribute to its onset. For instance, data from the World Mental Health Surveys (WMHS) conducted by the World Health Organization (WHO) reveal that between 25% and 40% of individuals diagnosed with PTSD will recover within the first 12 months, often resolving within the initial six months after the traumatic event. However, meta-analytic studies indicate that nearly 50% of those with PTSD may develop a chronic condition, particularly if the disorder is left untreated (47).

Understanding these various elements is key to developing effective prevention and intervention strategies. Continued research into the etiology of PTSD will aid in identifying at-risk populations and tailoring treatments that address the specific needs of individuals coping with the lasting effects of trauma.

2.3.4 Assessment of PTSD

Post-traumatic stress disorder (PTSD) can be assessed by using various tools to evaluate symptoms and responses to trauma. There are two main types of measures used to assess PTSD:

Structured Interviews involve a standardized set of questions that an interviewer (licensed expert) asks the participant.

Self-report questionnaires are printed questionnaires that participants fill out on their own. This measure typically takes less time to complete and can complement information gathered from structured interviews.

2.3.4.1 The Clinician-Administered PTSD Scale (CAPS-5)

The CAPS-5 (Clinician-Administered PTSD Scale for DSM-5) is the gold standard tool for assessing PTSD. This 30-item interview helps diagnose PTSD for both lifetime and current (past month) occurrences and evaluate symptoms over the past week. It examines 20 DSM-5 PTSD symptoms, including their onset, duration, and impact on daily life, such as work and relationships. The tool also measures overall PTSD severity, changes in symptoms over time, and dissociative symptoms like depersonalization and de-realization. Designed for clinicians or trained professionals with PTSD expertise, the interview takes 45–60 minutes, providing a thorough and standardized assessment of PTSD (48).

2.3.4.2 PTSD Symptom Scale Interview for DSM-5 (PSS-I-5)

The PSS-I-5 (PTSD Symptom Scale Interview for DSM-5) is a 24-item interview designed to evaluate PTSD symptoms over the past month and determine a diagnosis based on DSM-5 criteria. The assessment is to identify a specific trauma, especially when multiple events are reported. It measures the frequency and intensity of 20 PTSD symptoms across four categories: intrusion, avoidance, negative mood, and hyperarousal. Each symptom is rated on a 5-point scale, from 0 (not at all) to 4 (severe or occurring six or more times a week), with symptoms considered present if rated 1 or higher. The total score, ranging from 0 to 80, reflects overall symptom severity. A PTSD diagnosis requires at least 1 intrusion symptom, 1 avoidance symptom, 2 negative mood symptoms, and significant distress or functional impairment, defined as a score of 2 or higher on specific items. Additional questions assess symptom onset, duration, distress, and how symptoms interfere with daily life (49).

2.3.4.3 PTSD Checklist for DSM-5 (PCL-5)

One common self-report tool is the PTSD Checklist for DSM-5 (PCL-5), which consists of 20 items directly linked to DSM-5 criteria. The PCL-5 is useful for screening and tracking symptom changes during treatment (43). Self-report assessments are cost-effective and quick, making them helpful for initial screenings and complementing structured interviews.

However, self-report measures have limitations and should not be used alone for diagnosis due to potential biases and inaccuracies. These measures merely indicate the likelihood or "cases" of a mental disorder, serving as a preliminary screening tool that necessitates further clinical assessment. Additionally, self-report measures often lack details about the specific traumatic event or the clinical significance of the reported symptoms (47)

Reliability and validity of PCL-5: The PCL-5 has demonstrated strong diagnostic performance across different contexts. In one study, an optimal cut-score of 30 produced a sensitivity of 94.37% and a specificity of 93.89%. When applied to intentional injuries, the best cut-score was 34, yielding a sensitivity of 91.18% and a specificity of 97.37%. For non-intentional injuries, a cut-score of 22 resulted in 100% sensitivity and 92.25% specificity (50). According to the U.S. National Center for PTSD, a PCL-5 cutoff score between 31 and 33 is generally considered indicative of PTSD. Furthermore, a recent study among female Filipino migrant workers showed that the PCL-5 has excellent psychometric properties in migrant populations. The scale demonstrated high internal consistency, with a Cronbach's alpha of 0.95, indicating that all items reliably measure PTSD symptoms. It also showed strong convergent validity by correlating well with other tools that assess similar constructs (51).

In this study, the PTSD Checklist for DSM-5 (PCL-5) will be used as a screening tool to assess post-traumatic stress disorder (PTSD). Recognized for its reliability and validity, the PCL-5 aligns with DSM-5 criteria and can be adapted for various settings, including Mae Sot, where participants may have diverse literacy levels and language preferences. The tool is available in multiple languages; for this study, the researcher has translated it into Burmese to ensure cultural relevance and comprehension among Myanmar migrants. As a free and efficient tool, the PCL-5 is ideal for estimating the prevalence and severity of PTSD, which supports the study's goal of identifying PTSD and its associated factors in the target population.

2.3.5 Epidemiology of PTSD

Post-traumatic stress disorder (PTSD) is prevalent, with an estimated 6.8% of Americans experiencing it in their lifetime. Women (9.7%) are more than twice as likely to develop PTSD compared to men (3.6%). Annually, about 3.6% of U.S. adults (approximately 5.2 million people) have PTSD. Among those who have experienced a traumatic event, around 8% of men and 20% of women go on to develop PTSD, with roughly 30% of these cases becoming chronic. Common trauma sources for men include rape, combat exposure, and childhood abuse, while for women, they include rape, sexual molestation, and physical attacks (46).

The rates of PTSD vary based on the nature of the trauma. For instance, a 2009 study found that 47.9% of individuals reported traumatic experiences, with a lifetime PTSD prevalence of 34.9% and a current prevalence of 15.1%. This study highlighted the high rates of PTSD among people in conflict zones and the lack of treatment options (52).

In a 2015 study in Uganda, PTSD prevalence was 11.8% seven years post-conflict, showing that it remained years after trauma, with significant factors including exposure to war trauma, childhood trauma, and food insecurity (23). A 2024 meta-analysis found a PTSD prevalence of 48.4% in war-affected Ethiopian communities, identifying risk factors such as witnessing violence and experiencing depression (12).

Additionally, the 2017 WHO World Mental Health Surveys indicated that interpersonal violence traumas had the highest PTSD risk, with rape and other sexual assaults being particularly impactful. (7). A 2023 umbrella review of 59 studies suggested that PTSD prevalence is lower when assessed through structured clinical interviews compared to self-report instruments. Still, no significant differences were noted between interpersonal and non-interpersonal trauma assessments (47).

In summary, the prevalence of PTSD varies significantly among different populations and is influenced by demographic factors such as age and gender. The timing of prevalence measurements is crucial, as estimates can shift over time. Additionally, it is essential to recognize that prevalence is dynamic, changing across individuals, communities, and circumstances. Previous studies on migrants have identified significant trends in PTSD prevalence. A 2015 study conducted in Uganda revealed that the prevalence of PTSD stood at 11.8% seven years after the conflict, highlighting the long-lasting impact of trauma (23).

In addition, a five-year longitudinal study in Canada found that the PTSD rate among visible minority immigrants was 7.5%, which is twice that of the host population (24). Furthermore, a meta-analysis of communities affected by the Ethiopian war reported an alarmingly high PTSD prevalence of 48.5% (12). However, research on PTSD prevalence within the Myanmar migrant community in Thailand is still limited.

2.3.6 Treatments for Post-Traumatic Stress Disorder (PTSD)

The primary treatments for PTSD include psychotherapy and medication, both of which aim to help individuals cope with the emotional and psychological aftermath of traumatic events. Seeking professional help can be essential for effectively managing PTSD, and it is possible to find relief even many years after the trauma has occurred, highlighting that it is never too late to seek assistance (45).

Psychotherapy, or "talk therapy," is often the first line of treatment for those with PTSD. It involves working with trained mental health professionals who provide support and develop effective strategies to address emotional challenges. In cases of severe or persistent PTSD, a combination of psychotherapy and medication may be recommended (46). Cognitive Behavioral Therapy (CBT) is a particularly effective form of psychotherapy for PTSD. It focuses on helping individuals manage their issues by altering their thought patterns and behaviors. Trauma-focused CBT employs various techniques to assist individuals in processing and coming to terms with their traumatic experiences. Another promising therapy is Eye Movement Desensitization and Reprocessing (EMDR), which has shown effectiveness in reducing PTSD symptoms (45).

In addition to psychotherapy, medications such as antidepressants may also be prescribed to treat PTSD. Some commonly used medications include paroxetine, mirtazapine, amitriptyline, and phenelzine. Among these, paroxetine is the only one specifically licensed for PTSD treatment, while the others have also demonstrated effectiveness and are frequently recommended (45).

Overall, PTSD can be effectively treated through various forms of psychotherapy and medication. While there is no single best treatment, cognitive-behavioral therapy (CBT) has shown auspicious results, encompassing techniques like cognitive restructuring, exposure therapy, and EMDR (46).

2.3.7 Conceptual models

When applied to PTSD, these conceptual models offer valuable insights. The Bio-Psycho-Social Model highlights the need to address biological factors (such as neurochemical imbalances), psychological factors (like intrusive memories and avoidance behaviors), and social factors (including support systems and environmental stressors) in treatment (53, 54). The Cognitive Behavioral Model supports therapeutic approaches that modify negative thought patterns related to trauma (55, 56). The Diathesis-Stress Model underscores the importance of both inherent vulnerabilities and traumatic experiences in the development of PTSD (57, 58). The Social Determinants of Health (SDH) and Ecological Models also advocate for broader societal interventions to reduce risk factors and enhance protective factors for individuals exposed to trauma (59-63). The psychosocial model of mental health emphasizes the importance of understanding mental health problems within the context of an individual's life circumstances, social environment, and lived experiences (64).

Psychosocial Model

The psychosocial model of mental health emphasizes the interaction between an individual's psychological state and their social environment. It highlights that mental health is shaped by various factors such as socio-economic conditions, life experiences, and relationships, rather than being solely determined by biological or genetic causes. This approach focuses on addressing broader social determinants of mental health, including poverty, trauma, and social exclusion, as essential steps to promote recovery and well-being (64). The psychosocial health model offers a comprehensive view by defining mental well-being across various dimensions, including sexual, emotional, social, environmental, cognitive, religious, moral, and spiritual satisfaction. It offers a comprehensive framework for understanding and assessing mental disorders, going beyond traditional diagnostic approaches (15).

Key features of the psychosocial model include its holistic perspective, focusing on therapy, peer support, and community involvement instead of relying solely on medical interventions. It prioritizes respecting human rights, ensuring informed consent, and fostering self-determination for individuals facing mental health challenges. Additionally, it emphasizes the role of families, communities, and social networks in creating inclusive and supportive environments that promote mental health and reduce stigma (64).

The psychosocial model is applied across various sectors, including healthcare, education, and community-based services. It informs practices such as peer-support programs, trauma-informed care, and community mental health initiatives. Examples of its application comprise the development of community mental health services, school-based mental health education, and workplace programs aimed at fostering supportive and inclusive environments for mental health recovery (64).

The psycho-social model suits this study as it integrates psychological and social factors like trauma exposure, housing, and discrimination, offering a comprehensive framework to explore PTSD among Myanmar migrants and guide community-level interventions.

2.4 Relevant Research Findings

Following a thorough review of the existing literature, the researcher undertook an examination of the factors associated with post-traumatic stress disorder. These factors were selected due to their relevance to both pre-migration and post-migration trauma, as well as their alignment with the psychosocial model of mental health.

2.4.1 Demographic factors

2.4.1.1 Gender

In 2021, a cross-sectional study was conducted among Syrian refugees living in a camp in Turkey to assess the prevalence of PTSD. The diagnosis of PTSD was carried out through face-to-face psychiatric interviews following the DSM-IV-TR criteria. The study found that the prevalence of PTSD was significantly higher in women (44.1%) compared to men (18.1%), with an overall prevalence of 30.7%. (65). Interviews were conducted with 157 consenting participants from non-South African associations to explore the relationship between the total number of traumatic events and post-traumatic stress. The findings indicated that a higher number of traumatic life events experienced by women was associated with an increased risk of post-traumatic stress disorder ($\beta = 1.48$; $p < 0.001$) (66).

2.4.1.2 Age

A systematic review conducted in 2022 analyzed 34 studies involving a total of 15,549 migrants and found that specific characteristics of the migrant population, particularly a younger average age, were associated with an increased prevalence of post-traumatic stress disorder (PTSD). Specifically, younger age was linked to a higher likelihood of having current PTSD, with an odds ratio of 0.95 (95% confidence interval: 0.90–0.99) and a p-value of less than 0.01 (67). Additionally, a study on PTSD symptoms during the 2023 Israel-Hamas war revealed that older adults exhibited lower rates of PTSD compared to younger adults, with an odds ratio of 3.52 and a p-value of 0.001 (68).

2.4.1.3 Marital Status

In a Canadian longitudinal study on mid-age and older immigrants, widowed, divorced, or separated individuals showed significantly higher odds of PTSD (aOR 1.39, 95% CI 1.20–1.62, $p < 0.001$) compared to those married or living with a partner (69). Conversely, a 2024 cross-sectional study of Ethiopian refugees found no significant impact of marital status on PTSD prevalence (70). This suggests that marital status's influence on PTSD may vary by population and context.

2.4.1.4 Religion

A 2019 qualitative study conducted in Singapore examined how foreign domestic workers (FDWs) coped with migration-related stressors. The research, part of a cross-sectional survey examining the effects of social and occupational stress on health and quality of life, highlighted several adaptive strategies. These included relying on religion (such as prayer, singing, reading religious texts, and attending church), seeking social support, practicing positive reframing to maintain a positive outlook, and setting aside time for self-care through leisure activities, adequate sleep, and relaxation (71). However, studies conducted in Uganda, Ethiopia, and Turkey did not find any significant association with PTSD.

2.4.1.5 Ethnicity and Place of Origin

In a 2018 study, Arab Iraqi refugees, most of whom were presumed to be Muslim, displayed notably higher levels of PTSD symptoms compared to Chaldean Iraqi refugees and increased odds of potential PTSD, with an odds ratio of 3.83 (95% CI 0.75–19.64) (72). A 2021 study, conducted over three years, examined post-traumatic stress disorder (PTSD) in middle-aged and older adults, focusing on its connections to nutrition, ethnicity,

and immigrant status. Compared to Canadian-born white individuals, visible minority immigrants showed significantly higher odds of PTSD (OR 1.47, 95% CI 1.14–1.90, p -value <0.001). These results emphasize the need to consider ethnicity and immigrant status when studying PTSD in these age groups (69).

2.4.1.6 Education

In 2008, a study conducted in Diyarbakir, Turkey, a conflict-affected region, identified education as a predictor of current PTSD, with individuals having higher education levels showing reduced odds of PTSD (OR = 0.230, 95% CI = 0.076–0.695, p = 0.009) (52). Similarly, a community-based cross-sectional study in Tigray, Ethiopia, conducted among 2,132 internally displaced family heads in August 2021, found that primary and secondary school attendance was significantly associated with higher odds of PTSD (aOR = 2.1, 95% CI = 1.344–3.279; and aOR = 1.697, 95% CI = 1.067–2.7) (73).

2.4.1.7 Employment status, income, and occupation

In a 2012 study conducted in Italy, 391 immigrants were enrolled, and 10.2% of them exhibited PTSD symptoms. The study found that the most frequent post-migration living difficulties (PMLDs) were "no permission to work" (38.6%) and "poverty" (34.5%). The study concluded that an increased number of PMLDs significantly heightened the likelihood of developing PTSD, along with the broader literature, where economic and social challenges following migration, such as limited work opportunities and financial insecurity, are associated with higher rates of PTSD among migrant populations (74).

A cohort study using baseline data from the Canadian Longitudinal Study on Aging (CLSA) (2012–2015) found that immigrants earning less than a specified annual income were significantly more likely to develop PTSD, with odds ratios ranging from 1.39 to 2.58 ($p < 0.001$) (24). In contrast, a cross-sectional study conducted on Ethiopian refugees found that the prevalence of PTSD was higher among farmers (53%) compared to merchants (21%). The study concluded that merchants were 59% less likely to experience PTSD than farmers, with an adjusted odds ratio (adjOR) of 0.41 (95% CI: 0.02–0.85), suggesting that occupation is associated with PTSD risk (70).

2.4.1.8 Housing and Number of Family Members Living Together

A 2020 cross-sectional survey conducted in a Ugandan refugee camp analyzed factors related to mental health, revealing that family care was associated with a higher

odds ratio (OR = 2.00, P = 0.035) and access to housing also showed a significant relationship (OR = 1.83, P = 0.04) (75). Additionally, a study in Tigray, Uganda, found that internally displaced persons with family sizes greater than six had a significantly higher risk of developing PTSD, with an adjusted odds ratio (aOR) of 1.821, a 95% confidence interval (CI) of 1.124–2.950, and a P value of less than 0.05 (73). Overcrowding and inadequate housing conditions have consistently been linked to poorer mental health outcomes, including PTSD.

2.4.1.9 Length of Stay

A longer duration since displacement has been associated with a lower lifetime prevalence of PTSD, with an odds ratio of 0.88 (95% CI 0.81–0.95), indicating that PTSD prevalence decreases over time among migrants (76). However, a systematic review highlighted that the duration of residence, considered a component of postmigration stressors related to living and working conditions, is positively linked to PTSD symptoms among refugees and asylum seekers. Despite this connection, the strength of associations varied across studies, suggesting that other contextual factors may influence this relationship (77).

2.4.1.10 Language barrier

A 2023 study in Germany involving Arabic- or Farsi-speaking asylum seekers and refugees revealed that lower perceived social support was significantly linked to higher PTSD symptom severity ($\beta = -0.18$, $t = -3.58$, $p < 0.001$) (78).

2.4.1.11 Healthcare access (Legal Status, ability to access proper healthcare, Health insurance card)

A qualitative analysis of migrants across multiple countries, including China, Germany, the Netherlands, Romania, and South Africa, indicates that healthcare access is often restricted due to migrants' citizenship status. Many nations tie healthcare eligibility to legal status, which makes undocumented migrants particularly vulnerable when their applications for services are denied (79). Additionally, undocumented migrants report feelings of fear that prevent them from leaving their homes, moving freely, establishing social connections, or seeking healthcare, as they fear being reported to the authorities (13). A study conducted in the USA in 2013 further supports this, showing that having legal immigration status was linked to better PTSD outcomes, with a significant association (p -value < 0.001) [79]. The absence of health insurance is associated with PTSD among internally displaced migrants in Turkey (OR=2.445, CI=2.643-5.735, P=0.007) (52). These findings highlight

the critical role legal status plays in both healthcare access and mental health outcomes for migrants.

2.4.2 Psychological factors

2.4.2.1 Smoking

A 2022 study found that individuals with nicotine dependence had significantly higher odds of developing PTSD (OR = 1.59; 95% CI: 1.09–2.32; $p = .017$) compared to non-dependent individuals (75). Similarly, a Canadian longitudinal study on middle-aged and older immigrants found that those with a history of smoking also showed higher odds of reporting PTSD (aOR = 1.22; 95% CI: 1.09–1.37; $p = .001$) (69). This highlights a potential link between smoking behaviors and increased PTSD risk across different populations.

2.4.2.2 Alcohol and Substance Use

The association between substance use and PTSD among forced migrants has been explored in various studies. A systematic review found that the prevalence of hazardous or harmful alcohol use ranged from 17% to 36% in camp settings and 4% to 7% in community settings, indicating a notable concern regarding alcohol use in these populations (80). Furthermore, a study in Nakivale camp, Uganda, found a strong positive association between PTSD and substance use disorder, with an adjusted odds ratio (aOR) of 5.13 (95% CI: 2.32–11.33, $p < 0.001$), reinforcing the links between PTSD and substance use among refugees (75).

2.4.3 Social factors

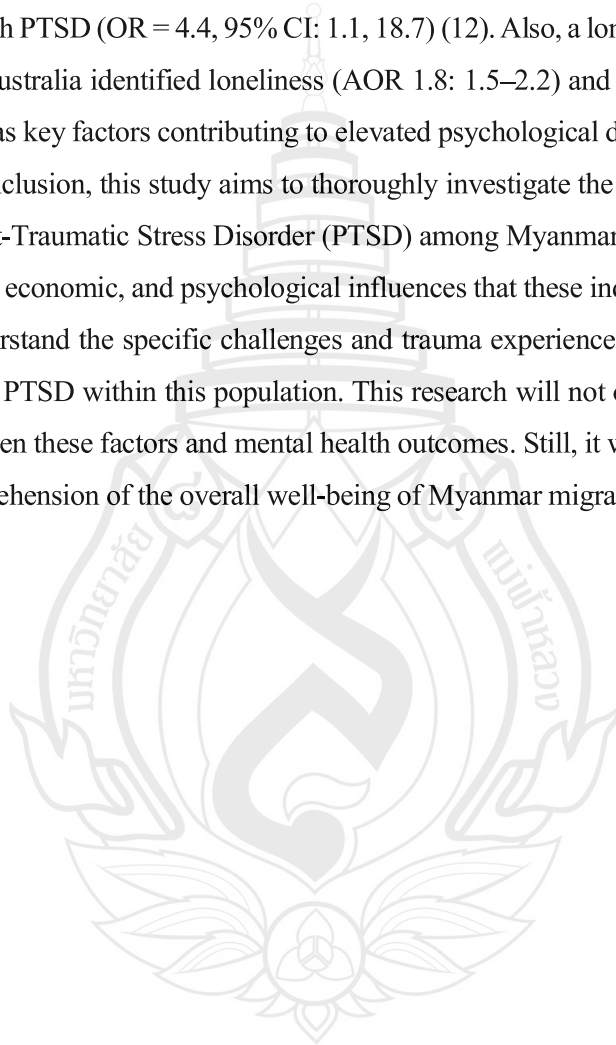
2.4.3.1 Neighborhood safety

A 2020 cross-sectional survey in a Ugandan refugee camp, involving 387 residents from nine countries, found that PTSD was significantly associated with several community factors. These included safety and protection for women (OR = 2.35, $P = 0.011$) [72]. As well, exposure to neighborhood violence was correlated with PTSD symptoms ($r = 0.396$, $P = 0.007$), though this finding was from a study on community-dwelling adults, not specifically migrants (81).

2.4.3.2 Social and community factors (Social support, Discrimination, and social exclusion)

Social factors can act as either stressors or protective factors for mental health. Social exclusion and discrimination, either by host communities or other migrants, can exacerbate mental health issues, including PTSD. Conversely, social connections and community support can serve as protective factors. A recent meta-analysis among the Ethiopian population in war-affected communities found that poor social support was significantly associated with PTSD (OR = 4.4, 95% CI: 1.1, 18.7) (12). Also, a longitudinal study among migrants in Australia identified loneliness (AOR 1.8: 1.5–2.2) and discrimination (adjOR 1.7: 1.3–2.2) as key factors contributing to elevated psychological distress (79).

In conclusion, this study aims to thoroughly investigate the various factors associated with Post-Traumatic Stress Disorder (PTSD) among Myanmar migrants. By examining the social, economic, and psychological influences that these individuals face, we seek to better understand the specific challenges and trauma experiences that contribute to the prevalence of PTSD within this population. This research will not only highlight the connection between these factors and mental health outcomes. Still, it will also contribute to a deeper comprehension of the overall well-being of Myanmar migrants.



CHAPTER 3

MATERIALS AND METHODS

This chapter presents the research design, study setting, study population, sample size, research tools, and their development, testing of instrument validity and reliability, data gathering process, data analysis, and ethical considerations.

3.1 Study Design

A cross-sectional study design was conducted to obtain data to estimate the prevalence and factors associated with PTSD among Myanmar migrants in Mae Sot district, Tak province, Thailand.

3.2 Study Setting

The study setting was Mae Sot, Mae Tao, and Tha Sai Luad sub-districts in Mae Sot district, Tak province, a culturally diverse town in western Thailand's Tak Province, near the Thai-Myanmar border. Known for its ethnic diversity and the presence of large Burmese, Karen, and other minority communities, these three sub-districts have historically been a hub for trade, cultural exchange, and migration. Burmese, Karen, and Thai languages are widely spoken, with local markets and shops displaying signs in multiple languages, including Thai, Burmese, and Chinese. Due to its strategic location, these three sub-districts have become an essential center for commerce, with trade heavily influenced by Chinese and Muslim communities from Myanmar.

Mae Sot, Mae Tao, and Tha Sai Luad sub-districts also play a significant role as a base for non-governmental organizations (NGOs) focused on providing healthcare, education, and social support to Burmese refugees and migrants who cross the border, often due to political and economic turmoil in Myanmar. This complex social and cultural landscape makes Mae Sot, Mae Tao, and Tha Sai Luad sub-district a unique and insightful setting for

studying migrant and refugee issues, especially in public health contexts, as the town reflects the challenges and resilience of displaced communities.

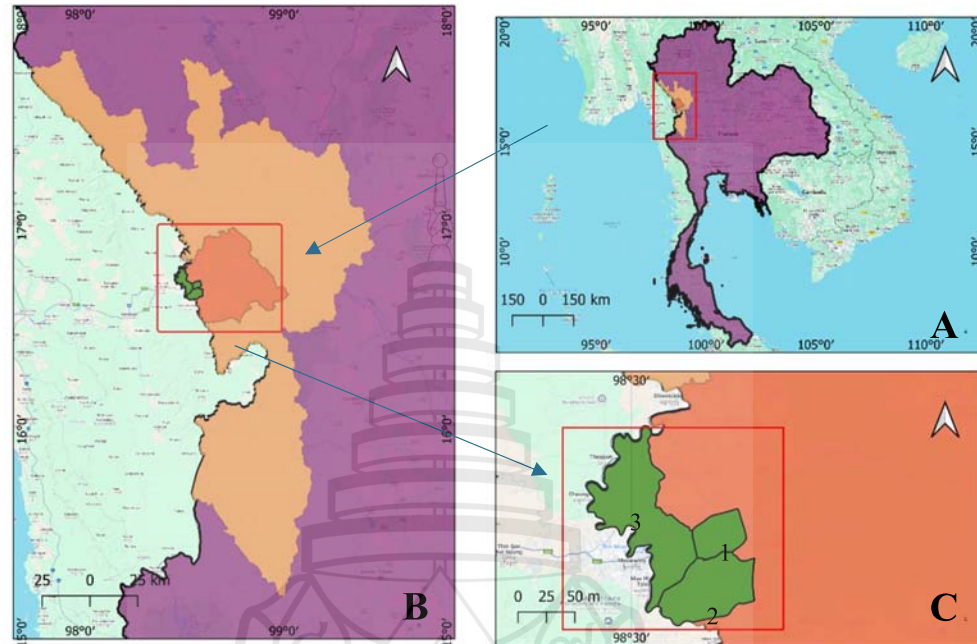


Figure 3.1 Study area map: (A) Tak province, Thailand, (B) Mae Sot district, (C) 1=MaeSot, 2=Mae Tao, and 3=Tha Sai Luat subdistricts.

3.3 Study Population

Population: According to the IOM data from October 2023, Mae Sot in Tak province, Thailand, hosts 81,000 Myanmar migrants (21). The main reasons for longer-term arrivals include visiting family or friends, finding work, and enjoying a lower cost of living. Some come due to conflict in their home countries. Most longer-term arrivals plan to work in manufacturing, especially women. The number of undocumented long-term arrivals has increased over the years. Most respondents come from Kayin State, Mon State, and the Bago (East) region (82).

3.3.1 Inclusion Criteria:

1. Adults from Myanmar, both males and females, aged 18 years and older, regardless of any type of documentation.

2. Myanmar migrants residing in the Mae Sot district for at least six months. (It is important to ensure that they are not individuals who frequently cross the border for daily activities; the investigators want to include only those migrants who have a specific reason for their migration.)

3. Myanmar migrants who are willing to participate in the study.

3.3.2 Exclusion Criteria:

1. Individuals with severe mental health and physical health conditions that prevent independent participation or comprehension of the study

2. Individuals with a language barrier that prevents effective communication or understanding of the survey questions.

3.3.3 Withdrawal criteria

Individuals who have not finished the questionnaire

3.4 Sample Size Estimation

A total of 360 was taken for this study to estimate PTSD prevalence. The sample size was calculated using the formula (83) for an infinite population, considering a proportion of PTSD for migrants with pre-migration exposure to armed conflict as 31% derived from a previous study (76).

$$n = \frac{Z^2 P(1-P)}{d^2}$$

Where;

n = estimated sample size estimation of Myanmar migrants in Tak province

P = estimated proportion of meta-analysis with premigration exposure to the arms conflict in 2022 (P = 31%) (76).

d = desired percussion set by the researcher (d=0.05)

Z = 95% confidence level set by the researcher (Z=1.96)

$$n = \frac{1.96^2 0.31(1-0.31)}{(0.05)^2}$$

$$n = 328.63$$

According to the calculations, the determined sample size was 328. An additional 10% was added to account for potential incomplete responses and withdrawals from the study, resulting in a final required sample size of 360.

3.5 Sampling Method

Step 1: Stratification and selection of subdistricts

Mae Sot district consists of eight subdistricts. For this study, the researcher employed stratified random sampling, in which each subdistrict serves as a stratum. Three subdistricts, Mae Sot, Mae Tao, and Tha Sai Luad, were randomly selected from the eight strata using the Excel formula =RANDBETWEEN (1,8). This approach ensured that the sample reflected diversity across different migrant dense areas within the Mae Sot district.

Step 2: Formation of sampling frames within each selected subdistrict

Within each selected subdistrict, key community clusters were identified with the support of the community leader and health volunteer. These clusters were used to form operational sampling frames representing different migrant groups, such as communities near health posts, migrant housing areas, factory-adjacent communities, and health-seeking locations.

Step 3: Participant recruitment within each stratum

Within the selected data collection, each stratum, convenience sampling was applied to recruit eligible participants due to feasibility constraints and the presence of undocumented or hard-to-reach populations.

To minimize selection bias at this stage:

1. The researcher visited the Madinah community health post during office hours and conducted visits in hidden communities during evenings and weekends to reach both home-based migrants and daytime workers.
2. In Mae Tao subdistrict, recruitment was also conducted in collaboration with civil society organizations (CSOs) and factory-adjacent communities due to the high concentration of migrant workers.

3. In the Tha Sai Luat subdistrict, the Mae Tao Clinic served as a major recruitment site to reach health-seeking migrants.

4. Community leaders and health volunteers assisted in reaching undocumented migrants and individuals reluctant to disclose their location.

A total of 360 participants across the selected subdistricts who met the inclusion criteria were recruited.

3.6 Research Tools and Development

Based on the psychosocial model, a self-developed questionnaire was utilized. The questionnaire was informed by similar studies and reviewed by three external experts. The study's outcome variable will be PTSD, determined by PCL-5 according to DSM-5 criteria

In Part 1, the researcher collected demographic information from participants using a structured questionnaire that consisted of closed-ended questions. This questionnaire captured various variables, including gender, age, marital status, religion, ethnicity, region of origin, education level, employment status, occupation, income, housing, number of family members, length of stay, language barrier, legal status, ability to access health services, and health insurance coverage. This comprehensive data helped characterize the study population and served as independent variables for analyzing the outcome variable, PTSD. Validity of instruments in part 1 was assessed using Item Objective Congruence (IOC), with three experts, 0.98, as shown in Appendix K.

In Part 2, participants' psychological factors, essential for understanding the development of PTSD, were assessed. This section includes individual and migration-related factors. Smoking, alcohol drinking, and substance use within the past month were measured using closed-ended yes/no questions. Validity of instruments in part 2 was assessed using Item Objective Congruence (IOC), with three experts, 0.85, as shown in Appendix K.

In Part 3, the study focuses on social factors that participants encounter after migration, including neighborhood safety, discrimination, and perceived social support.

Neighborhood safety, perceived social exclusion, and perceived discrimination were evaluated using closed-ended questions and additional explanations for clarity. Validity of instruments was 1.00, as shown in Appendix K.

The multidimensional scale of perceived social support (MSPSS) was used to evaluate the social support index. This 12-item tool measures perceptions of support received from family, friends, and significant others, and MSPSS utilizes a 7-point Likert scale (84). Scoring of MSPSS: To calculate the total score, Sum across all 12 items. This total score can also be calculated as a mean score (divided by 12). Any mean scale score ranging from 1 to 2.9 could be considered low support; a score of 3 to 5 could be considered moderate support; a score from 5.1 to 7 could be regarded as high support [83, 84]. Reliability of MSPSS: The Burmese version of the MSPSS was tested on 30 Burmese migrants in Chiang Rai before data collection and scored 0.86.

In Part 4, PTSD Assessment: PCL-5 (PTSD Checklist for DSM-5): A validated 20-item self-report measure that assesses PTSD symptoms. Each item is rated on a 5-point Likert scale, with a total score determining symptom severity. This tool is widely used and validated for diverse populations, is quicker to administer, requires fewer resources, and is ideal for large sample sizes. A total score is calculated as the sum of the 20 items with a range of 20–100.

Cut-Off Scores: The optimal cut-off score for identifying PTSD can vary based on the context; however, a score of 33 or higher is frequently used as a threshold for diagnosing PTSD, but clinical confirmation is necessary for a definitive diagnosis. According to the DSM-5 criteria, individuals without at least one traumatic event will be assumed to have a negative PTSD screening.

Table 3.1 Criteria for interpretation of prevalence

Traumatic Event Types	PCL-5	Result
Positive (+)	Positive (+)	Positive (+)
Positive (+)	Negative (-)	Negative (-)
Negative (-)	Positive (+)	Negative (-)
Negative (-)	Negative (-)	Negative (-)

Note Traumatic Event Types Positive (+) = individual with at least one traumatic event
 Traumatic Event Types Negative (-) = individual without any traumatic event
 PCL-5 Positive (+) = PCL-5 score > 33
 PCL-5 Negative (-) = PCL-5 score ≤ 33

Reliability of PCL-5: A Cronbach's alpha of the Burmese version of the PCL-5 was tested on 30 Burmese migrants in Chiang Rai before data collection, and scored 0.85. Additionally, the number of traumatic events experienced, which may contribute to prolonged PTSD, will be recorded as an open-ended response in numerical format. These data provide valuable insights into the factors that enable the development of PTSD.

3.7 Process of Data Gathering

The study was conducted in the following steps:

Step 1: After obtaining ethical approval from Mae Fah Luang University, the Researcher contacted Myanmar migrant community leaders to identify the locations of migrants. and tried to get the ethical approval from the Community Ethics Advisory Board (CEAB) at the Mae Tao Clinic in Mae Sot.

Step 2: Because Myanmar migrants are a hidden population, participants will be recruited using convenience sampling. After explaining the study's objectives, informed consent will be obtained from the Myanmar migrant.

Step 3: The data collection process was conducted in Burmese to ensure that participants fully understood and felt comfortable. Face-to-face interviews were conducted at either the participants' workplaces or homes, depending on their availability, and will be conducted privately, away from others. To maintain privacy and safety, especially regarding

sensitive questions, participants had the option to skip any questions they preferred not to answer.

Step 4: If a participant feels increased panic or anxiety from the questionnaire, which may trigger unwanted memories, the researcher, who is a medical doctor, is available to offer counseling and reassurance.

Step 5: Daily checks were conducted during data collection to ensure data quality.

3.8 Data Analysis

The collected data were cleaned, coded, and analyzed using IBM's Statistical Package for the Social Sciences (SPSS) Version 20. Descriptive statistics such as frequencies, percentages, means, standard deviations, maximum, and minimum values were incorporated into the analysis. Appropriate summary statistics were utilized to describe the data: continuous data were summarized using either the mean and standard deviation or the median and interquartile range, depending on the normality of the data distribution. Categorical data were summarized using frequencies and percentages. These statistics provide a summary of the demographic characteristics of the participants. The prevalence of PTSD among Myanmar migrants in the Mae Sot district of Tak province was estimated using the PCL-5, which was included in the questionnaire.

Inferential statistical analyses, chi-square tests, were conducted to examine the relationships between potential factors and PTSD, with a significance level set at $\alpha < 0.05$. Logistic regression was used to detect the associations between variables in both univariate and multivariate models. The backward LR method was used to get the final model of multivariate analysis with a significance level set at $\alpha < 0.05$. These analyses will provide insights into the specific factors that contribute to PTSD among Myanmar migrants in Mae Sot district, Tak province.

3.9 Ethical Consideration

The research protocol and tools were approved by the Ethical Committee on Human Research at Mae Fah Luang University (EC 25042-18) and the Community Ethics

Advisory Board (CEAB) at the Mae Tao Clinic in Mae Sot (CEAB-2025-006), ensuring adherence to ethical standards for studies involving human participants. The ethical approvals are attached in Appendix A-F.



CHAPTER 4

RESULTS

This chapter presents the findings of the study on the prevalence and associated factors of Post Traumatic Stress Disorder (PTSD) among Myanmar migrants residing in Mae Sot, Tak Province, Thailand. The analysis is organized to provide a comprehensive understanding of the participants' demographic, psychological, and social characteristics, followed by their relationship with PTSD outcomes. The results are presented in three sections:

1. Descriptive analysis of demographic, psychological, and social characteristics of the study population.
2. Comparison of these factors in relation to PTSD.
3. Identification of factors associated with PTSD through inferential statistical analysis.

4.1 Descriptive Analysis

4.1.1 Demographic Factors

A total of 360 Myanmar migrants participated in the study. Among them, 31.9% were male, 63.3% female, and 17 individuals identified as non-binary. The majority were <30 years, with a median age of 31 years (IQR: 21–41 years). More than half of the participants were single, and most identified as Buddhist. In terms of ethnicity, 65% reported being Bamar, and a large proportion originated from the Bago region of Myanmar (30%) (Figure 4.1). Educational attainment varied, with 30.6% holding a university degree, while 39.4% reported being unemployed. Of all participants, 22.5% worked in factories, farming, or construction (Table 4.1)

Regarding income, 40.6% earned more than 5,000 Thai Baht per month, with a median income of 4,000 (IQR: 0–7,000). Almost half (49.7%) lived in rented rooms while the remainder stayed at their workplaces or in shared housing. About 32% were separated

from their families, and 70% had resided in Thailand between six months to four years (migrants between 2021 to 2024). Language barriers were common, with 65% reporting difficulties in seeking health services, while 66.1% held some form of legal status. In terms of healthcare access, more than half (52.8%) of the participants pursued services at the Mae Tao Clinic, and 38.1% were covered by health insurance, most frequently through the M-Fund scheme ($n = 67$) (Table 4.1)

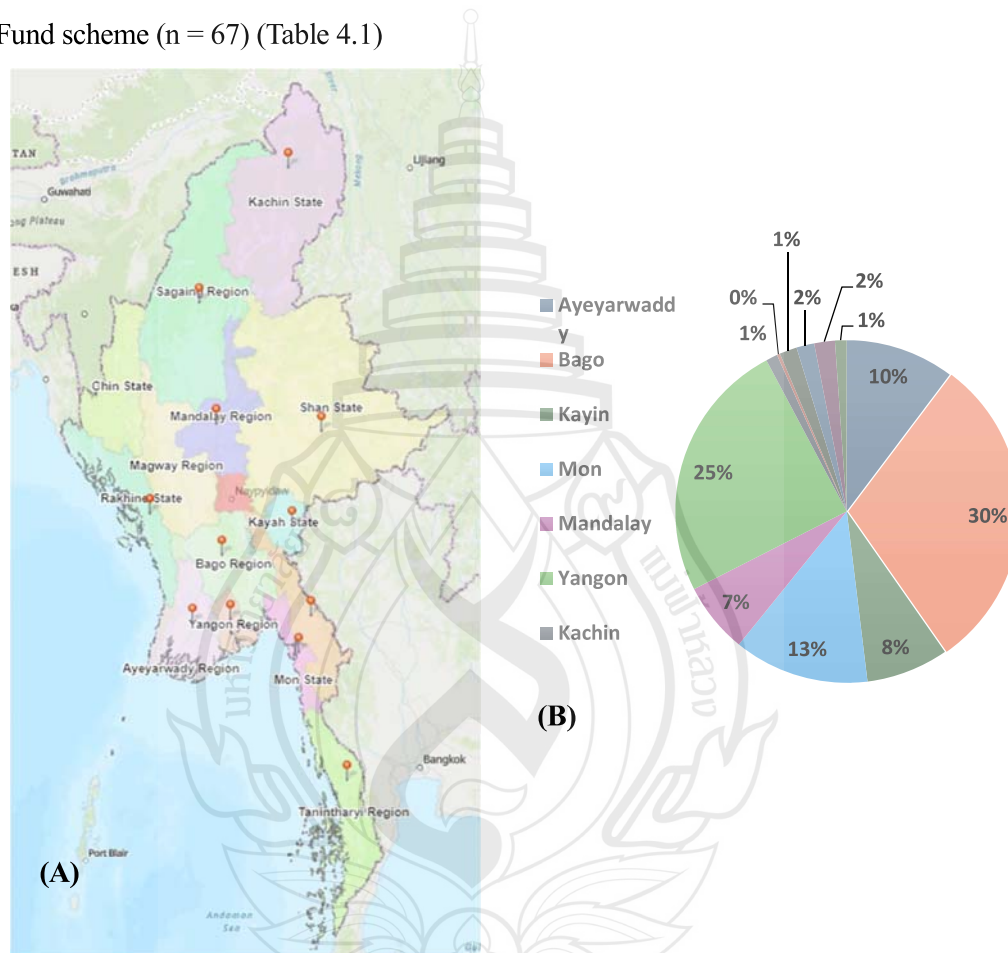


Figure 4.1 (A) Spot map of participants' place of origin, (B) Contribution of participants by regions

Table 4.1 Demographic factors (n=360)

Characteristics	n	%
Gender		
Male	129	35.8
Female	231	64.2
Age		
≤30	179	49.7
31-40	88	24.4
41-50	53	14.7
≥51	40	11.1
Median=31 years (IQR=21-41), Min=18, Max=75		
Marital Status		
Single	163	45.3
Married	160	44.4
Widow	16	4.4
divorced	21	5.8
Marital Status		
Single, separated individuals	200	55.6
Married, having a partner	160	44.4
Religion		
Buddhist	288	80
Christian	36	10
Islam	22	6.1
Others	14	3.9
Ethnicity		
Burmese (Bamar)	234	65.0
Karen	69	19.2
Others	33	9.2
Shan	14	3.9
Mon	10	2.8

Table 4.1 (continued)

Characteristics	n	%
Place of Origin		
Bago	108	30
Yangon	89	24.7
Mon	46	12.8
Ayeyarwady	37	10.3
Kayin	28	7.8
Mandalay	24	6.7
Shan	7	1.9
Rakhine	6	1.7
Sagaing	6	1.7
Kachin	4	1.1
Tanintharyi	4	1.1
Kayar	1	0.3
Originating from conflict-affected areas		
Generally safe area (Bago, Yangon, Ayeyarwady, Mandalay, Tanintharyi)	262	72.8
Conflict zones (Kayin, Kayar, Mon, Shan, Sagaing, Rakhine, Kachin)	98	27.2
Education		
Illiterate	13	3.6
Primary	65	18.1
Middle	68	18.9
High	104	28.9
Graduated	110	30.6

Table 4.1 (continued)

Characteristics	n	%
Employment Status		
No	142	39.4
Yes	218	60.6
Factory worker	57	15.8
Domestic worker	14	3.9
Farmer	9	2.5
Vendor	24	6.7
Construction	15	4.2
Office	37	10.3
Professional/freelance	62	17.2
Income (Thai Baht)		
0	133	36.9
1-5000	77	21.4
5001-10000	105	29.2
10001-15000	26	7.2
≥15001	19	5.3
Median=4000 (IQR=0-7000), Min=0, Max=45000		
Place of residence		
Dormitory	179	49.7
Shared room	151	41.9
Work compound	30	8.3
Stay with family		
No	116	32.2
Yes	244	67.8
Number of family members staying together		
0	116	32.2
1-5	194	53.9
≥6	50	13.9
Median=3 people (IQR=0-5), Min=0, Max=10		

Table 4.1 (continued)

Characteristics	n	%
Duration of living in Thailand		
6 months-4 years	252	70.0
>4 years	108	30.0
Median = 2 years (IQR=1-7), Min=6months, Max=40 years		
Difficulty in the Language of Health-Seeking		
No	125	34.7
Yes	235	65.3
Legal Status		
No	92	25.6
Yes	238	66.1
Preferred not to answer	30	8.3
Place of health-seeking		
Mae Tao Clinic	190	52.8
Pharmacy	63	17.5
Hospital	56	15.6
Private clinics	24	6.7
Do nothing	27	7.5
Health Insurance		
No	223	61.9
Yes	137	38.1
Type of Health Insurance		
No	223	61.9
M-Fund	67	18.6
SSS	45	12.5
MHIS	25	6.9

4.1.2 Psychological factors

Regarding psychological factors and health-related behaviors, 35.8% of participants reported tobacco use, including smoking and betel quid chewing with tobacco paste. Alcohol consumption within the past month was reported by 30.6% of participants. The majority (94.4%) indicated no use of psychoactive substances such as cannabis, cocaine, amphetamines, inhalants, sedatives, hallucinogens, or opioids (Table 4.2).

With respect to traumatic experiences, 46.7% of participants reported no history of traumatic events, while 53.3% reported exposure to at least one traumatic event in life. Among participants who reported exposure to a traumatic event, the majority had the experience of war-related trauma (Table 4.2).

Table 4.2 Psychological factors

Psychological factors	n	%
Tobacco used		
No	231	64.2
Yes	129	35.8
Alcohol consumption		
No	250	69.4
Yes	110	30.6
Substance used		
No	340	94.4
Yes (marijuana/Glue/amphetamine/sleeping pills)	20	5.6
Number of Traumatic events in life		
No	168	46.7
Yes	192	53.3
Cumulative traumatic events (n=192)		
1 event	123	34.2
2 events	32	8.9
3 events	27	7.5
4 events	10	2.8
Median = 1 event (IQR= 0-1), Min = 0, Max = 4		

Table 4.2 (continued)

Psychological factors	n	%
Type of traumatic event in life (n=192)		
War-related trauma	97	26.9
Physical abuse	37	10.3
Sexual abuse	23	6.4
Others (accident, natural disaster, loss of a loved one)	35	9.7

4.1.3 Social factors

The descriptive analysis of social factors among the 360 participants revealed mixed experiences. A large majority of participants, 78.9%, reported feeling safe within their neighborhoods. Most respondents (86.4%) indicated that they did not feel excluded from social activities. However, 33.3% of respondents noted perceived discrimination, primarily from host Thai individuals or longer-term residents. Regarding support, 50.3% of participants reported high levels of support (MSPSS), while only 7.5% reported low levels (Table 4.3).

Table 4.3 Social factors

Social factors	n	%
Perceived Neighborhood Safety		
No	76	21.1
Yes	284	78.9
Perceived discrimination		
No	240	66.7
Yes	120	33.3
Perceived social exclusion		
No	311	86.4
Yes	49	13.6

Table 4.3 (continued)

Social factors	n	%
MSPSS		
Low (mean score of 12 - 35.9)	27	7.5
Moderate (mean score of 36 – 60)	152	42.2
High (mean score of 60.1-84)	181	50.3
Mean= 57.8, SD = 13.5, Min= 19, Max= 84		

4.1.4 Number and Type of Traumatic Events

Among the 360 participants, 192 reported having experienced at least one traumatic event in their lifetime. Of this group, 123 had experienced a single traumatic event, while 97 reported exposure to war-related trauma in the past (Table 4.4).

Table 4.4 Number and Type of Traumatic Events

Number of Traumatic events in life	n	%
No	168	46.7
Yes	192	53.3
Cumulative traumatic events		
1 event	123	34.2
2 events	32	8.9
3 events	27	7.5
4 events	10	2.8
Median = 1 event (IQR= 0-1), Min = 0, Max = 4		
Type of traumatic event in life		
War-related trauma	97	26.9
Physical abuse	37	10.3
Sexual abuse	23	6.4
Others (accident, natural disaster, loss of a loved one)	35	9.7

4.1.4 Prevalence of PTSD

The estimated prevalence of PTSD among Myanmar migrants who are residing in the Mae Sot district is 31.7%.

Table 4.5 PTSD prevalence

PTSD	n	%
No	246	68.3
Yes (PCL-5 $\geq$ 33 and having at least one traumatic event in life)	114	31.7

4.2 Comparison of Factors in Relation to PTSD

4.2.1 Comparison of demographic factors in relation to PTSD

Significant differences in the prevalence of PTSD were found across various socio-demographic factors. Individuals who were younger, single or separated, from conflict-affected areas of Myanmar, held a university degree, were unemployed, worked as free-lancers, and earned a monthly income exceeding 15,000 Thai Baht, exhibited a higher prevalence of PTSD compared to their counterparts. Additionally, participants who lived alone, had been residing in Thailand for less than four years, or had M-fund health insurance, also reported higher rates of PTSD.

In contrast, a lower prevalence of the issue was observed among older individuals, married or living with a partner, originated from relatively safe regions of Myanmar, had lower educational attainment, held stable jobs in formal sectors, had lower incomes, lived with their families, had been in Thailand for more than four years, and were covered by insurance through the Social Security Scheme (SSS) and the Migrant Health Insurance Scheme (MHIS) (Table 4.6).

Table 4.6 Comparison of demographic factors in relation to PTSD

Demographic factors	PTSD		χ^2	<i>p</i> -value
	No 246(68.3%)	Yes 114(31.7%)		
Gender				
Male	93(72.1)	36(27.9)	1.31	0.252
Female	153(66.2)	78(33.8)		
Age				
≤30	121(67.6)	58(32.4)	8.25	0.041*
31-40	57(64.8)	31(35.2)		
41-50	33(62.3)	20(37.2)		
≥51	35(87.5)	5(12.5)		
Marital Status				
Single, separated individual	127(63.5)	73(36.5)	4.86	0.028*
Married, having a partner	119(74.4)	41(25.6)		
Religion				
Buddhist	204(70.8)	84(29.2)	6.23	0.101
Christian	23(63.9)	13(36.1)		
Islam	13(59.1)	9(40.9)		
Others	6(42.9)	8(57.1)		
Ethnicity				
Karen	47(68.1)	22(31.9)	0.72	0.948
Mon	6(60.0)	4(40.0)		
Burma	160(68.4)	74(31.6)		
Shan	9(64.3)	5(35.7)		
Others	24(72.7)	9(27.3)		

Table 4.6 (continued)

Demographic factors	PTSD		χ^2	<i>p</i> -value
	No 246(68.3%)	Yes 114(31.7%)		
Place of origin				
Conflict zones (Kayin, Kayar, Mon, Shan, Sagaing, Rakhine, Kachin)	59(60.2)	39(39.8)	4.11	0.043*
Generally safe areas (Bago, Yangon, Ayeyarwady, Manda- lay, Tanintharyi)	187(71.4)	75(28.6)		
Education				
Illiterate	11(84.6)	2(15.4)	16.13	0.003*
Primary	55(84.6)	10(15.4)		
Middle	48(70.6)	20(29.4)		
High	69(66.3)	35(33.7)		
Graduated	63(57.3)	47(42.7)		
Employment Status				
No	87(61.3)	55(38.7)	5.41	0.020*
Yes	159(72.9)	59(27.1)		
Types of Occupation				
Unemployed	87(61.3)	55(38.7)	23.30	<0.001*
Factory, farmers & con- struction	70(86.4)	11(13.6)		
Domestic workers & merchants	31(81.6)	7(18.4)		
Office	23(62.2)	14(37.8)		
Professional/freelance	35(56.5)	27(43.5)		

Table 4.6 (continued)

Demographic factors	PTSD		χ^2	p-value
	No	Yes		
	246(68.3%)	114(31.7%)		
Income (Thai Baht)				
0	83(62.4)	50(37.6)	16.04	0.003*
1-5000	53(68.8)	24(31.2)		
5001-10000	85(81.0)	20(19.0)		
10001-15000	17(65.4)	9(34.6)		
≥15001	8(42.1)	11(57.9)		
Place of residence				
Dormitory	120(67.0)	59(33.0)	2.07	0.356
Shared house	102(67.5)	49(32.5)		
Work compound	24(80.0)	6(20.0)		
Stay with family				
No	69(59.5)	47(40.5)	6.13	0.013*
Yes	177(72.5)	67(27.5)		
Number of family members staying together				
0	69(59.5)	47(40.5)	6.204	0.045*
1-5	141(72.7)	53(27.3)		
≥6	36(72.0)	14(28.0)		
Duration of living in Thailand				
6months - ≤4 years	157(62.3)	95(37.7)	14.12	<0.001*
>4 years	89(82.4)	19(17.6)		
Difficulty in the Language of Health-Seeking				
No	83(66.4)	42(33.6)	0.33	0.565
Yes	163(69.4)	72(30.6)		

Table 4.6 (continued)

Demographic factors	PTSD		χ^2	<i>p</i> -value
	No	Yes		
	246(68.3%)	114(31.7%)		
Legal Status				
No	64(69.6)	28(30.4)	0.11	0.946
Yes	162(68.1)	76(31.9)		
Preferred not to answer	20(66.7)	10(33.3)		
Place of health-seeking				
Do nothing	17(63.0)	10(37.0)	5.45	0.244
Hospital	33(58.9)	23(41.1)		
Mae Tao Clinic	138(72.6)	52(27.4)		
Private clinics	18(75)	6(25.0)		
Pharmacy	40(63.5)	23(36.5)		
Health Insurance				
No	154(69.1)	69(30.9)	0.14	0.706
Yes	92(67.2)	45(32.8)		
Type of Health Insurance				
No	154(69.1)	69(30.9)	4.99	0.172
SSS	34(75.6)	11(24.4)		
MHIS	19(76.0)	6(24.0)		
M-Fund	39(58.2)	28(41.8)		

Note* Statistically significant level at *p*-value < 0.05.

4.2.2 Comparison of psychological factors in relation to PTSD

Tobacco use and substance use emerged as significant factors influencing the prevalence of PTSD. Individuals who used tobacco products demonstrated a higher proportion of PTSD compared to non-users (Table 4.7).

Table 4.7 Comparison of psychological factors in relation to PTSD

Psychological factors	PTSD		χ^2	<i>p</i> -value
	No	Yes		
	246(68.3%)	114(31.7%)		
Tobacco used				
No	171(74.0)	60(26.0)	9.65	0.002*
Yes	75(58.1)	54(41.9)		
Alcohol consumption				
No	174(69.6)	76(30.4)	0.61	0.436
Yes	72(65.5)	38(34.5)		
Substance used				
No	238(70.0)	102(30.0)	7.86	0.005*
Yes	8(40.0)	12(60.0)		

Note* Statistically significant level at *p*-value <0.05.

4.2.3 Comparison of social factors in relation to PTSD

Within the domain of social factors, a significantly higher proportion of participants who perceived discrimination from host communities, as well as those who felt excluded from community activities, were found to have PTSD.

Table 4.8 Comparison of social factors in relation to PTSD

Social factors	PTSD		χ^2	<i>p</i> -value
	No	Yes		
	246(68.3%)	114(31.7%)		
Perceived neighborhood safety				
No	46(60.5)	30(39.5)	2.71	0.100
Yes	200(70.4)	84(29.6)		
Perceived discrimination				
No	177(73.8)	63(26.2)	9.76	0.002*
Yes	69(57.5)	51(42.5)		
Perceived social exclusion				
No	222(71.4)	89(28.6)	9.81	0.002*
Yes	24(49.0)	25(51.0)		
Perceived social support				
Low	19(70.4)	8(29.6)	0.70	0.706
Moderate	107(70.4)	45(29.6)		
High	120(66.3)	61(33.7)		

Note* Statistically significant level at *p*-value <0.05.

4.3 Identification of Factors Associated with PTSD Through Inferential Statistical Analysis

4.3.1 Univariate analysis to identify factors associated with PTSD

In the univariable logistic regression analysis. Thirteen variables were found to be associated with PTSD: age, marital status, religion, place of origin, occupational status, type of occupation, income, stay with family, duration of stay in Thailand, tobacco use, substance use, perceived discrimination, and social exclusion.

In our study, those Individuals who were aged 30 or less, 31-40, and 41-50 had higher odds of developing PTSD than those who were aged 51 or older with OR = 3.36 (95%CI: 1.25-9.01), OR = 3.81 (95%CI: 1.35-10.71), and OR = 1.82 (1.43-12.61), correspondingly. Those who were single or separated had an OR = 1.67 (95% CI: 1.15–2.85),

indicating greater odds of PTSD than those with partners. Those who practice any other religion than Buddhism had OR = 3.24 (95% CI: 1.09-9.62), with higher odds of PTSD. Migrants originating from conflict-affected areas of Myanmar had OR = 1.65 (95% CI: 1.02-2.68), showing greater odds than those from relatively safe regions (Table 4.9)

Employment status was significantly associated with PTSD. Unemployed participants had more than twice the odds of developing PTSD compared to those who were employed (OR: 1.71, 95% CI: 1.08-2.67). When divided into each occupational group, unemployed individuals still had a higher risk (OR = 4.02, 95% CI: 1.96-8.26), those in office jobs (OR = 3.87, 95% CI: 1.54-9.71), and those working professional/freelance (OR = 4.91, 95% CI: 2.18-11.04). These groups were more likely to experience PTSD than factory workers, farmers, and construction workers. Regarding income, individuals earning less than 15,001 THB per month had a lower risk of PTSD compared to those earning more. Living arrangements were strongly associated with PTSD. Individuals not staying with family members had greater odds than those living with family (OR = 1.80, 95% CI = 1.13-2.87). Migrants who had lived in Thailand for between 6 months-four years or less were at higher risk (OR = 2.83, 95% CI: 1.62-4.94) than those with longer residence (Table 4.9)

Behavioral and trauma-related factors also showed strong associations. Tobacco users (smoking or betel quid with tobacco) had higher odds of PTSD compared with non-users (OR = 2.05, 95% CI: 1.29-3.24). Those who used substances (marijuana/Glue/amphetamine/sleeping pills) had higher odds than those who did not. (OR = 3.50, 95% CI = 1.39 - 8.81).

Additionally, social and structural vulnerability experiences were significant. Individuals who reported feeling discrimination had higher odds of PTSD (OR = 2.07, 95% CI: 1.31-3.30), and those who experienced social exclusion were also more likely to develop PTSD with OR = 2.60 (95%CI: 1.41 - 4.80) (Table 4.9)

Table 4.9 Univariate analysis to identify factors associated with PTSD

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Gender					
Male	93(72.1)	36(27.9)	1.00		
Female	153(66.2)	78(33.8)	1.32	0.82-2.11	0.252
Age					
≤30	121(67.6)	58(32.4)	3.36	1.25-9.01	0.016*
31-40	57(64.8)	31(35.2)	3.81	1.35-10.71	0.011*
41-50	33(62.3)	20(37.2)	4.24	1.43-12.61	0.009*
≥51	35(87.5)	5(12.5)	1.00		
Marital Status					
Single, separated individual	127(63.5)	73(36.5)	1.67	1.06-2.64	0.028*
Married, having a partner	119(74.4)	41(25.6)	1.00		

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Religion					
Buddhist	204(70.8)	84(29.2)	1.00		
Christian	23(63.9)	13(36.1)	1.37	0.66-2.84	0.392
Islam	13(59.1)	9(40.9)	1.68	0.69-4.08	0.251
Others	6(42.9)	8(57.1)	3.24	1.09-9.62	0.034*
Ethnicity					
Karen	47(68.1)	22(31.9)	1.00		
Mon	6(60.0)	4(40.0)	1.42	0.37-5.56	0.611
Burma	160(68.4)	74(31.6)	1.00	0.55-1.76	0.967
Shan	9(64.3)	5(35.7)	1.19	0.36-3.96	0.780
Others	24(72.7)	9(27.3)	.801	0.32-2.01	0.636
Place of Origin					
Conflict zones	59(60.2)	39(39.8)	1.65	1.02-2.68	0.044*
Generally safe areas	187(71.4)	75(28.6)	1.00		

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Education					
Illiterate	11(84.6)	2(15.4)	1.00		
Primary	55(84.6)	10(15.4)	1.00	0.19-5.209	1.000
Middle	48(70.6)	20(29.4)	2.29	0.47-11.29	0.308
High	69(66.3)	35(33.7)	2.79	0.59-13.28	0.198
Graduated	63(57.3)	47(42.7)	4.10	0.87-19.40	0.075
Employment Status					
No	87(61.3)	55(38.7)	1.71	1.08-2.67	0.021*
Yes	159(72.9)	59(27.1)	1.00		
Types of Occupation					
Unemployment	87(61.3)	55(38.7)	4.02	1.96-8.26	<0.001*
Domestic workers & merchants	31(81.6)	7(18.4)	1.43	0.51-4.05	0.494
Office	23(62.2)	14(37.8)	3.87	1.54-9.71	0.004*
Professional/free-lance	35(56.5)	27(43.5)	4.91	2.18-11.04	0.001*
Factory, farmers & construction	70(86.4)	11(13.6)	1.00		

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No 246(68.3%)	Yes 114(31.7%)			
Income (Thai Baht)					
0	83(62.4)	50(37.6)	0.44	0.17-1.16	0.097
1-5000	53(68.8)	24(31.2)	0.33	0.12-0.92	0.035*
5001-10000	85(81.0)	20(19.0)	0.17	0.06-0.48	0.001*
10001-15000	17(65.4)	9(34.6)	0.39	0.14-1.30	0.124
≥15001	8(42.1)	11(57.9)	1.00		
Place of residence					
Dormitory	120(67.0)	59(33.0)	1.97	0.76-5.07	0.162
Shared house	102(67.5)	49(32.5)	1.92	0.74-5.01	0.181
Work compound	24(80.0)	6(20.0)	1.00		
Stay with family					
No	69(59.5)	47(40.5)	1.80	1.13-2.87	0.013*
Yes	177(72.5)	67(27.5)	1.00		
Number of family members staying together					
0	69(59.5)	47(40.5)	1.75	0.85-3.60	0.127
1-5	141(72.7)	53(27.3)	0.97	0.48-1.93	0.923
≤6	36(72.0)	14(28.0)	1		

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Duration of living in Thailand					
6 months - ≤4 years	157(62.3)	95(37.7)	2.83	1.62-4.94	<0.001*
>4 years	89(82.4)	19(17.6)	1.00		
Difficulty in the Language of Health-Seeking					
No	83(66.4)	42(33.6)	1.15	0.72-1.82	0.565
Yes	163(69.4)	72(30.6)	1		
Legal Status					
No	64(69.6)	28(30.4)	1.00		0.793
Yes	162(68.1)	76(31.9)	1.07	0.64-1.80	
Preferred not to answer	20(66.7)	10(33.3)	1.14	0.47-2.75	0.766
Place of health-seeking					
Do nothing	17(63.0)	10(37.0)	1.00		0.725
Hospital	33(58.9)	23(41.1)	1.19	0.46-3.05	
Mae Tao Clinic	138(72.6)	52(27.4)	0.64	0.28-1.50	0.301
Private clinics	18(75.0)	6(25.0)	0.57	0.17-1.90	0.358
Pharmacy	40(63.5)	23(36.5)	0.98	0.38-2.49	0.962

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Health Insurance					
No	154(69.1)	69(30.9)	0.92	0.58-1.45	0.706
Yes	92(67.2)	45(32.8)	1.00		
Type of Health Insurance					
No	154(69.1)	69(30.9)	1.00		
SSS	34(75.6)	11(24.4)	0.72	0.35-1.50	0.386
MHIS	19(76.0)	6(24.0)	0.71	0.27-1.84	0.475
M-Fund	39(58.2)	28(41.8)	1.60	0.91-2.81	0.100
Tobacco used					
No	171(74.0)	60(26.0)	1.00		
Yes	75(58.1)	54(41.9)	2.05	1.29-3.24	0.002*
Alcohol consumption					
No	174(69.6)	76(30.4)	1.00		
Yes	72(65.5)	38(34.5)	1.208	0.75-1.95	0.436
Substance use					
No	238(70.0)	102(30.0)	1.00		
Yes	8(40.0)	12(60.0)	3.50	1.39-8.81	0.008*

Table 4.9 (continued)

Characteristics	PTSD		cOR	95%CI	p-value
	No	Yes			
	246(68.3%)	114(31.7%)			
Perceived neighborhood safety					
No	46(60.5)	30(39.5)	1.55	0.92-2.63	0.101
Yes	200(70.4)	84(29.6)	1.00		
Perceived discrimination					
No	177(73.8)	63(26.2)	1.00		0.002*
Yes	69(57.5)	51(42.5)	2.07	1.31-3.30	
Perceived social exclusion					
No	222(71.4)	89(28.6)	1.00		0.002*
Yes	24(49.0)	25(51.0)	2.60	1.41-4.80	
MSPSS					
Low	19(70.4)	8(29.6)	1.00		0.998
Moderate	107(70.4)	45(29.6)	0.99	0.48-2.84	
High	120(66.3)	61(33.7)	1.21	0.50-2.92	0.675

Note* Statistically significant level at p-value <0.05.

4.3.2 Multivariate analysis to identify factors associated with PTSD

After adjusting for potential confounding variables, thirteen variables were independently associated with PTSD: Gender, age, religion, place of origin, occupational status, type of occupation, stay with family, duration of residence in Thailand, difficulty in the language of health seeking, tobacco use, substance use, perceived discrimination, and perceived social exclusion (Table 4.10).

Female participants were significantly more likely to develop PTSD than males ($\text{adjOR} = 2.34$, 95% CI: 1.25-4.40). Those who were 30 or less ($\text{adjOR} = 4.76$, 95% CI: 1.40-16.16), in their 30s ($\text{adjOR} = 6.04$, 95% CI: 1.71-21.32), and in their 40s ($\text{adjOR} = 4.01$, 95% CI: 1.11-14.45) had higher odds of developing PTSD compared to those age 51 or older. Christian ($\text{adjOR} = 3.12$, 95% CI: 1.14-8.63), Islamic ($\text{adjOR} = 6.86$, 95% CI: 1.78-26.49), and other religions ($\text{adjOR} = 5.88$, 95% CI: 1.28-26.94) have a higher chance of developing PTSD than Buddhist migrants. Migrants originating from conflict-affected areas of Myanmar also had higher odds compared with those from generally safe regions ($\text{adjOR} = 2.69$, 95% CI: 1.32–5.47). Individuals without employment had higher odds of reporting PTSD compared with those who had a job ($\text{adjOR} = 7.42$, 95% CI: 3.00–18.38). Those who are doing professional/freelance work had higher odds than those working in the formal sector (such as factory workers, farmers, and construction workers) ($\text{adjOR} = 6.12$, 95% CI: 2.26-16.63).

Those who did not stay with their family have higher odds than those who did ($\text{adjOR} = 1.94$, 95% CI: 1.04–3.61). The shorter duration of stay in Thailand was also significant; migrants who had lived in the country for between six months to four years were at a substantially higher risk than those with longer residence ($\text{adjOR} = 7.81$, 95% CI: 1.04–3.61). Those who reported no language difficulty in seeking health services had greater odds than those who faced barriers to health seeking ($\text{adjOR} = 3.03$, 95% CI: 1.41-6.54). Tobacco use was strongly associated with PTSD, with users having higher odds than non-users ($\text{adjOR} = 3.09$, 95% CI: 1.70-5.60). Also, those who reported that they used some kind of substance (marijuana/Glue/amphetamine/sleeping pills) were at a higher risk than those who did not ($\text{adjOR} = 3.26$, 95% CI: 1.07-9.99).

Finally, perceived discrimination ($\text{adjOR} = 2.43$, 95% CI: 1.32–4.49) and perceived social exclusion ($\text{adjOR} = 2.90$, 95% CI: 1.32-6.39) also remained significant predictors of PTSD in the adjusted model than those who did not.

Table 4.10 Multivariate analysis to identify factors associated with PTSD

Characteristics	Crude		Adjust		p-value
	OR	95%CI	OR	95%CI	
Gender					
Male	1.00		1.00		
Female	1.32	0.82-2.11	2.34	1.25-4.40	0.008*
Age					
≤30	3.36	1.25-9.01	4.76	1.40-16.16	0.012*
31-40	3.81	1.35-10.71	6.04	1.71-21.32	0.005*
41-50	1.82	1.43-12.61	4.01	1.11-14.45	0.034*
>51	1.00		1.00		
Religion					
Buddhist	1.00				
Christian	1.37	0.66-2.84	3.12	1.14-8.63	0.027*
Islam	1.68	0.69-4.08	6.86	1.78-26.49	0.005*
Others	3.24	1.09-9.62	5.88		0.023*
Place of origins					
Conflict zones	1.65	1.02-2.68	2.69	1.32-5.47	0.006*
Generally safe areas	1.00		1.00		

Table 4.10 (continued)

Characteristics	Crude		Adjust		p-value
	OR	95%CI	OR	95%CI	
Occupational status					
No	1.71	1.08-2.67	7.42	3.00-18.38	<0.001*
Yes	1.00		1.00		
Type of occupation					
Jobless	4.02	1.96 - 8.26			0.001*
Domestic workers & merchants	1.43	0.51-4.05			
Office	3.87	1.54-9.71			
Professional/freelance	4.91	2.18-11.04	6.12	2.26-16.63	
Factory, farmers & construction	1.00		1.00		
Stay with family					
No	1.80	1.13-2.87	1.94	1.04-3.61	0.037*
Yes	1.00		1.00		
Duration of living in Thailand					
6 months -4 years	2.83	1.62-4.94	7.81	3.19-19.13	<0.001*
>4 years	1.00		1.00		

Table 4.10 (continued)

Characteristics	Crude		Adjust		<i>p</i> -value
	OR	95%CI	OR	95%CI	
Difficulty in the language of health seeking					
No	1.15	0.72-1.82	3.03	1.41-6.54	0.005*
Yes	1.00		1.00		
Tobacco use					
No	1.00		1.00		<0.001*
Yes	2.05	1.29-3.24	3.09	1.70-5.60	
Substance use					
No	1.00		1.00		0.038*
Yes	3.50	1.39-8.81	3.26	1.07-9.99	
Perceived discrimination					
No	1.00		1.00		0.004*
Yes	2.07	1.31-3.30	2.43	1.32-4.49	
Perceived social exclusion					
No	1.00		1.00		0.009*
Yes	2.60	1.41-4.80	2.902	1.32-6.39	

Note* Statistically significant level at p -value ≤ 0.05 .

CHAPTER 5

DISCUSSION AND CONCLUSION

This chapter presents the discussion, conclusion, and recommendations of the study. The study aimed to estimate the prevalence of PTSD among Myanmar migrants in Mae Sot and identified factors associated with PTSD.

5.1 Discussion of the Findings

This cross-sectional study examined the prevalence and associated factors of post-traumatic stress disorder (PTSD) among Myanmar migrant workers in Mae Sot, Thailand. The findings revealed several demographic, occupational, behavioral, and social factors that were significantly associated with PTSD. These results provide new insights into the mental health challenges faced by Myanmar migrants in border areas. They can be compared with previous studies conducted among both migrant and conflict-affected populations.

5.1.1 General characteristics

The demographic data from our study population, which was predominantly female, aligns with broader trends noted in the Mae Sot region. Several studies indicate that women constitute approximately half of the total migrant population in this area (25), and official statistics report a slightly lower proportion of female migrant workers. However, the actual number is likely higher due to the significant presence of undocumented women (21). Many of these women are crucial financial providers for their families in Myanmar, often working in sectors such as domestic labor and agriculture. The restrictive nature of migration policies often pushes these jobs into the informal economy, contributing to the underrepresentation of female migrants in official data (85).

Our findings indicate that most participants were under 37 years of age (68.1%), a demographic trend likely influenced by the political situation in Myanmar. The recent enactment of a national conscription law by the military junta has become a powerful push

factor, driving many young people to migrate to Thailand to escape mandatory military service (86). This context helps to explain the youthful age distribution observed in our study population.

Buddhism is the most common religion among the study participants, reflecting Myanmar's predominantly Buddhist population. While Mae Sot is close to Karen State, most participants in this study were Burmese (Bamar), particularly from the Bago and Yangon regions. This finding is consistent with previous research on migrants in the Samut Sakhon district, Thailand (25).

The high level of education among our participants, with most holding a bachelor's degree, is a notable finding that distinguishes our study from previous research on migrant workers in Samut Sakhon and Samut Prakan (25, 26). This difference can be attributed to the unique circumstances of migrants in Mae Sot. Unlike many documented migrant workers who arrive via Memorandums of Understanding (MOUs), a significant portion of Mae Sot's migrant population is migrating due to political situations. This influx of educated and higher-income individuals is a direct result of two primary factors. First, the political persecution and the widespread Civil Disobedience Movement (CDM) following the 2021 coup have compelled many professionals and educated youth to flee Myanmar and to seek better business and work opportunities abroad (87). The occupations reported by our participants support this idea; a majority are engaged in freelance work, such as online teaching or remote work, which leverages their education and skills and reflects their unique migration motivations.

Most of the participants, 66.1%, have a kind of legal document to stay in Thailand, but 61.9% claimed that they don't have any type of health insurance. These findings are irrelevant and need to be explored further, with more research needed on their legal status and health insurance for a better understanding.

Our findings reveal that the language barrier isn't a challenge for participants seeking healthcare in Mae Sot. Most of them seek health services at the Mae Tao Clinic (MTC), a well-established, community-based organization located on the border with Myanmar. Founded in 1989 by Dr. Cynthia Maung, the clinic provides essential and free healthcare to displaced individuals, including refugees and migrant workers from Myanmar (88). So that they can communicate with the Burmese and Karen languages about their health problems.

In terms of health insurance types, many participants opted for M-Fund, a non-profit, low-cost health protection scheme. This scheme operates on a low monthly premium model, offering coverage at a network of partner clinics and hospitals along the border (89). The preference for M-Fund highlights the need for affordable and accessible healthcare options that are specifically tailored to the vulnerabilities of this migrant population.

5.1.2 Post-traumatic stress disorder prevalence

The prevalence of PTSD among Myanmar migrants in Mae Sot is 31.7%, which is a finding that is remarkably consistent with several major meta-analyses. For instance, a review of Syrian refugees resettled in high-income Western countries found a pooled PTSD prevalence of 31% (9). A comprehensive meta-analysis of migrants with pre-migration exposure to armed conflict also reported a current PTSD prevalence of 31% (67). This places our findings squarely within the expected range for refugees with significant trauma exposure. It is higher than the overall PTSD prevalence found in an umbrella review of 59 meta-analyses, which was 23.95% (47), that review included a wide variety of trauma types. However, lower than the prevalence found in other highly distressed groups, such as migrants "living in limbo" (asylum seekers, undocumented migrants), who have a pooled PTSD prevalence of 40.8% (13), and the 57.7% PTSD prevalence among internally displaced persons in Tigray, Ethiopia, following intense civil war, provides another high-end benchmark (73). The finding of 31.7% is highly unlikely, higher than the 11.9% prevalence of depression and/or anxiety symptoms found among Myanmar migrant workers in Samut Sakhon, Thailand (25). The Samut Sakhon sample consisted of more stable factory and fishery workers, who were further removed from the border conflict zones. Most of our sample is from the civil war-affected border region.

5.1.3 Factors associated with PTSD

This study investigated the factors associated with PTSD among Myanmar migrant workers in Mae Sot. Out of the 25 variables initially examined, 13 showed associations in univariable analysis, and 13 remained significant after adjustment in the multivariable model. The key predictors included sex, age, religion, marital status, place of origin, occupational status, type of occupation, duration of residence in Thailand, difficulty in language of health seeking, tobacco use, substance use, perceived discrimination, and perceived social exclusion. These findings highlight the complex interplay between sociodemographic,

behavioral, and psychosocial factors in shaping the mental health outcomes of migrant populations.

5.1.3.1 Gender

In our study, women were more likely to experience PTSD than men, with a prevalence of 33.8% among females compared to 27.9% among males. This pattern aligns with findings from other migrant and displaced populations, including studies in Ethiopia (12), among Syrian refugees in Turkey (9), and among migrants in Australia (78). Similarly, in Thailand, research on Myanmar migrant workers revealed that women were 4.75 times more likely to experience mental health challenges such as anxiety and depression than men (25). In Mae Sot, many women support their families in Myanmar by working in physically demanding or unstable jobs such as domestic labor and agriculture. Because of restrictive migration policies, these jobs are often part of the informal economy, which makes women's contributions less visible in official statistics (85). This also explains why the male-to-female ratio in our study was not balanced.

Additionally, a recent study suggests that the lower reported rates of mental disorders among men, as well as their reduced likelihood of seeking support, are strongly shaped by social expectations of masculinity (89). In Burmese culture, men are typically expected to provide for their families, protect their communities, and show resilience. Traits like emotional restraint, self-reliance, and physical strength are valued, while expressing fear, sadness, or vulnerability is often viewed as weakness or not manly. Because of these norms, men's mental distress is frequently hidden or unreported in most of the studies, meaning the true prevalence in our study may be underestimated due to the masking effect of masculinity and social expectations.

5.1.3.2 Age

In terms of age, our findings revealed that individuals under 50 years old were more likely to experience PTSD compared to those age 51 and over. This pattern highlights a paradox often noted in the many studies that both younger and older age can serve as predictors of PTSD, depending on the context. A meta-analysis of migrants exposed to armed conflict reported that younger individuals face a higher risk of PTSD, a finding that resonated from war-affected populations such as those impacted by the Israel–Hamas conflict (67, 68). In our study, older adults were rarely represented, which reflects Myanmar's current political reality. Since the 2021 military coup, the newly enforced conscription law

has become a major push factor, driving countless young and middle-aged people to flee to Thailand in search of safety and stability (86). Many of them left behind their families, professions, and identities, stepping into an unfamiliar world filled with uncertainty.

They are old enough to carry family responsibilities yet young enough to still be chasing the dreams they had before the crisis. Losing their professional identity, enduring the stress of displacement, and facing unfulfilled expectations after migration can deeply compound their emotional strain. It is not only the trauma they fled that haunts them, but also the loss of who they once were and the uncertainty of who they might become.

5.1.3.3 Religion

The findings of this study indicate that Christian, Muslim, and other religions Myanmar migrants have a higher risk of mental health problems, including PTSD, compared to Buddhist migrants. This difference may be explained by a combination of cultural, social, and environmental factors rather than religion alone. Buddhist migrants may benefit from culturally congruent coping strategies, such as mindfulness and meditation, as well as reduced acculturative stress due to shared religious practices, dietary habits, and social norms with the Thai host population (71). Living in communities with similar religious values may also strengthen social support networks, which are known protective factors for mental health.

5.1.3.4 Place of origin

The most direct link between place of origin and PTSD is exposure to conflict. Research consistently demonstrates that populations from war-torn or conflict-affected regions bear a substantially higher burden of mental disorders. For example, a study of internally displaced persons during the war in Tigray, Ethiopia, reported high rates of PTSD (73), while a survey conducted in Diyarbakir, Turkey, a region with a long history of armed conflict, also revealed elevated prevalence (52). These findings underscore that originating from a conflict-affected area is a major pre-migration risk factor, which is consistent with our study.

In our sample, participants from Kayin, Mon, Shan, Sagaing, Rakhine, and Kachin were considered to be conflict regions. In contrast, those from Yangon, Mandalay, Bago, Ayeyarwady, and Tanintharyi were classified as originating from relatively safe areas. However, it must be acknowledged that civil war affects the entire country to some extent. Migrants originating from conflict-affected areas of Myanmar were more than 2

times likely to develop PTSD compared with those from generally safe regions. This suggests that pre-migration exposure to violence and instability plays a significant role in increasing vulnerability to mental health problems.

5.1.3.5 Employment status

In our study, individuals without employment had higher odds of reporting PTSD compared with those who were employed. This finding aligns with evidence from other displaced and migrant populations. For example, a study of immigrants in Turkey identified unemployment or being unqualified as predictors of current PTSD (52), while a systematic review and meta-analysis of displaced populations in Africa similarly found that unemployment was significantly associated with PTSD, nearly doubling the odds (90).

The relationship between unemployment and poor mental health is multifactorial. Lack of employment can result in financial hardship, reduced self-esteem, social isolation, and diminished opportunities for social participation, all of which serve as chronic stressors that may precipitate or intensify PTSD and depression (30). Moreover, unemployment, underemployment, and precarious working conditions are consistently highlighted as major post-migration stressors that predict poor mental health outcomes, including PTSD, across diverse migrant and refugee populations.

5.1.3.6 Type of occupation

An unexpected finding from our study is that individuals working in professional or freelance roles were at a higher risk of PTSD compared to those employed in factories, agriculture, or construction. This contrasts with many previous studies, for instance, research among Ethiopian refugees reported higher PTSD prevalence among farmers (70). There are two key reasons why professionals and educated migrants may suffer more in our study population. First, many leave their home country with hopes of using their skills and building a better future. When reality in the host country falls short of these expectations, the resulting disappointment can be emotionally damaging. A recent study among Nigerian migrants highlighted this expectation–reality gap, showing that skilled migrants often end up underemployed or unable to work in their trained professions due to structural barriers (91). Second, our study context is shaped by political instability. A large portion of our participants are educated individuals and professionals who fled Myanmar following the 2021 military coup. The political persecution and widespread Civil Disobe-

dience Movement (CDM) forced many teachers, civil servants, and skilled workers to escape in search of safety and opportunities abroad (87). These individuals did not migrate purely for economic reasons; they left behind careers, credibility, and social status.

Carrying the weight of forced displacement, uncertainty, and interrupted professional identity may place them at greater risk than those who have always worked in manual labor sectors. In this sense, trauma is not only shaped by the work people do, but also by what they lost, what they expected, and what they can no longer become.

5.1.3.7 Stay with family

The finding in our study is consistent with other studies in similar populations. A study in Ugandan refugee camps found that family care was associated with higher odds of psychological distress, suggesting that caregiving burdens in resource-limited settings may exacerbate stress (75). In contrast, studies among Ebola survivors and their families in Uganda demonstrated that individuals living in households with two or more members had a significantly lower prevalence of PTSD compared with those living alone, with solitary living consistently linked to higher rates of anxiety and PTSD (92). Similarly, among internally displaced persons in Tigray, loss of contact with family members markedly increased the likelihood of developing PTSD (73). Separation from family and the inability to return home were also identified as key post-migration stressors associated with higher PTSD symptom scores, highlighting the protective role of family presence and social support in buffering trauma-related mental health problems.

5.1.3.8 Duration of living in Thailand

Duration of stay in Thailand was also significant; migrants who had lived in Thailand between six months to four years were more likely to develop PTSD compared to those with a longer residence. Previous studies of Myanmar migrants in Samut Sakhon and Samut Prakan found that duration of stay was not a significant predictor of mental health problems, anxiety, or depression (25, 26). However, the populations studied were different from ours. Other research has shown that a longer duration since displacement is linked to a lower prevalence of PTSD, suggesting that the longer migrants remain in the host country, the less likely they are to experience PTSD (76). This is also aligned with the context of the military coup and civil war, which has been ongoing since 2021, marking a challenging period of four years. Individuals who came to Thailand before 2021 might not be affected by political instability.

5.1.3.9 Difficulty in the language of health seeking

In Mae Sot, most people seek healthcare at Mae Tao Clinic because they can receive services without a translator and because their legal status is not a barrier. Mae Tao Clinic (MTC) is a well-established, community-based organization located on the border with Myanmar. Founded in 1989 by Dr. Cynthia Maung, the clinic provides essential and free healthcare to displaced individuals, including refugees and migrant workers from Myanmar (88). So that they can communicate with the Burmese and Karen languages about their health problems.

As a result, many participants with PTSD reported no language difficulties when accessing care there. Thus, we cannot conclude that people without language barriers are at higher risk of PTSD. These observations apply specifically to the Mae Sot context and should not be generalized beyond it.

5.1.3.10 Tobacco and substance use

In Myanmar culture, many people consume tobacco by chewing betel with tobacco paste, regardless of gender. During data collection, we observed that many women had stained teeth and that some women also smoked. Among the younger generation, mixing marijuana or weed with tobacco has become increasingly common. In our study, participants who were dependent on nicotine had a higher likelihood of developing PTSD compared to those who were not. Similarly, a 2022 study in Uganda reported an association between nicotine dependence and PTSD, and a Canadian longitudinal study on immigrants also found that a history of smoking was linked to PTSD. These findings are consistent with our results (69, 75).

5.1.3.11 Perceived discrimination and social exclusion

Discrimination and social exclusion are not merely unpleasant experiences; they are harmful stressors that undermine mental health and increase the risk of PTSD through several mechanisms. For individuals who have already endured pre-migration trauma such as war, persecution, or violence, post-migration discrimination can function as a secondary traumatic event. A mixed-methods review identified social exclusion, stigmatization, and the threat of deportation as the most prominent stressors for migrants with precarious legal status. Restrictive policies often prevent meaningful participation in society, leaving individuals feeling like “passive recipients who just exist” (13). This context

closely mirrors the situation of our study participants. In our study, individuals who reported feeling discriminated against and lacking social activities (self-limiting and excluded) had more than twice the risk of developing PTSD compared to others.

In summary, this study found that PTSD among Myanmar migrant workers in Mae Sot was shaped by a combination of sociodemographic, behavioral, and psychosocial factors. Women were significantly more vulnerable than men, resonating with global evidence of higher female susceptibility to trauma-related disorders. Adult migrants from conflict-affected regions of Myanmar faced more than double the risk compared to those from safer areas. Unemployment, single or separated individuals, lack of family living together, and shorter duration of residence in Thailand (between 6 months to four years) were also linked to higher PTSD risk, reflecting the importance of stability and social support in post-migration contexts, and most of the participants claimed that they have not a language barrier in seeking health services since they go to the Mae Tao clinic. Psychological behavior risks, such as nicotine dependence, further increase vulnerability. At the same time, perceived discrimination and social exclusion acted as secondary traumas, further compounding mental health risks. Together, these findings highlight the multifaceted and cumulative nature of PTSD risk among Myanmar displaced and migrant populations.

5.2 Strengths and Limitations of the Study

This study is the first to investigate PTSD among Myanmar migrants in Thailand, offering new insights into a highly vulnerable and under-researched population living in the border area. The use of a cross-sectional design was both cost-effective and time-efficient, enabling data collection within limited resources. Using a quantitative approach facilitated a systematic examination of related factors and provided evidence that can improve understanding of PTSD among Myanmar migrants in Mae Sot. Significantly, data collection was completed without missing responses, which enhances the reliability of the results. Additionally, participants received brochures with information on mental health counseling services at Mae Tao Clinic and Mae Sot Hospital, ensuring ethical consideration and offering potential support to those in need.

This study has a few limitations. First, the cross-sectional design shows results from only one point in time. Since migrants are a moving population, the prevalence and related factors may change over time. The PCL-5 is a self-report instrument and may not capture all diagnostic criteria or clinical impairment required for a formal PTSD diagnosis. Consequently, the reported prevalence reflects probable PTSD rather than confirmed clinical cases. Nevertheless, the instrument is well-validated and widely used in community-based and migrant research, supporting the reliability of the associations identified in this study.

Apart from those limitations, this study would help to better understand the mental health of Myanmar migrants in border areas.

5.3 Conclusion

Myanmar migrants in Mae Sot have a high prevalence of PTSD, which is strongly associated with social and psychological factors, yet many remain unaware of their mental health conditions. Seeking support is often avoided due to fear of being scrutinized, evaluated, or judged by others. The community remains culturally sensitive and requires more services to foster effective coping mechanisms. PTSD can persist for years if untreated, and its effects extend beyond the individual. When trauma is left unaddressed, its weight can quietly transfer, affecting families, weakening communities, and touching even those who were not directly exposed. Later, it impacts physical health, economic stability, lifestyle, and even the mental well-being of the host population. Just as infectious diseases can spread from one person to another, psychological distress can also be passed on. Therefore, tailored mental health interventions for migrants are urgently needed. We cannot change the experiences they had (pre-migration trauma) in the past; however, we can improve their mental health by reducing post-migration stressors and offering migrant-friendly services.

5.4 Recommendations

This study estimated the prevalence and identified the factors associated with PTSD among Myanmar migrants in Mae Sot. According to these findings, the following recommendations are made.

5.4.1 Recommendations to participants

Seeking mental health support or speaking openly about mental health is not taboo. Just as our body can become sick from unhealthy habits or difficult situations, our mind also cannot always remain in a stable state. When we feel physically unwell, we visit a doctor; in the same way, it is completely normal and sometimes necessary to seek counseling or mental health support when we experience prolonged emotional distress. Supporting one another by building a warm, non-judgmental community and encouraging participation in social activities can greatly improve our overall well-being and quality of life.

5.4.2 Recommendations to local and international aid organizations

Organizations often focus on strengthening health systems and providing essential support to vulnerable migrant populations. However, mental health screening and support services remain very limited in border regions. There is a pressing need to prioritize culturally adapted mental health interventions and ensure that services reach even the most hidden and underserved communities. One practical approach would be to establish mental health screening programs in high-traffic areas, such as Mae Tao Clinic, in collaboration with community-based organizations (CBOs), such as Rise Center.

5.4.3 Recommendations to the district health level

Mental health screening should be incorporated into primary healthcare settings, with training provided for primary care staff and migrant health volunteers (MHVs) in community hospitals and outpatient facilities to routinely assess conditions such as depression, anxiety, and PTSD. Using simple and validated screening tools that are culturally and linguistically adapted for Myanmar migrants can make this process feasible and effective. To strengthen support systems, partnerships with community-service organizations (CSOs) should be formalized, ensuring better coordination of care. Additionally, developing a clear, visual, and multilingual directory of available mental health services within Mae Sot.

5.4.4 Recommendations to policymakers

Policymakers at the district level should prioritize a more inclusive and strategic approach to migrant health. This involves advocating for a faster and more affordable documentation process to reduce the number of undocumented migrants who are currently excluded from formal healthcare systems. Additionally, implementing cross-cultural training programs and formal interpreter services within the public health system is essential for

overcoming language and cultural barriers, thereby ensuring that migrant populations have equitable access to care.

Simultaneously, the Thai Migrant Health Insurance Scheme (MHIS) does not have a specific mental health package. These studies recommend that there is an urgent need to enhance the mental health benefits within MHIS for migrants.

Finally, it is crucial to establish a formal mechanism for the Ministry of Public Health to provide sustainable funding to trusted community-based organizations and NGOs, such as the Mae Tao Clinic. This collaboration would leverage the existing and essential services provided by these groups.

5.4.5 Recommendations for further study

Further research is needed to fully understand the complexities of the migrant population in Mae Sot. A longitudinal study is recommended to track changes in mental health over time and to gain a better understanding of how migration impacts well-being in the long term. To explore the underlying reasons for specific health issues, such as PTSD, qualitative research, like in-depth interviews, should be conducted to provide a deeper understanding of migrants' lived experiences. Finally, to see if the trends observed in our study are unique to Mae Sot or are more widespread, similar research should be conducted in other border areas of Thailand for a comparative analysis.

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APPENDIX A

ETHICAL APPROVAL CERTIFICATE (THAI VERSION)



The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, Chiang Rai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

หนังสือรับรองด้านจริยธรรมการวิจัย

COA: 78/2025 รหัสโครงการวิจัย: EC 25042-18

ชื่อโครงการวิจัย: ความชุกและปัจจัยที่สัมพันธ์กับภาวะเครียดหลังเผชิญเหตุการณ์รุนแรงของกลุ่มผู้
อพยพชาวพม่าในพื้นที่อำเภอแม่สลด จังหวัดตาก ประเทศไทย

ชื่อผู้วิจัยหลัก: Mr. Arkar Mann Kyaw

สำนักวิชา: วิทยาศาสตร์สุขภาพ

ผู้สนับสนุนการวิจัย: หุ่นส่วนตัว

การรับรอง :

(1) โครงการวิจัย	ฉบับที่ 2 วันที่ 9 เมษายน 2568
(2) เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย	ฉบับที่ 2 วันที่ 9 เมษายน 2568
(3) แบบสอบถาม	ฉบับที่ 1 วันที่ 14 กุมภาพันธ์ 2568
(4) แผนพับ	ฉบับที่ 2 วันที่ 9 เมษายน 2568
(5) ผู้วิจัย และผู้วิจัยร่วม	

- Mr. Arkar Mann Kyaw - ผู้ช่วยศาสตราจารย์ ดร.พิลาสินี วงษ์นุช

- อาจารย์ ดร.ธนาปกรณ์ เรือนใจ

ขอรับรองว่าโครงการดังกล่าวข้างต้นได้ผ่านการพิจารณารับรองจากคณะกรรมการจริยธรรมการวิจัย
ในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง ว่าสอดคล้องกับแนวทางจริยธรรมสากล ได้แก่ ปฏิญญาเฮลซิงกิ (Declaration
of Helsinki) รายงานเบลมอนต์ (Belmont Report) แนวทางจริยธรรมสากลสำหรับการวิจัยในมนุษย์ของสภา
องค์การสากลด้านวิทยาศาสตร์การแพทย์ (CIOMS) และแนวทางการปฏิบัติการวิจัยที่ดี (ICH-GCP)

วันที่รับรองด้านจริยธรรมของโครงการวิจัย: 1 พฤษภาคม 2568

วันสิ้นสุดการรับรอง: 30 เมษายน 2569

ความถี่ของการส่งรายงานความก้าวหน้าของการวิจัย: 1 ปี

ลงนาม 
(อาจารย์ นพ.จุลพงศ์ อังสพงศ์)

ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง



The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, Chiang Rai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rechumangmfl.ac.th

ผู้วิจัยที่โครงการวิจัยผ่านการรับรองจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง
ต้องปฏิบัติตามดังต่อไปนี้

- (1) ดำเนินการวิจัยตามที่ระบุในโครงการวิจัยอย่างเคร่งครัด
- (2) ใช้เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย / แบบสอบถาม / แบบบันทึกข้อมูล / เอกสาร
ประชาสัมพันธ์ ที่มีตราประทับของคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง เท่านั้น
- (3) ผู้วิจัยต้องส่งรายงานความก้าวหน้าของการวิจัย (AP 05/2024) ตามระยะเวลาที่คณะกรรมการฯ กำหนด และ
ภายใน 30 วัน ก่อนหมดอายุการรับรอง ในกรณีที่การวิจัยยังไม่เสร็จสิ้น ผู้วิจัยต้องส่งจดหมายขอต่ออายุ
การรับรอง
- (4) เมื่อมีการแก้ไขเพิ่มเติมโครงการวิจัย ผู้วิจัยต้องส่งรายงานส่วนแก้ไขเพิ่มเติมโครงการวิจัย (AP 06/2024) และ
โครงการวิจัยที่มีการแก้ไขเพิ่มเติม เพื่อแจ้งให้คณะกรรมการฯ พิจารณารับรองก่อนดำเนินการตามที่ได้แก้ไข
เพิ่มเติม (ยกเว้นในกรณีที่การแก้ไขเพิ่มเติมนั้นกระทำเพื่อความปลอดภัยของอาสาสมัคร)
- (5) เมื่อมีเหตุการณ์ไม่พึงประสงค์ชนิดร้ายแรง "ในสถาบัน" ผู้วิจัยต้องส่งรายงานเหตุการณ์ไม่พึงประสงค์ชนิด
ร้ายแรง (AP 07/2024) ตามข้อกำหนดของ ICH-GCP
- (6) เมื่อมีการเบี่ยงเบนหรือไม่ปฏิบัติตามโครงการวิจัยที่ได้รับการรับรอง ผู้วิจัยต้องส่งรายงานการการเบี่ยงเบน
หรือไม่ปฏิบัติตามข้อกำหนด (AP 08/2024)
- (7) เมื่อการวิจัยเสร็จสิ้น หรือ มีการยุติโครงการวิจัยก่อนกำหนดเวลาที่กำหนด ผู้วิจัยต้องส่งรายงาน
ปิดโครงการวิจัย (AP 09/2024)

หมายเหตุ สามารถ Download แบบรายงานต่าง ๆ ได้ที่ <https://ethic.mfl.ac.th>

ข้าพเจ้าในฐานะ ผู้วิจัย ยินยอมที่จะปฏิบัติตามข้อกำหนดดังกล่าว

(Mr. Arkar Mann Kyaw)

วันที่ ๑๕.๐๕.๖๖

APPENDIX B

ETHICAL APPROVAL CERTIFICATE (ENGLISH VERSION)



The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, Chiang Rai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rechumangmfu.ac.th

CERTIFICATE OF APPROVAL

COA: 78/2025

Protocol No: EC 25042-18

Title: Prevalence and factors associated with post traumatic stress disorder (PTSD) among Myanmar migrants in Mae Sot, Tak province, Thailand

Principal investigator: Mr. Arkar Mann Kyaw

School: Health science

Funding support: Personal Budget

Approval:

- | | |
|---|---|
| 1) Research protocol | Version 2 Date April 9, 2025 |
| 2) Information sheet and informed consent documents | Version 2 Date April 9, 2025 |
| 3) Questionnaire | Version 1 Date February 14, 2025 |
| 4) Brochure | Version 2 Date April 9, 2025 |
| 5) Principal investigator and Co-investigators | |
| - Mr. Arkar Mann Kyaw | - Assistant Professor Pilasinee Wongnuch, Ph.D. |
| - Thapakorn Ruanjai, Ph.D. | |

The aforementioned documents have been reviewed and approved by the Mae Fah Luang University Ethics Committee on Human Research in compliance with international guidelines such as Declaration of Helsinki, the Belmont Report, CIOMS Guidelines and the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use - Good Clinical Practice (ICH - GCP)

Date of Approval: May 1, 2025

Date of Expiration: April 30, 2026

Frequency of Continuing Review: 1 year

(Jullapong Achalapong, M.D.)

Chairperson of the Mae Fah Luang Ethics Committee on Human Research



The Mae Fah Luang University Ethics Committee on Human Research
 333 Moo 1, Thasud, Muang, Chiang Rai 57100
 Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rechuman@mfu.ac.th

For research protocol approved by the Mae Fah Luang University Ethics Committee on Human Research (MFU EC), the investigators must comply with the followings:

1. Strictly conduct the research as required by the protocol.
2. Use only the information sheet, consent form, questionnaire, case record form and advertisement bearing the MFU EC stamp of approval.
3. Submit a progress report (AP 05/2024) for continuing review and for renewing the approval within 30 days before expiration date.
4. When there are changes of the protocol, the investigator must submit an amendment report (AP 06/2024) with amended protocol for MFU EC approval before implementing any changes in the research (unless those changes are required urgently for the safety of the research subjects).
5. When there is any unanticipated problem or serious adverse event, the investigator must submit a safety report (AP 07/2024) as set forth in the ICH-GCP.
6. When there is any deviation or non-compliance with the approved protocol, the investigator must submit a protocol deviation/non-compliance report (AP 08/2024).
7. When the research is complete or terminated, the investigator must submit a closing report (AP 09/2024).

Please go to <https://ethic.mfu.ac.th> to download MFU EC forms for reporting.

I, as an investigator, agree to comply with the above obligation.

(Mr. Arkar Mann Kyaw)

Date 21/05/2025

APPENDIX C

ETHICAL APPROVAL CERTIFICATE (CEAB)

Community Ethics Advisory Board (CEAB)
702, Moo 1, Thasailoud, Mae Sot, Tak 63110, Thailand
ms.ethicsboard@gmail.com

Ref: CEAB-2025-006

9 July 2025

Arkar Mann Kyaw
Mae Fah Luang University, Chiang Rai, Thailand
Drarkarmannkyaw.job@gmail.com

Subject: Letter of approval to conduct the study

Dear Arkar Mann Kyaw,

The Community Ethics Advisory Board (CEAB) acknowledges the submission of the research proposal titled: **"Prevalence and factors associated with Post Traumatic Stress Disorder (PTSD) among Myanmar migrants in Mae Sot, Tak province, Thailand."**

Following a comprehensive review of the study's objectives, methodology, and ethical considerations, the CEAB acknowledges that there are no major ethical concerns with the proposed approach. The study has been reviewed with attention to its relevance, ethical soundness, and sensitivity to the affected communities.

Acknowledgement Details:

- **Reference Number:** CEAB-2025-006
- **Review Period Validity:** 9 July 2025 – 8 June 2026

The study is expected to be implemented in accordance with the version of the proposal reviewed by CEAB. Any subsequent changes to the research objectives, questions, methodology, or data collection tools must be submitted to CEAB for further consideration.

The CEAB recognizes the potential of this research to contribute valuable insights into community health challenges and responses. A final report is requested upon completion of the study. Additionally, CEAB would appreciate receiving any publications or outputs that arise from this research.

This letter serves as formal confirmation that CEAB has reviewed the study and found no major ethical concerns at this stage.

Your sincerely,



Saw Than Lwin (Thanet)
Coordinator,
Community Ethics Advisory Board (CEAB)

APPENDIX D

INFORMED CONSENT (ENGLISH VERSION)

Version.....2..... Date 9.4.2025

AP 03_1/2022

Information Sheet and Informed Consent

Research Project Title: PREVALENCE AND FACTORS ASSOCIATED WITH POST TRAUMATIC STRESS DISORDER (PTSD) AMONG MIGRANTS FROM MYANMAR/ BURMA IN MAE SOT, TAK PROVINCE, THAILAND
Principal Investigator: Arkar Mann Kyaw
Affiliation: School of Health Science, Mae Fah Luang University
Advisor: Asst. Prof. Dr.Pilasinee Wongnuch
Source of Research Funding/Sponsor: Mae Fah Luang University

1. Introduction and Project Summary

My name is Mr. Arkar Mann Kyaw, and I am a master's student in Public Health at Mae Fah Luang University in Thailand. Currently, I am researching the prevalence of post-traumatic stress disorder (PTSD) and the factors associated with it among Migrants from Myanmar/ Burma in Mae Sot, Tak Province, Thailand. I want to share information about the research and invite you to participate. Participation is completely voluntary. If you decide not to participate, it will not affect your healthcare or any rights you are entitled to. Once you choose to participate, you can withdraw anytime if you change your mind. If you have any questions or need clarification, please ask; I am here to help.

The purposes of this study are to estimate the prevalence of PTSD among Migrants from Myanmar/ Burma in Mae Sot, Tak Province, Thailand, and to identify the key factors contributing to its occurrence.

Post-Traumatic Stress Disorder (PTSD) is a mental health condition that can develop after someone experiences or witnesses a traumatic event, such as a natural disaster, a serious accident, or violence. People with PTSD may have upsetting memories, feel anxious or afraid, or have trouble sleeping. It's important to remember that experiencing these symptoms after a traumatic event is normal, but if these symptoms persist for more than a few weeks and interfere with daily life, it may be a sign of PTSD.

The tentative duration of the study in the participants and the involvement of the research process and procedures will entail completing a questionnaire, which should take approximately 30 minutes to complete. Survey research by questionnaires and face-to-face interviews will be carried out by the principal investigator and two trained research assistants.



There are no anticipated risks associated with participating in this research. While answering the questionnaire, you may experience some discomfort, but since it will be conducted in a private setting, this is unlikely to occur. However, if you do feel uncomfortable at any point during the process, you have the option to stop answering the questions and withdraw from the study. The debriefing sessions after participation to discuss emotions and coping strategies are offered and mental health support referrals to Mae Sod Hospital/Mae Tao clinic also offer if needed.

Participating in this research may not directly benefit you, but it will contribute to providing insights into the mental health needs of Migrants from Myanmar/ Burma, tailoring the development of strategies and interventions to enhance access to mental healthcare services and promote better mental health outcomes for Migrants from Myanmar/ Burma in the study area.

If you do not want to participate in a research study as a participant, you can inform the researcher. The refusal of participation will not affect your rights.

2. A statement indicating that this is a research project and that participation in this research is voluntary

You are invited to participate in this research. Please take time to read this document as it provides information about your involvement in the research. The decision to participate is entirely voluntary. If you choose not to participate, your healthcare and the rights you are entitled to will not be changed.

Your participation in this research is based on your voluntary decision.

- You have the freedom to decide whether to participate in this research or not.
- You can consult with your family or your physician before making the decision. You may also ask any questions; the researcher will provide explanations and answers until you have a clear understanding.
- After deciding to participate in this research, you still have the right to withdraw at any time.

3. Rationale and Significance of the Research

This research focuses on the mental health challenges faced by Migrants from Myanmar/ Burma in Mae Sot, particularly the prevalence and factors associated with PTSD. Migrants often experience pre-migration trauma and post-migration stressors, which can

significantly impact their mental health and well-being. Currently, mental health services for migrants are limited, with barriers such as lack of access, cultural differences, and stigma preventing effective care. By providing data-driven insights, this study aims to address these gaps, guiding public health policies and interventions to improve mental health outcomes and overall quality of life for this vulnerable population.

4. Qualifications and Number of Participants

Individuals who meet the criteria as adults from Myanmar, both males and females, 18 years and older, regardless of their legal status, residing in the Mae Sot district, specifically in the sub-districts of Mae Sot, Mae Tao, and Tha Sai Luat, for at least six months (regular migrants), and are willing to participate in the study. A total of 360 participants were interviewed by the research team and included in the research. Data will be collected through face-to-face interviews by the research team with participants, using a structured questionnaire."

5. Research Objectives

1. To estimate the prevalence of PTSD among Migrants from Myanmar/ Burma in Mae Sot, Thailand.
2. To identify the psychological, social, and demographic factors associated with PTSD in this population
3. To generate evidence-based policy recommendations to improve mental health/social services for migrants in collaboration with stakeholders.

6. Research Design

Survey research using questionnaires and face-to-face interviews is conducted to estimate the prevalence of PTSD and identify associated factors among Migrants from Myanmar/ Burma in Mae Sot, Thailand. And to generate evidence-based policy recommendations to improve mental health/social services for migrants in collaboration with stakeholders

7. Research Procedure and Duration of Participation



Migrants from Myanmar/ Burma aged 18 and older, residing in the Mae Sot, Mae Tao, and Tha Sai Luat sub-districts, Mae Sot district of Tak province, Thailand, are invited to participate in this study. Your participation will involve completing a questionnaire that will take approximately 30 minutes to fill out independently. A face-to-face interview will be conducted by the principal investigator and two trained research assistants. Please rest assured that the information you provide will be kept strictly confidential and will not be shared with anyone

8. Potential Risks and Discomfort from Participating in Research

Participation in this research involves minimal anticipated risks. While completing the questionnaire, you may experience some discomfort; however, since the session will take place in a private setting, this is unlikely to happen. If you do feel uncomfortable at any point during the process, you have the option to stop answering questions and withdraw from the study. If you experience heightened panic or anxiety due to the questionnaire, which may trigger unwanted memories, the researcher, who is also a medical doctor, will be available to provide counseling and reassurance. The mental health support referrals to Mae Sod Hospital/Mae Tao clinic also offer if needed.

9. Potential Benefits of Participating in the Research

Participating in this research may not provide immediate benefits to you, but it will contribute to us achieving the research objectives. While there may not be direct societal advantages at this moment, the findings will enhance our understanding of the prevalence of post-traumatic stress disorder (PTSD). This knowledge is crucial for doctors and public health officials, as it enables them to understand the extent of the problem better. With this information, they can plan more effective healthcare services, allocate resources where they are most needed, and work on preventing more cases of PTSD and its associated factors. Ultimately, this research will contribute to collective progress and inform the development of healthcare policies and programs tailored to the needs of those affected.

10. Alternatives if Choosing NOT to Participate

Participation in this research is entirely voluntary, and choosing not to participate will not affect your access to healthcare or other services. If you choose not to take part, you can still seek mental health support or PTSD assessment through the addresses in the brochure. The refusal of participation will not affect your rights.

11. Guidelines for Managing Situations that May Arise during the Research

Situations	Guidelines
If you decide to withdraw during the research	Participants have the right to withdraw from the research at any point. If you choose to withdraw, please inform the researcher as soon as possible. Your decision to withdraw will be respected, and any data collected up to that point will be treated confidentially and not included in the study.
If there is new information regarding the research or your safety	If any new information arises during research that may impact your safety or the nature of the study, the researcher will promptly inform you. You will then have the opportunity to decide whether you wish to continue participating in the research or withdraw. Your safety and well-being are of the utmost importance, and any concerns will be addressed promptly.

12. Potential Benefits after the Completion of the Research

After the completion of the research, there may not be direct potential benefits for the participants. The researcher will notify you of the results once the research has been completed.

13. Confidentiality of Data and Limitations

We assure you that all information about you will remain confidential and will not be shared with anyone outside the research team. All data collected in this research project will be kept private. Each participant will be assigned a unique number instead of using names, and only the researcher will have access to the corresponding numbers, which will be securely stored on a password-protected computer. The precise location of each participant's residence will not be revealed or shared.

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

01 MAY 2025

APPROVED

When presenting the research results, we will ensure that no identifying information about participants is disclosed. However, certain individuals or groups—such as the ethics committee, research coordinators, research supervisors, and authorized personnel from governmental institutions or organizations responsible for audits—may have access to your data to verify the accuracy of the data and research procedures.

The research findings will be disseminated publicly through seminars or publications, allowing professionals, implementers, and policymakers to learn from and apply relevant insights. Rest assured, confidential information will not be disclosed or shared in any form.

14. Reimbursement for Participation

The participants will receive a brochure about PTSD to enhance their understanding. Apart from this, participants will not receive any monetary or material compensation for their participation in the study.

15. Expenses that the participants must bear

There are no expenses that the participants must bear in this study.

16. Care and Compensation Guidelines if the participants experience harm or adverse effects from participating in the research

If the individual experiences increased panic or anxiety due to the questionnaire, which may trigger unwanted memories, the research team will help them connect with appropriate care and support.

The first step is to discuss the results in a non-judgmental and supportive manner. It's important to emphasize that a high score indicates a need for further evaluation but does not serve as a definitive diagnosis of PTSD. If the individual experiences increased panic or anxiety due to the questionnaire, which may trigger unwanted memories, the researcher, who is also a medical doctor, will provide counseling. As a certified professional, he is qualified to discuss mental health issues and offer reassurance.

Next, a referral to a qualified mental health professional for a formal diagnostic assessment is critical. This can involve using structured interviews like the CAPS-5 (Clinician-Administered PTSD Scale) to confirm the diagnosis. Connecting the individual with local resources, such as Mae Tao clinics or Mae Sot Hospital.

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

1 MAY 2025

APPROVED

Version.....2..... Date 9.4.2025

AP 03_1/2022

All participants will receive a brochure designed to enhance their understanding of PTSD and other mental health conditions. The brochure will cover signs and symptoms, coping strategies for managing mental health issues, and recommended contact information for resources, such as Mae Tao Clinic and Mae Sot Hospital.

17. Contact Person in Case of Questions or Concerns

If you have any questions or concerns regarding the research or safety during participation, you can ask the researcher directly.

Principal Investigator

Name: Arkar Mann Kyaw

Mobile: 0927689311

Email: drarkarmannkyaw.job@gmail.com

Advisor

Name: Asst. Prof. Dr. Pilasinee Wongnuch

Mobile: +66 (0) 5391 6921

Email: pilasinee.won@mfu.ac.th

If you have questions regarding your rights, you can contact the Mae Fah Luang University Ethics Committee on Human Research at the Academic Service building (AS), 4th floor, tel. (053) 917-170 to 1 or (053) 916-551, fax. (053) 917-170, or e-mail: rec.human@mfu.ac.th to ensure that your rights, your safety, and your well-being are protected under the international standards of human-research ethics.



Informed Consent Form

I, _____, have decided to participate in [the title of the research project]. I have received information and explanations about this research, and I have had the opportunity to ask questions and receive satisfactory answers. I have had sufficient time to read and understand the information provided in the documents thoroughly and have decided to participate in this research.

I understand that I have the freedom to choose not to participate in this research, and I can withdraw from this research at any time without any impact on my care or rights that I am entitled to.

By signing this document, I do not waive any rights that I am entitled to under the law, and after signing, I will receive a copy of the information sheet and the informed consent.

Participant's Signature _____ Date _____

..... (For illiterate participants who can understand through listening)

I cannot read, but the researcher has read this information sheet and informed consent form to me, and I understand it well. Therefore, I voluntarily sign or place my fingerprint.

Participant's signature/fingerprint _____ Date _____

Signature of the person requesting consent _____ Date _____

Testimony of a witness who is not a stakeholder in the research (If the participant cannot read but can understand through listening)

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

01 MAY 2025

APPROVED

Version.....2..... Date 9.4.2025

AP 03_1/2022

I have been present during the consent request process and confirm that the person requesting consent has read/explained the information sheet to _____ . The aforementioned person had the opportunity to ask questions and decided to participate voluntarily after understanding the information in this document.

Witness's signature _____ Date _____
(_____)



APPENDIX E

INFORMED CONSENT (BURMESE VERSION)

Version.....2..... Date 9.4.2025

AP 03_1/2022

အချက်အလက်စာရွက်နှင့် သတင်းအချက်အလက် သဘောတူညီမှု

သုတေသန စီမံကိန်း ခေါင်းစဉ် - ထိုင်းနိုင်ငံ၊ မဲဆောက်မြို့ရှိ မြန်မာနိုင်ငံမှ ရွှေပြောင်းနေထိုင်သူများအကြား စိတ်ဒဏ်ရာနောက်ပိုင်း စိတ်ဖိစီးမှုဝေဒနာ (PTSD) နှင့်ဆက်သွယ်နေသော ပျံ့နှံ့မှုနှင့် အကြောင်းရင်းများ

အဓိက စုံစမ်းစစ်ဆေးသူ - Arkar Mann Kyaw

ပူးပေါင်းဆောင်ရွက်ခြင်း - ကျန်းမာရေးသိပ္ပံကျောင်း၊ Mae Fah Luang တက္ကသိုလ်

အကြံပေးသူ - Asst.Prof. Dr.Pilasinee Wongnuch

သုတေသန ရန်ပုံငွေ/ဓပွန်ဆာ : Mae Fah Luang တက္ကသိုလ်

၁။ စိတ်ဆက်ခြင်းနှင့် စီမံကိန်း အကျိုးချုပ်

ကျွန်တော့်နာမည်က မစ္စတာ အာကာမန်းကျော်ဖြစ်ပြီး ကျွန်တော်ဟာ ထိုင်းနိုင်ငံက Mae Fah Luang တက္ကသိုလ်က ပြည်သူ့ကျန်းမာရေးမှာ ကျွမ်းကျင်သူ ကျောင်းသားတစ်ယောက်ပါ။ လောလောဆယ်တွင် ပြင်းထန်စွာထိခိုက်ပြီးနောက် စိတ်ဖိစီးမှုဝေဒနာ (ပီတီအက်စ်ဒီ) ပျံ့နှံ့နေကြောင်းနှင့် ထိုင်းပြည်နယ်၊ မဲဆောက်မြို့ရှိ မြန်မာ ရွှေပြောင်းနေထိုင်သူများအကြား ဆက်သွယ်နေသော အကြောင်းရင်းများကို ရှာဖွေလေ့လာနေပါသည်။ သုတေသနနဲ့ပတ်သက်တဲ့ သတင်းအချက်အလက်တွေကို ဝေမျှပြီး ပါဝင်ဖို့ ဖိတ်ခေါ်ချင်ပါတယ်။ ပါဝင်ခြင်းသည် လုံးဝ စေတနာအလျောက်ဖြစ်သည်။ မပါဝင်ရန် ဆုံးဖြတ်ပါက သင်ကျန်းမာရေးစောင့်ရှောက်မှု သို့မဟုတ် သင်ရပိုင်ခွင့်ရှိသည့် မည်သည့်အခွင့်အရေးကိုမျှ ထိခိုက်မည်မဟုတ်ပါ။ သင်ပါဝင်ရန် ရွေးချယ်လိုက်သည်နှင့် စိတ်ပြောင်းသွားပါက မည်သည့်အချိန်မဆို ဆုတ်ခွာနိုင်သည်။ မေးခွန်းတွေရှိတယ် ဒါမှမဟုတ် ရှင်းလင်းချက်လိုအပ်တယ်ဆိုရင် ကျေးဇူးပြု၍ မေးပါ။ ကျွန်တော် ဒီမှာ ကူညီပေးဖို့ ရောက်လာတာပါ။

စိတ်ဒဏ်ရာရပြီးနောက် စိတ်ဖိစီးမှုဝေဒနာ (PTSD) သည် သဘာဝဘေးဒဏ်၊ ပြင်းထန်သောမတော်တဆမှု သို့မဟုတ် အကြမ်းဖက်မှုကဲ့သို့သော စိတ်ဒဏ်ရာဖြစ်ရပ်တစ်ခုကို တစ်ဦးတစ်ယောက် တွေ့ကြုံပြီးနောက် ဖြစ်ပေါ်လာနိုင်သည်။ စိတ်ကျန်းမာရေးအခြေအနေတစ်ခုဖြစ်သည်။ PTSD ရှိသူများသည် စိတ်ပျက်ဖွယ် မှတ်ဉာဏ်များရှိနိုင်သည်။ စိုးရိမ်ပူပန်ခြင်း သို့မဟုတ် ကြောက်ရွံ့ခြင်း သို့မဟုတ် အိပ်ရေးအခက်အခဲရှိပေမည်။ စိတ်ဒဏ်ရာရပြီးနောက် ဤလက္ခဏာများကို တွေ့ကြုံရခြင်းသည် သာမန်ဖြစ်သည်ကို သတိရရန် အရေးကြီးသည်။ သို့သော် ဤလက္ခဏာများသည် ရက်သတ္တပတ်အနည်းငယ်ကျော် ဆက်လက်တည်ရှိပြီး နေ့စဉ်အသက်တာကို အနှောင့်အယှက်ပေးမည်ဆိုလျှင် PTSD လက္ခဏာတစ်ခုဖြစ်နိုင်သည်။

THE MAE FAH LUANG UNIVERSITY

ETHICS COMMITTEE ON HUMAN RESEARCH

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ဤလေ့လာမှု၏ ရည်ရွယ်ချက်များမှာ ထိုင်းနိုင်ငံ ၊ မဲဆောက် မြို့ရှိ မြန်မာ ရွှေ့ပြောင်း နေထိုင်သူများ အကြား ပီတီအက်စ်ဒီ၏ ပျံ့နှံ့မှုကို ခန့်မှန်းရန်နှင့် ၎င်း၏ ဖြစ်ပွားမှုကို အထောက်အကူပြုသော အဓိက အချက်များကို ဖော်ထုတ်ရန် ဖြစ်သည်။

ပါဝင်သူများတွင် လေ့လာမှု၏ အသေအချာကာလ၊ သုတေသနလုပ်ငန်းစဉ်နှင့် လုပ်ထုံးလုပ်နည်းတွေ ပါဝင်ပတ်သက်မှုတွေမှာ မေးခွန်းလွှာတစ်ခု ပြီးအောင်လုပ်သင့်တဲ့ မေးခွန်းလွှာကို ပြီးစီးစေပါလိမ့်မယ်။ ခန့်မှန်းခြေအားဖြင့် မိနစ် ၃၀ အတွင်းပြီးစီးရန်ဖြစ်သည်။ စစ်ဆေးမေးမြန်းမှုသုတေသနပြုချက်တွေနဲ့ မျက်နှာချင်းဆိုင် တွေ့ဆုံ မေးမြန်းမှုများကို အဓိက စုံစမ်း စစ်ဆေးသူက ဆောင်ရွက်လိမ့်မည်။ ဤသုတေသနပြုမှုတွင် ပါဝင်ခြင်းနှင့်ဆက်သွယ်သည့် မျှော်မှန်းထားသော အန္တရာယ်များ မရှိပါ။

မေးခွန်းလွှာကို ဖြေဆိုရာတွင် စိတ်အနှောင့်အယှက်တချို့ ကြုံတွေ့ရပေမည်။ သို့သော် ဖြစ်နိုင်ဖွယ်နည်းပါသည်။ ဒါပေမဲ့ စိတ်အနှောင့်အယှက်ဖြစ်နေရင်တော့ သို့သော် ဖြစ်စဉ်အတွင်း မည်သည့်အချိန်တွင်မဆို သင်သည် သက်သောင့်သက်သာမရှိဟု ခံစားရပါက မေးခွန်းများကို ဖြေဆိုခြင်းကို ရပ်တန့်ပြီး သင်အံ့မှမူ နုတ်ထွက်ရန် ရွေးချယ်ပိုင်ခွင့်ရှိသည်။ စိတ်လှုပ်ရှားမှုနှင့် ကိုင်တွယ်ဖြေရှင်းနည်းများကို ဆွေးနွေးရန် ပါဝင်ပြီးနောက် အစီရင်ခံစာများကို ကမ်းလှမ်းပြီး လိုအပ်ပါက စိတ်ကျန်းမာရေး ထောက်ပံ့မှုကိုလည်း မေ့ဆော့ဒ်ဆေးရုံ/မေတာအို ဆေးခန်းသို့ လွှဲပြောင်းပေးသည်။

ဒီသုတေသနပြုမှုမှာ ပါဝင်ခြင်းက သင့်ကို တိုက်ရိုက်အကျိုးပြုမှာ မဟုတ်ပါဘူး။ သို့သော် မြန်မာနိုင်ငံမှ ရွှေ့ပြောင်းနေထိုင်သူများ၏ စိတ်ပိုင်းဆိုင်ရာ ကျန်းမာရေးလိုအပ်ချက်များကို ပိုမိုသိမြင်စေရန်၊ စိတ်ကျန်းမာရေး ဝန်ဆောင်မှုများ တိုးမြှင့်ရန် နည်းဗျူဟာများနှင့် ကြားဝင်ဆောင်ရွက်မှုများ၊ ဖွံ့ဖြိုးတိုးတက်မှုနှင့် ကြားဝင်ဆောင်ရွက်မှုများ ဖွံ့ဖြိုးတိုးတက်စေရန်နှင့် လေ့လာမှုနယ်ပယ်တွင် မြန်မာ ရွှေ့ပြောင်းနေထိုင်သူများအတွက် စိတ်ကျန်းမာရေး ရလဒ်များ ပိုမိုကောင်းမွန်စေရန် အထောက်အကူပြုပါလိမ့်မည်။

ပါဝင်သူအဖြစ် သုတေသနလေ့လာမှုတွင် မပါဝင်လိုပါက အသိပေးနိုင်သည်။ ပါဝင်ခွင့်ကိုငြင်းပယ်ခြင်းက သင့်အခွင့်အရေးအပေါ် အကျိုးသက်ရောက်မည်မဟုတ်ပါ။

၂။ ဒါဟာ သုတေသန စီမံကိန်းတစ်ခုဖြစ်ပြီး ဒီသုတေသနမှာ ပါဝင်ခြင်းဟာ စေတနာအလျောက်ဖြစ်တယ်လို့ ဖော်ပြထားတဲ့ ကြေညာချက်တစ်ခု ဒီသုတေသနမှာ ပါဝင်ဖို့ စိတ်ဝင်ပါတယ်။ သုတေသနတွင် သင် ပါဝင် ပတ်သက်မှုနှင့် ပတ်သက်၍ သတင်း အချက်အလက်များ ပေးသောကြောင့် ဤ စာရွက်စာတမ်းကို အချိန်ယူပါ။

THE MAE FAH L HANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH
8 1 MAY 2025
APPROVED

။ ပါဝင်ရန် ဆုံးဖြတ်ချက်မှာ လုံးဝ စေတနာအလျောက်ဖြစ်သည်။ သင်သည် မပါဝင်ရန် ရွေးချယ်မည်ဆိုလျှင် သင့်ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် အခွင့်အရေးများကို ပြောင်းလဲမည်မဟုတ်ပါ။

ဤသုတေသနပြုချက်တွင် သင်ပါဝင်ခြင်းသည် သင်၏ စေတနာအလျောက်ဆုံးဖြတ်ချက်အပေါ် အခြေခံသည်။

ဒီသုတေသနပြုမှုမှာ ပါဝင်ဖို့လား၊ မပါဝင်ဖို့ သင်မှာ လွတ်လပ်စွာ ဆုံးဖြတ်ပိုင်ခွင့်ရှိပါတယ်။ ဆုံးဖြတ်ချက်မချခင် သင့်မိသားစု ဒါမှမဟုတ် ဆရာဝန်နဲ့ တိုင်ပင်ဆွေးနွေးနိုင်ပါတယ်။ မေးခွန်းတွေလည်း မေးနိုင်ပါတယ်။ သုတေသီက ရှင်းပြချက်တွေနဲ့ အဖြေတွေကို ရှင်းရှင်းလင်းလင်း နားလည်နိုင်တဲ့အထိ ရှင်းပြချက်တွေနဲ့ အဖြေတွေကို ပေးပါလိမ့်မယ်။

- ဤသုတေသနပြုချက်တွင် ပါဝင်ရန် ဆုံးဖြတ်ပြီးနောက် မည်သည့်အချိန်၌မဆို ဆုတ်ခွာပိုင်ခွင့်ရှိဆဲဖြစ်သည်။

၃။ သုတေသနပြုချက်၏ ဆင်ခြင်တုံတရားနှင့် အရေးပါမှု

ဤ သုတေသန သည် မဲဆောက်တွင် မြန်မာ ရွှေ့ပြောင်း နေထိုင် သူ များ ရင်ဆိုင် နေ ရသော စိတ်ပိုင်း ဆိုင်ရာ ကျန်းမာရေး စိန်ခေါ်မှု များ ၊ အထူးသဖြင့် ပီတီအက်စ်ဒီ နှင့် ဆက်စပ် နေသော ပျံ့နှံ့မှု နှင့် အကြောင်းရင်း များ အပေါ် အာရုံစိုက် သည် ။ ပြောင်းရွှေ့လာသူများသည် မိမိတို့၏စိတ်ပိုင်းဆိုင်ရာ ကျန်းမာရေးနှင့် ကျန်းမာရေးကို သိသိသာသာ ထိခိုက်စေနိုင်သည့် ရွှေ့ပြောင်းမှုမတိုင်မီ စိတ်ဒဏ်ရာများနှင့် လူဝင်မှုကြီးကြပ်ရေးနောက်ပိုင်း စိတ်ဖိစီးမှုများကို ခံစားရလေ့ရှိသည်။ လောလောဆယ်တွင် ပြောင်းရွှေ့လာသူများအတွက် စိတ်ကျန်းမာရေးဝန်ဆောင်မှုများသည် အကန့်အသတ်သာရှိပြီး ဝင်ရောက်ခွင့်မရှိခြင်း၊ ယဉ်ကျေးမှုကွဲပြားမှုများနှင့် ထိရောက်သောပြုစုစောင့်ရှောက်မှုကို တားဆီးပေးခြင်းကဲ့သို့သော အတားအဆီးများရှိသည်။ ဒီလေ့လာမှုက ဒီကွာဟချက်တွေကို ဖြေရှင်းဖို့၊ စိတ်ကျန်းမာရေးဆိုင်ရာ ရလဒ်တွေ တိုးတက်ကောင်းမွန်စေဖို့ ပြည်သူ့ကျန်းမာရေး မူဝါဒတွေနဲ့ ကြားဝင်ဆောင်ရွက်မှုတွေကို လမ်းညွှန်ပေးဖို့နဲ့ ဒီအားနည်းတဲ့ လူဦးရေအတွက် ဘဝအရည်အသွေးတစ်ခုလုံးကို တိုးတက်ကောင်းမွန်စေဖို့ ရည်ရွယ်ပါတယ်။

၄။ အရည်အချင်းများနှင့် ပါဝင်သူအရေအတွက်

မြန်မာနိုင်ငံမှ အရွယ်ရောက်သူများအနေနှင့် စံနှုန်းများကို ပြည့်မီသူများ၊ ၁၈ နှစ်နှင့်အထက် အမျိုးသားနှင့် အမျိုးသမီး နှစ်ဦးစလုံးသည် တရားဝင်အနေအထားမည်သို့ပင်ရှိပါစေ

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မေဆော့ခရိုင်တွင် အနည်းဆုံး ခြောက်လကြာ နေထိုင်ကြပြီး လေ့လာမှုတွင် ပါဝင်လိုကြသည်။ စုစုပေါင်း ၃၆၀ ပါဝင်သူများကို သုတေသန အဖွဲ့က တွေ့ဆုံ မေးမြန်းခဲ့ပြီး သုတေသန တွင် ပါဝင်ခဲ့သည်။ အချက်အလက်များကို ဖွဲ့စည်းထားသော မေးခွန်း မေးမြန်းချက်တစ်ခုကို အသုံးပြု၍ ပါဝင်သူများနှင့်အတူ သုတေသန အဖွဲ့က မျက်နှာချင်းဆိုင် တွေ့ဆုံ မေးမြန်းခြင်း မှတစ်ဆင့် စုဆောင်း လိမ့်မည်။

၅။ သုတေသနရည်မှန်းချက်များ

- ၁။ မြန်မာနိုင်ငံမှ ရွှေ့ပြောင်းနေထိုင်သူများအကြား ပီတီအက်စ်ဒီ ပျံ့နှံ့မှုကို ခန့်မှန်းရန်။
- ၂။ ဤလူဦးရေတွင် ပီတီအက်စ်ဒီနှင့်ဆက်သွယ်နေသော စိတ်ဗိုင်းဆိုင်ရာ၊ လူမှုရေးနှင့် လူဦးရေဆိုင်ရာ အကြောင်းရင်းများကို ခွဲခြားသိမြင်ရန်။
- ၃။ သက်ဆိုင်သူများနှင့် ပူးပေါင်း၍ ပြောင်းရွှေ့သူများအတွက် စိတ်ကျန်းမာရေး/လူမှုရေးဝန်ဆောင်မှုများကို တိုးတက်စေရန် အထောက်အထားအခြေပြုမှုဝါဒ အကြံပြုချက်များကို ထုတ်လုပ်ရန်။

၆။ သုတေသန ဒီဇိုင်း

မေးခွန်းလွှာများနှင့် မျက်နှာချင်းဆိုင် တွေ့ဆုံမေးမြန်းမှုများကို အသုံးပြု၍ စစ်တမ်းသုတေသနပြုမှုကို ပီတီအက်စ်ဒီ ပျံ့နှံ့မှုကို ခန့်မှန်းရန်နှင့် ထိုင်းနိုင်ငံ၊ မဲဆောက်မြို့ရှိ မြန်မာ ရွှေ့ပြောင်းနေထိုင်သူများအကြား ဆက်စပ်နေသော အကြောင်းရင်းများကို ဖော်ထုတ်ရန် ဆောင်ရွက်ခဲ့သည်။

၇။ သုတေသနလုပ်ထုံးလုပ်နည်းနှင့် ပါဝင်ချိန်ကာလ

အသက် ၁၈ နှစ်နှင့် အသက်ပိုကြီးသော မြန်မာနိုင်ငံမှ ရွှေ့ပြောင်းနေထိုင်သူ မြန်မာနိုင်ငံမှ ပြောင်းရွှေ့လာသူများသည် ထိုင်းနိုင်ငံ၊ တာခ်ပည်နယ်မှ မိုင်းဆော့ခရိုင်၊ မိုင်းဆော့ခရိုင်၊ မိုင်းဆော့ခရိုင်တွင် နေထိုင်လျက် ဤလေ့လာမှုတွင် ပါဝင်ရန် ဖိတ်ခေါ်ထားသည်။ သင် ပါဝင်ခြင်း တွင် လွတ်လပ်စွာ ဖြည့်ရန် ခန့်မှန်းခြေ မိနစ် ၃၀ ကြာ မည် မေးခွန်းလွှာ တစ်ခု ပြီးစီးခြင်း ပါဝင် လိမ့်မည်။ မျက်နှာချင်းဆိုင် တွေ့ဆုံ မေးမြန်းခန်း တစ်ခုကို အဓိက စုံစမ်း စစ်ဆေးသူက ဆောင်ရွက် လိမ့်မည်။ သင်ပေးသော သတင်းအချက်အလက်များကို တင်းကျပ်စွာ လျှို့ဝှက်ထားမည်ဖြစ်ပြီး မည်သူ့ကိုမျှ ဝေမျှမည်မဟုတ်သောကြောင့် ကျေးဇူးပြု၍ စိတ်ချပါ။

၈။ သုတေသနလုပ်ငန်းတွင် ပါဝင်ခြင်းမှ ဖြစ်နိုင်ခြေရှိသော အန္တရာယ်များနှင့်

စိတ်အနှောင့်အယှက်များ

ဤသုတေသနပြုချက်တွင် ပါဝင်ခြင်းတွင် ကြိုတင်ခန့်မှန်းထားသော အန္တရာယ်အနည်းဆုံးပါဝင်သည်။ မေးခွန်းလွှာကို အပြီးသတ်နေရင်း စိတ်အနှောင့်အယှက်မရှိပါ။

ကြိုရနိုင်ပါတယ်။ သို့သော် ပုဂ္ဂလိကအခြေအနေတွင် မေးမြန်းမည်ဖြစ်ရာ ယင်းသို့ဖြစ်နိုင်ဖွယ်မရှိချေ။ အကယ်၍ သင်သည် ဖြစ်စဉ်အတွင်း မည်သည့်အချိန်၌မဆို စိတ်အနှောင့်အယှက်ဖြစ်နေမည်ဆိုလျှင် မေးခွန်းများကို မဖြေဆိုတော့ဘဲ လေ့လာမှုမှ ဆုတ်ခွာရန် ရွေးချယ်ခွင့်ရှိသည်။ အကယ်၍ သင်သည် မလိုလားအပ်သော အမှတ်တရများကို အစပျိုးပေးနိုင်သည့် မေးခွန်းလွှာကြောင့် ထိတ်လန့်မှု သို့မဟုတ် စိုးရိမ်ပူပန်မှုများ မြင့်တက်လာပါက ဆေးဆရာဝန်လည်းဖြစ်သော သုတေသီသည် အကြံဉာဏ်ပေးခြင်းနှင့် အာမခံချက်ပေးနိုင်ပါလိမ့်မည်။ စိတ်ကျန်းမာရေးထောက်ပံ့မှုက Mae Sot Hospital/Mae Tao ဆေးခန်းကိုလည်း လိုအပ်မယ်ဆိုရင် ကမ်းလှမ်းပါတယ်။

၉။ သုတေသနလုပ်ငန်းတွင် ပါဝင်ခြင်း၏ ဖြစ်နိုင်ခြေရှိသော အကျိုးကျေးဇူးများ

ဤသုတေသနပြုချက်တွင်ပါဝင်ခြင်းက သင့်အတွက် ချက်ချင်းအကျိုးကျေးဇူးပေးနိုင်မည်မဟုတ်သော်လည်း သုတေသနရည်မှန်းချက်များကို အထမြောက်စေပါလိမ့်မည် ။ ဤအခိုက်အတန့်တွင် တိုက်ရိုက် လူမှုရေးအကျိုးကျေးဇူးများ မရှိနိုင်သော်လည်း အဆိုပါတွေ့ရှိချက်များက စိတ်ဒဏ်ရာနောက်ပိုင်း စိတ်ဖိစီးမှုဝေဒနာ (ပီတီအက်စ်ဒီ) ပျံ့နှံ့နေကြောင်း ကျွန်ုပ်တို့၏နားလည်မှုကို တိုးမြှင့်ပေးပါလိမ့်မည်။ ဤအသိပညာသည် ဆရာဝန်များနှင့် ပြည်သူ့ကျန်းမာရေးအရာရှိများအတွက် အရေးပါသည်။ အကြောင်းမှာ ပြဿနာ၏အတိုင်းအတာကို ပိုမိုနားလည်နိုင်စေသည်။ ဤ သတင်း အချက်အလက် များ နှင့်အတူ ၊ သူ တို့ သည် ပိုမို ထိရောက် သော ကျန်းမာရေး စောင့်ရှောက် မှု ဝန်ဆောင် မှု များ ကို စီစဉ် နိုင် ပြီး ၊ သူ တို့ အများဆုံး လိုအပ် သော နေရာ တွင် အရင်းအမြစ် များ ခွဲဝေ ပေး နိုင် ပြီး ၊ ပီတီအက်စ်ဒီ နှင့် ၎င်း ၏ ဆက်စပ် နေ သော အချက်အလက် များ နှင့် ဆက်စပ် နေ သော အချက်အလက် များ ကို ကာကွယ် ရန် လုပ်ဆောင် နိုင် သည် ။ နောက်ဆုံးတွင် ဤသုတေသနပြုချက်သည် စုပေါင်းတိုးတက်မှုအတွက် အထောက်အကူပြုမည်ဖြစ်ပြီး ထိခိုက်ခံရသူများ၏လိုအပ်ချက်များနှင့် ကိုက်ညီသော ကျန်းမာရေးစောင့်ရှောက်မှု မူဝါဒများနှင့် အစီအစဉ်များ ဖွံ့ဖြိုးတိုးတက်မှုကို အသိပေးပါလိမ့်မည်။

၁၀။ မပါဝင်ရန် ရွေးချယ်မည်ဆိုလျှင် ရွေးချယ်စရာများ

ဤ သုတေသန တွင် ပါဝင် ခြင်း သည် လုံးဝ စေတနာ အလျောက် ဖြစ် ပြီး ၊ မ ပါဝင် ရန် ရွေးချယ် ခြင်း သည် ကျန်းမာရေး စောင့်ရှောက် မှု သို့မဟုတ် အခြား ဝန်ဆောင် မှု များ ကို သင် ရရှိ ခြင်း ကို ထိခိုက် လိမ့်မည် မ ဟုတ် ပါ ။ သင် မပါဝင်ရန် ရွေးချယ်ပါက စိတ်ကျန်းမာရေးထောက်ပံ့မှု သို့မဟုတ် ပီတီအက်စ်ဒီ အကဲဖြတ်ချက်များကို ဘဏ္ဍာတွင်ဖော်ပြထားသော လိပ်စာများမှတစ်ဆင့်

ရှာဖွေနိုင်ဆဲဖြစ်သည်။ ပါဝင်ခွင့်ကိုငြင်းပယ်ခြင်းက သင့်အခွင့်အရေးအပေါ် အကျိုးသက်ရောက်မည်မဟုတ်ပါ။

11. Guidelines for Managing Situations that May Arise during the Research

အခြေအနေ	လမ်းညွှန်ချက်များ
သုတေသနကာလအတွင်း ဆုတ်ခွာရန် ဆုံးဖြတ်ပါက	ပါဝင်သူများသည် ဆုတ်ခွာပိုင်ခွင့်ရှိကြမည်သည့်အချိန်မဆို ဆုတ်ခွာဖို့ရွေးချယ်မယ်ဆိုရင် သုတေသီကို အမြန်ဆုံး အသိပေးပါ။ ရပ်ဆိုင်းရန် သင်၏ဆုံးဖြတ်ချက်ကို လေးစားမည်ဖြစ်ပြီး ထိုနေရာအထိ စုဆောင်းထားသော မည်သည့်အချက်အလက်ကိုမဆို လျှို့ဝှက်စွာထားမည်ဖြစ်ပြီး လေ့လာမှုတွင် မပါဝင်ပါ။
သုတေသန ဒါမှမဟုတ် သင့်လုံခြုံမှုနဲ့ပတ်သက်ပြီး သတင်းအချက်အလက်အသစ်တွေ ရှိရင်	သင်တန်းကာလအတွင်း သတင်းအချက်အလက်အသစ်များ တက်လာပါက သင့်လုံခြုံမှုကို ထိခိုက်စေနိုင်တဲ့ သုတေသနကို လေ့လာမှုရဲ့ သဘောသဘာဝကို သုတေသီက ချက်ချင်း အသိပေးပါ။ အဲဒီနောက် ခင်ဗျားတို့ ရပါလိမ့်မယ် ဆန္ဒရှိမရှိ ဆုံးဖြတ်ရန် အခွင့်အရေး သုတေသန သို့မဟုတ် သုတေသနလုပ်ငန်းတွင် ဆက်လက်ပါဝင်နေ ဆုတ်ခွာသည်။ သင့်ရဲ့ လုံခြုံမှုနဲ့ ကောင်းကျိုးတွေဟာ အလွန်အရေးကြီးပြီး မည်သည့်စိုးရိမ်ပူပန်မှုမဆို ချက်ချင်းပြောဆိုခဲ့သည်။

၁၂။ သုတေသနပြီးစီးပြီးနောက် ဖြစ်နိုင်ခြေအကျိုးကျေးဇူးများ

သုတေသနပြုပြီးနောက် တိုက်ရိုက်အကျိုးကျေးဇူးများ ရှိနိုင်မည်မဟုတ်ပါ။ ပါဝင်သူများအနေနဲ့ သုတေသီက သုတေသနပြုပြီးတဲ့ နောက်ပိုင်း ရလဒ်တွေကို အသိပေးပါလိမ့်မယ်။



၁၃။ ဒေတာနဲ့ ကန့်သတ်ချက်တွေရဲ့ လျှို့ဝှက်ချက်

သင် နှင့် ပတ်သက် သော သတင်း အချက်အလက် အားလုံး သည် လျှို့ဝှက် နေ လိမ့်မည် ဖြစ် ပြီး သုတေသန အဖွဲ့ ပြင်ပ ရှိ မည်သူ့ ကိုမျှ ဝေမျှ လိမ့်မည် မ ဟုတ် ကြောင်း သင့် ကို ကျွန်ုပ် တို့ အာမခံ ပါ သည် ။ ဤ သုတေသန စီမံကိန်း တွင် စုဆောင်း ထား သော အချက်အလက် အားလုံး ကို သီးသန့် ထား ရှိ လိမ့်မည် ။ ပါဝင်သူတစ်ဦးစီကို အမည်များအသုံးပြုမည့်အစား ထူးခြားသော နံပါတ်တစ်ခု ပေးအပ်မည်ဖြစ်ပြီး သုတေသီတစ်ဦးတည်းသာ စကားတုတ်ကာကွယ်ထားသော ကွန်ပျူတာတစ်ခုတွင် လုံခြုံစွာ သိမ်းဆည်းထားမည့် အလားတူနံပါတ်များကို အသုံးပြုနိုင်မည်ဖြစ်သည်။ ပါဝင် သူ တစ် ဦး စီ ၏ နေအိမ် ၏ တိကျ သော တည်နေရာ ကို ဖော် ထုတ် လိမ့်မည် သို့မဟုတ် ဝေမျှ လိမ့်မည် မ ဟုတ် ပါ ။

သုတေသနရလဒ်များကို တင်ပြသည့်အခါ ပါဝင်သူများနှင့်ပတ်သက်သော သတင်းအချက်အလက်များကို ခွဲခြားသိရှိရန် သေချာစေပါလိမ့်မည်။ သို့သော် လူ့ကျင့်ဝတ်ကော်မတီကဲ့သို့သော အချို့ပုဂ္ဂိုလ်များ သို့မဟုတ် အုပ်စုများက သုတေသန ညှိနှိုင်းရေးမှူးများ၊ သုတေသန ညှိနှိုင်းရေးမှူးများ၊ စစ်ဆေးမှုအတွက် တာဝန်ရှိသော အစိုးရအဖွဲ့အစည်းများ သို့မဟုတ် အဖွဲ့အစည်းများမှ ခွင့်ပြုထားသော ဝန်ထမ်းများသည် အချက်အလက်များနှင့် သုတေသနလုပ်ထုံးလုပ်နည်းများ၏ တိကျမှန်ကန်မှုကို စစ်ဆေးရန် သင့်အချက်အလက်များကို ရရှိနိုင်ပါသည်။

သုတေသန တွေ့ရှိချက် များ ကို နှိုးနှောဖလှယ်ပွဲ များ သို့မဟုတ် စာပေ များ မှတစ်ဆင့် လူသိရှင်ကြား ဖြန့်ဝေ လိမ့်မည် ။ ကျွမ်းကျင် သူ များ ၊ အကောင်အထည်ဖော် သူ များ ၊ နှင့် မူဝါဒ ချမှတ် သူ များ ကို သင်ယူ ရန် နှင့် သက်ဆိုင် သော ထိုးထွင်း သိမြင် မှု များ ကို ကျင့်သုံး ရန် ခွင့်ပြု ခြင်း ဖြင့် လူသိရှင်ကြား ဖြန့်ဝေ လိမ့်မည် ။ လျှို့ဝှက်သတင်းအချက်အလက်များကို မည်သည့်ပုံစံဖြင့်မျှ ထုတ်ဖော်ပြောဆိုမည် သို့မဟုတ် ဝေမျှမည်မဟုတ်ကြောင်း သေချာစေပါ။

၁၄။ ပါဝင်မှုအတွက် ပြန်ပေးငွေ

ပါဝင်သူများသည် သူတို့၏နားလည်မှုကို တိုးမြှင့်ပေးရန် PTSD အကြောင်း ဘရှိရှာတစ်စောင်ရရှိကြမည်။ ၎င်း အပြင် ၊ ပါဝင် သူ များ သည် လေ့လာ မှု တွင် သူ တို့ ၏ ပါဝင် မှု အတွက် မည်သည့် ငွေကြေး သို့မဟုတ် ပစ္စည်း လျော်ကြေး ကိုမျှ လက်ခံ ရ လိမ့်မည် မ ဟုတ် ပါ ။

၁၅။ ပါဝင်သူများအတွက် ကုန်ကျစရိတ်များ

ဒီလေ့လာမှုမှာ ပါဝင်သူတွေလုပ်ရမယ့် ကုန်ကျစရိတ်တွေ မရှိဘူး။

၁၆။ ပါဝင်သူများသည် သုတေသနတွင် ပါဝင်ခြင်းမှ ထိခိုက်မှု သို့မဟုတ် ဆိုးကျိုးများ ခံစားရပါက ပြုစုစောင့်ရှောက်မှုနှင့် လျော်ကြေးလမ်းညွှန်ချက်များ



အကယ်၍ တစ်ဦးချင်းစီ၏ အတွေ့အကြုံများသည် မလိုလားအပ်သော အမှတ်ရစရာများကို အစပျိုးပေးနိုင်သော၊ မေးခွန်းလွှာကြောင့် ထိတ်လန့်မှု သို့မဟုတ် စိုးရိမ်ပူပန်မှုတိုးများလာလျှင်၊ သူတို့သည် သင့်တော်သော ပြုစုစောင့်ရှောက်မှုနှင့် ထောက်ပံ့မှုရရှိရန် သေချာစေရန် အမှုစီမံခန့်ခွဲမှုကို အကောင်အထည်ဖော်ပါ။

ပထမခြေလှမ်းမှာ တရားစီရင်ခြင်းမရှိသော နှင့် ထောက်ပံ့မှုမရှိသော အပြုအမူတစ်ခုတွင် ရလဒ်များကို ဆွေးနွေးရန်ဖြစ်သည်။ ၎င်းသည် မြင့်မားသော ရမှတ်တစ်ခုသည် နောက်ထပ် အကဲဖြတ်မှုအတွက် လိုအပ်ချက်တစ်ခုကို ညွှန်ပြသော်လည်း ပီတီအက်စ်ဒီ၏ တိကျသော ရောဂါစစ်ဆေးမှုတစ်ခုအဖြစ် ဆောင်ရွက်ခြင်းမရှိကြောင်း အလေးပေးရန်အရေးကြီးသည်။ မလိုလားအပ်သော အမှတ်တရတွေကို အစပျိုးပေးနိုင်သော မေးခွန်းလွှာကြောင့် အတွေ့အကြုံတွေက ထိတ်လန့်မှု၊ ဒါမှမဟုတ် စိုးရိမ်ပူပန်မှုတွေ တိုးများလာမည်ဆိုရင် ဆေးဆရာဝန်လည်းဖြစ်တဲ့ သုတေသီက အကြံဉာဏ်ပေးပါလိမ့်မယ်။ အသိအမှတ်ပြုခံရသော ကျွမ်းကျင်သူတစ်ဦးအနေနှင့် သူသည် စိတ်ကျန်းမာရေးပြဿနာများကို ဆွေးနွေးရန်နှင့် အာမခံချက်ပေးရန် အရည်အချင်းပြည့်မီသူဖြစ်သည်။

ထို့နောက် အရည်အချင်းပြည့်မီသော စိတ်ကျန်းမာရေးကျွမ်းကျင်သူတစ်ဦးအား ရောဂါအမည်တပ်ထားသည့် အကဲဖြတ်ချက်အတွက် အရည်အချင်းပြည့်မီသော စိတ်ကျန်းမာရေးပညာရှင်တစ်ဦးအား ရည်ညွှန်းပေးခြင်းသည် အရေးပါ၏။ ယင်းတွင် စီအေပီအက်စ်-၅ (Clinician-Administered TD Scale) ကဲ့သို့ ဖွဲ့စည်းထားသော အင်တာဗျူးများကို အသုံးပြု၍ ရောဂါအမည်တပ်ရန် ပါဝင်နိုင်သည်။ မိုင်တာအိုဆေးခန်းများ သို့မဟုတ် Mae Sot Sot ဆေးရုံကဲ့သို့သော ဒေသခံအရင်းအမြစ်များနှင့် ဆက်သွယ်ခြင်း။

ပါဝင်သူအားလုံးသည် ပီတီအက်စ်ဒီနှင့် အခြားစိတ်ကျန်းမာရေးအခြေအနေများနှင့်ပတ်သက်၍ နားလည်မှုတိုးမြှင့်ရန် ရည်ရွယ်ထားသည့် ဘဏ္ဍာကို ရရှိကြပါလိမ့်မည်။ အဆိုပါ ဘဏ္ဍာသည် စိတ်ပိုင်းဆိုင်ရာ ကျန်းမာရေးပြဿနာများကို စီမံခန့်ခွဲရေးအတွက် နည်းဗျူဟာများကို ကိုင်တွယ်ဖြေရှင်းခြင်း၊ လက္ခဏာများနှင့် လက္ခဏာများကို ဖုံးအုပ်လိမ့်မည်ဖြစ်ပြီး၊ မိုင်တိုဆေးခန်းနှင့် မိုင်ဆော့ဆေးရုံကဲ့သို့၊ အရင်းအမြစ်များအတွက် ဆက်သွယ်ရေးသတင်းအချက်အလက်များကို အကြံပြုခဲ့သည်။

၁၇။ မေးခွန်းများ သို့မဟုတ် စိုးရိမ်ပူပန်မှုများတွင် အဆက်အသွယ်လုပ်သူ

ပါဝင်နေချိန်အတွင်း သုတေသန သို့မဟုတ် လုံခြုံမှုနှင့်ပတ်သက်၍ မေးခွန်းများ သို့မဟုတ် စိုးရိမ်ပူပန်မှုများ ရှိပါက သုတေသီကို တိုက်ရိုက်မေးနိုင်ပါသည်။



အဓိက စုံစမ်း စစ်ဆေး သူ

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သင့်အဖွဲ့အရေးနှင့်ပတ်သက်၍ မေးခွန်းများရှိပါက ပညာရေးဆိုင်ရာ ဝန်ဆောင်မှုအဆောက်အအုံ (အေအက်စ်)၊ ၄ ထပ်၊ တဲလ်တွင် လူ့သုတေသနဆိုင်ရာ လူ့သုတေသနဆိုင်ရာ Mae Fah Luang တက္ကသိုလ် ကျင့်ဝတ်ကော်မတီနှင့် ဆက်သွယ်နိုင်ပါသည်။ (၀၅၃) ၉၁၇-၁၇၀ မှ ၁ သို့မဟုတ် (၀၅၃) ၉၁၆-၅၅၁၊ ဖုန်း။ (၀၅၃) ၉၁၇-၁၇၀ (သို့) အီးမေးလ် - Rec.human@mfu.ac.th သင်၏အဖွဲ့အရေးများ၊ လုံခြုံမှုနှင့် သင့်ကျန်းမာရေးတို့ကို လူ့သုတေသနပြုမှုဆိုင်ရာ နိုင်ငံတကာစံနှုန်းများအရ ကာကွယ်ပေးရန် သေချာစေရန်ဖြစ်သည်။



အသိပညာရှိတဲ့ သဘောညီညာမှုပုံစံ

[သုတေသန စီမံကိန်း၏ ဘွဲ့အမည်]

တွင်ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။ ဒီသုတေသနပြုချက်နဲ့ပတ်သက်တဲ့ သတင်းအချက်အလက်တွေနဲ့ ရှင်းပြချက်တွေကို ကျွန်တော်ရရှိခဲ့ပြီး မေးခွန်းတွေမေးဖို့နဲ့ ကျေနပ်ဖွယ်အဖြေတွေရဖို့ အခွင့်အရေးရခဲ့တယ်။ စာရွက်စာတမ်းတွေမှာဖော်ပြထားတဲ့ သတင်းအချက်အလက်တွေကို ကောင်းကောင်းနားလည်ဖို့ အချိန်အလုံအလောက်ရှိခဲ့ပြီး ဒီသုတေသနမှာပါဝင်ဖို့ ဆုံးဖြတ်လိုက်တယ်။

ဒီသုတေသနမှာ မပါဝင်ဖို့ လွတ်လပ်စွာရွေးချယ်ခွင့်ရှိတယ်ဆိုတာ ကျွန်တော်နားလည်တယ်။ ဒီသုတေသနပြုချက်ကနေ ဘယ်အချိန်မှာမဆို ကျွန်တော်ရထိုက်တဲ့ ဂရုစိုက်မှု ဒါမှမဟုတ် အခွင့်အရေးတွေအပေါ် သက်ရောက်မှုမရှိဘဲ ဆုတ်ခွာနိုင်ပါတယ်။

ဒီစာရွက်စာတမ်းကို လက်မှတ်ရေးထိုးခြင်းအားဖြင့် ဥပဒေအရ ကျွန်တော်ရပိုင်ခွင့်ရှိတဲ့ ဘယ်အခွင့်အရေးကိုမှ လက်မှတ်မထိုးဘူး။ လက်မှတ်ရေးထိုးပြီးတဲ့နောက် သတင်းအချက်အလက်စာရရှိပြီးတဲ့နောက် သတင်းအချက်အလက်စာရရှိပြီး သတင်းအချက်အလက်စာရရှိမယ်။

တက်ရောက်သူရဲ့ လက်မှတ် _____ ရက်စွဲ _____

..... (နားထောင်နေသော်လည်း နားလည်နိုင်သည့်

စာမတတ်သူများအတွက်)

ကျွန်တော် မ ဖတ် နိုင် ပါ ဘူး ၊ ဒါပေမဲ့ သုတေသီ က ဒီ သတင်း အချက်အလက် စာရွက် နဲ့ အသိဉာဏ် ရှိ တဲ့ သဘောထား ပုံစံ ကို ဖတ် ခဲ့ ပြီး ၊ ဒါ ကို ကောင်းကောင်း နားလည် ပါ တယ် ။ ဒါကြောင့် ကျွန်မရဲ့လက်ဗွေရာကို စိတ်လိုကိုယ်လျှောက် လက်မှတ်ထိုးတယ် ဒါမှမဟုတ် နေရာချလိုက်တယ်။

တက်ရောက်သူရဲ့ လက်မှတ်/လက်ဗွေရာ/လက်ဗွေရာ _____

Version.....2..... Date 9.4.2025

AP 03_1/2022

သဘောတူညီချက်တောင်းခံသူရဲ့ လက်မှတ်ရေးထိုးချက် _____

Date_____

()

သုတေသန တွင် ပါဝင် သူ တစ် ဦး မ ဟုတ် သော သက်သေ တစ် ဦး ၏ သက်သေခံ ချက် (ပါဝင်
သူ သည် စာမ ဖတ် နိုင် သော်လည်း နားထောင် ခြင်း ဖြင့် နားလည် နိုင် လျှင်)

သဘောတူညီချက်တောင်းဆိုချိန်အတွင်း ကျွန်တော်ရောက်ရှိနေပြီး

သဘောတူညီချက်တောင်းခံသူက သတင်းအချက်အလက်စာရွက်ကို ဖတ်ပြီး

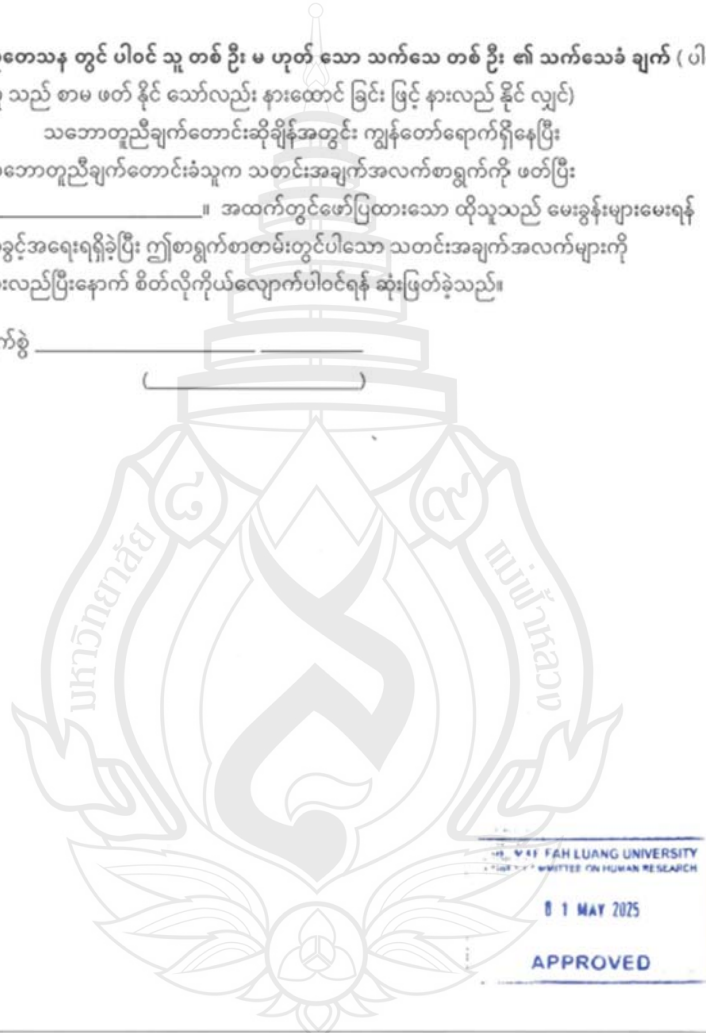
_____။ အထက်တွင်ဖော်ပြထားသော ထိုသူသည် မေးခွန်းများမေးရန်

အခွင့်အရေးရရှိခဲ့ပြီး ဤစာရွက်စာတမ်းတွင်ပါသော သတင်းအချက်အလက်များကို

နားလည်ပြီးနောက် စိတ်လိုက်ယုံလျောက်ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။

ရက်စွဲ _____

()



APPENDIX F

INFORMED CONSENT (KAREAN VERSION)

လံာ်တၢ်ဂ့ၢ်တၢ်ကျိၤဒီးတၢ်ပျဲလၢတၢ်သ့ၣ်ညါလီၤ

တၢ်ယူထံၣ်သ့ၣ်ညါအဂ့ၢ်ဒိၣ်တီ: တၢ်အိၣ်အါအိၣ်စ့ၤဒီးတၢ်ဂ့ၢ်လၢအဘၣ်ထွဲဒီးတၢ်ဆူးတၢ်ဆါဖဲ
လၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)လၢပုၤကီၢ်ပယီၤဖိလၢဟဲအိၣ်ဆိးဖဲ
မဲၣ်ဆိၣ်ကီၢ်ဆၢ, တးကီၢ်ရၣ်, ကီၢ်က့ၣ်တဲၣ်

ပုၤယိထံၣ်သ့ၣ်ညါတၢ်အမံၤ: Mr. Arkar Mann Kyaw

တၢ်ဖဲးလိမၤဒီးအလီၢ်: ဆူၣ်ချ့ပီၤညါ, Mae Fah Luang ဖုၣ်စိမိၤ

ပုၤဟ့ၣ်ကူၣ်တၢ်: Asst. Prof. Dr. Pilasinee Wongnuch

ပုၤလၢအဟ့ၣ်မၤစၢၤတၢ်ယူထံၣ်သ့ၣ်ညါ: Mae Fah Luang ဖုၣ်စိမိၤ

1. တၢ်ကတိၤအိးထီၣ်ဒီးတၢ်ယူထံၣ်သ့ၣ်ညါအဂ့ၢ်အဖျၢၣ်ကီၢ်

ယမံၤမ့ၢ်ဝဲ Mr. Arkar Mann Kyaw လီၤ. ယမၤလိတၢ်ဖဲ Mae Fah Luang
ဖုၣ်စိမိၤဒီးယမ့ၢ်ပုၤကီၢ်ပယီၤဆူၣ်ချ့ပီၤညါတဂၤလီၤ. ခဲအံၤယမၤတၢ်ယူထံၣ်သ့ၣ်ညါဘၣ်ဃးဒီးတၢ်ဆူး
တၢ်ဆါဖဲလၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)လၢပုၤကီၢ်ပယီၤဖိလၢဟဲအိၣ်ဆိးဖဲမဲၣ်
ဆိၣ်ကီၢ်ဆၢတးကီၢ်ရၣ်, ကီၢ်က့ၣ်တဲၣ်. ယအဲၣ်ဒီးမၤနီၣ်မၤဃါတၢ်ဂ့ၢ်တၢ်ကျိၤဒီးကွဲၣ်မုၢ်နၤလၢနက
ပုၤဃုၣ်လၢယတၢ်ယူထံၣ်သ့ၣ်ညါအပူၤလီၤ.

ယတင်ယုထံၣ်သ့ၣ်ညါမ့ၢ်တၢ်သးအိၣ်လီၤန့ၢ်မ့ၢ်ဟံလီၤနသးလၢနတဟံၣ်ဃုာ်ဘၣ်ဒီးတၢ်
အံၤတဘၣ်ထွဲဒီးနတၢ်ကူၤစါမ့ၢ်ဂ့ၤနတၢ်ခွဲးတၢ်ယာ်လၢနဒီးန့ၢ်ဘၣ်တဖၣ်မ့ၢ်ဂ့ၤနီတမံၤဘၣ်.ဖဲနယု
ထၢလၢနကဘၣ်တၢ်ဒီးတၢ်သံကွၢ်အခါ, နထူးကွၢ်နသးကဒါက့ၤဖဲလဲၣ်ဂ့ၤဖဲလဲၣ်ဂ့ၤသ့ဝဲလီၤ.
နမ့ၢ်အိၣ်ဒီးတၢ်သံကွၢ်မ့ၢ်ဂ့ၤ ဒီး လိာ်ဘၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤလီၤတံၢ်မ့ၢ်ဂ့ၤ, နသ့ကွၢ်သ့လီၤ
ယအိၣ်ဖဲအံၤလၢကမၤစၢၤနလီၤ.

တၢ်မၤလိတၢ်အံၤအတၢ်တိာ်ဟံတဖၣ်မ့ၢ်ဝဲလၢကတယာ်ဆိတၢ်အိၣ်အါထီၣ်စ့ၤလီၤဘၣ်
ဃးတၢ်ဆူးတၢ်ဆါဖဲလၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)လၢပုၤကီၢ်ပယီၤဖိလၢဟဲ
အိၣ်ဆိးဖဲမဲၣ်ဆိၣ်ကီၢ်ဆၢ,တးကီၢ်ရဲၣ်,ကီၢ်ကီၣ်တဲၣ်ဒီးတၢ်ဂ့ၢ်လၢအဘၣ်ထွဲဒီးတၢ်ဆူးတၢ်ဆါတ
ဖၣ်န့ၣ်လီၤ.

တၢ်ဆူးတၢ်ဆါဖဲလၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(Post-Traumatic Stress Dis-
or-
der)မ့ၢ်ဝဲသးအတၢ်အိၣ်ဆူၣ်အိၣ်ချ့ဖဲလၢပုၤတဂၤလဲၤခီဖျိမ့ၢ်ဂ့ၤ,ထံၣ်ဘၣ်မ့ၢ်ဂ့ၤတၢ်မၤအသးလၢ
အမၤဘၣ်ဒိဘၣ်ထံးသး,ဒ်ပစံးတၢ်အသိးတၢ်ဟဲကဲထီၣ်သးသတူၢ်ကလံာ်ခီဖျိန့ၣ်တၢ်မၤတပျုာ်
တပျီၤ,တၢ်ဘၣ်ဒိလၢတၢ်တဆိကမိၣ်,မ့တမ့ၢ်တၢ်မၤဆူၣ်မၤစီး.ပုၤလၢအအိၣ်ဒီးPTSDတဖၣ်က
အိၣ်ဒီးတၢ်သ့ၣ်နီၣ်ထီၣ်က့ၤတၢ်လၢအမၤတမုာ်သးတဖၣ်,သးကီၢ်မ့တမ့ၢ်ပျံၤတၢ်,မ့တမ့ၢ်မံတန့ၢ်
ဘၣ်န့ၣ်လီၤ.တၢ်အရဲဒိၣ်လၢပကြးသ့ၣ်ညါမ့ၢ်တၢ်ကနီၣ်ဒ်သိးအံၤတဖၣ်မ့ၢ်တၢ်လၢအညီၣ်န့ၢ်မၤအ
သးလီၤ.ဘၣ်ဆၢတၢ်ပနီၣ်ဒ်သိးအံၤတဖၣ်မ့ၢ်အါန့ၢ်လၢအနွံဒီးမၤတံာ်တံာ်ဝဲပတၢ်အိၣ်မူဒီးဘၣ်တ
ဘၣ်ကမ့ၢ်ဝဲPTSDလီၤ.

လၢတၢ်ဃုသ့ၣ်ညါတကတီၢ်အံၤ တၢ်ဆၢကတီၢ်လၢကဘၣ်တၢ်သူအီၤကမ့ၢ် ၃၀ မံးနံး. တၢ်ဃုသ့ၣ်ညါအံၤကမ့ၢ်ဝဲမဲၣ်သကိးမဲၣ်တၢ်သံကွၢ်စံးဆၢဒီးပုၤလၢကမၤသကိးတၢ်တဖၣ်မ့ၢ်ပုၤယိ ထံၣ်သ့ၣ်ညါအကစၢ်ဒီးပုၤမၤစၢၤတၢ်ဃုသ့ၣ်ညါခံၤလီၤ.

လၢတၢ်ဃုသ့ၣ်ညါအပူၤကအိၣ်ဝဲဒီးတၢ်ဘၣ်ယိၣ်တနီၤလီၤ.ပုၤလၢအဘၣ်တၢ်ဒီးသံကွၢ် တဖၣ်ဘၣ်တဘၣ်ကတူၢ်ဘၣ်တၢ်တဖၣ်တလၢလၢတၢ်သံဒီးသံကွၢ်အပူၤလီၤဆီဒၣ်တၢ်ပုၤကီၢ်ပ ယီၤဖိတဖၣ်လၢအအိၣ်ဆိးလၢယိၤကီၢ်န့ၣ်လီၤ.

နီၣ်သးအတၢ်လီၤပျံၤလီၤဖုး:

တၢ်မၤဘၣ်ဒိကဒါက့ၤ: တၢ်တဲသကိးတၢ်ဒီးတၢ်သံကွၢ်တဖၣ်, လီၤဆီဒၣ်တၢ် PCL-5, သံကွၢ်ဘၣ်ဃးတၢ်လဲၤခီဖျိလၢအမၤဘၣ်ဒိဘၣ်ထံးတၢ်.တၢ်အံၤကမၤသ့ၣ်နီၣ်ထီၣ်က့ၤတၢ်သ့ၣ်နီၣ် ထီၣ်က့ၤလၢအမၤတရူၤသး, တၢ်ထံၣ်က့ၤတၢ်, သးကိၢ်, သးတမ့ၢ်, ဒီးတၢ်သ့ၣ်ညါအါထီၣ်တၢ်နီၣ်ထီၣ်နီၣ်ဖး.

တၢ်အိၣ်တၢ်ဆိးအတၢ်လီၤပျံၤလီၤဖုး:

လၢတၢ်ထီၣ်တၢ်သံကွၢ်သံဒီးအဆၢကတီၢ်ကဘၣ်အိၣ်ဒီးတၢ်ဘၣ်ဘၢလၢပုၤဒီးသံကွၢ်တၢ် ဖိအဂီၢ်,

ဘၣ်ဆၣ်တၢ်သံကွၢ်ကအိၣ်ဝဲတနီၤလၢကဒုးအိၣ်ထီၣ်ဝဲတၢ်သးတမ့ၢ်,တၢ်ကွၢ်တလီၤမ့တမ့ၢ်တၢ် အဂုၤအဂၤတခါခါလၢကဲထီၣ်သးသ့စ့ၢ်ကိးလီၤလၢပုၤတဝၢအပူၤသ့စ့ၢ်ကီၤလီၤ.

နီၣ်ခိအတၢ်လီၤပျံၤလီၤဖုး:

နိမိတ်တော်တော်တော်အိပ်ဝဲဆုံးကိတ်ဖိလီ၊ဘန်ဆန်နီသးအတော်လီပျံလီဖုးတဖန်
ကအိပ်ဝဲတနီစုကီးဒ်ပစံးတော်အသီး(အဒိ၊မံတနုဂုၤဂုၤဘန်ဒီးသွံထီၣ်သုစုကီးလီၤ).ဖဲနဒီးသံ
ကွၢ်သးအဆာကတီၢ်,ဘန်တဘန်နကတူၢ်ဘန်တမုၢ်တလၢသုစုကီးဘန်ဆန်ခီဖျိတၢ်သံဒီးသံ
ကွၢ်အဆာကတီၢ်ဘန်တၢ်မၤအီၤလၢတၢ်ဘံၣ်ဘၢအလီၢ်အယိတၢ်တၢ်ဘန်ဒ်သီးန့ၤတဖန်ကဲထီၣ်
သးတသုလ့ၤတက့ၤဘန်.ဘန်ဆန်နတူၢ်ဘန်မုၢ်တမုၢ်ဘန်ဖဲနဒီးသံကွၢ်သးအဆာကတီၢ်ဒီး,နအိပ်
ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢနကပတုၢ်တၢ်ယုသုၣ်ညါကိးဆာကတီၢ်ဒီးလီၤ.ဒီးနကဒီးန့ၢ်ဘန်တၢ်နီၣ်သးတၢ်
မၤစၢၤဒီးတၢ်ဟ့ၣ်ဂံၢ်ဟ့ၣ်ဘါအါန့ၢ်အန့ၢ်ကဘန်တၢ်စိာ်ဆုၤစုကီးန့ၤဆူမံၢ်ဆီးတၢ်ဆါဟံၣ်မုၢ်တမုၢ်
မံၢ်တီတၢ်ဆါဟံၣ်ဒ်သီးကဒီးန့ၢ်ဘန်ပတီၢ်ထီၣ်တၢ်အံးထွဲကွၢ်ထွဲအဂီၢ်န့ၣ်လီၤ.

လၢနတၢ်ဟံၣ်ဖျိမၤသကိးတၢ်လၢတၢ်ယုသုၣ်ညါတဘျီအံၤတၢ်လၢကဲထီၣ်တၢ်ဘျးတၢ်
ဖျိလၢနဂီၢ်တအိပ်နီတမံၤဘန်,ဘန်ဆန်တၢ်အဆာလၢပဒီးန့ၢ်ဘန်အံၤကဟ့ၣ်ပုၤတၢ်အဆာတခါ
ခါလၢတၢ်အသီဒီးတၢ်ဆီတလဲဒီးဒုးအိပ်ထီၣ်တၢ်အသီလၢပုၤကီၢ်ပယီၤဖိလၢအဘန်ကွၢ်ဆၢမံၢ်
ဝဲနီၣ်သးတၢ်တူၢ်ဘန်တဖန်န့ၣ်လီၤ.

နသးမ့ၢ်တလီၤကလိာ်လၢနကဟံၣ်ဟံၣ်ဂီၢ်လၢတၢ်ယုသုၣ်ညါအံၤဘန်ဒီး,နတဲဘန်ပုၤယု
သုၣ်ညါတၢ်ဖိသုလီၤ.ခီဖျိလၢနတဟံၣ်ဖျိမၤသကိးအယိဘန်ဒီးတၢ်ကီတၢ်ခဲလၢကဲထီၣ်သးဒီး
န့ၤတအိပ်ဝဲနီတမံၤဘန်.

လံာ်တၢ်ဟံၣ်ဖျါဘန်သးတၢ်ယုသုၣ်ညါအံၤမ့ၢ်ဝဲမုၢ်သးအတၢ်မၤလီၤ

ယကွဲမုၢ်န့ၤလၢနကဟံၣ်ဟံၣ်ယတၢ်ယုသုၣ်ညါအံၤလီၤ.ဝံသးစူၤဖးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ
ဘန်တၢ်ဟံၣ်ဖျါလၢတၢ်ယုသုၣ်ညါအပူၤအံၤတဖန်.ပုၤလၢအဟံၣ်ဟံၣ်လၢတၢ်ယုသုၣ်ညါအံၤအပူၤမ့ၢ်

မှ်သးအတၢ်မၤလီၤ,

နမ့ၢ်တၢ်ဟံၣ်ဘၣ်သ့ၤလီၤဒီးတမၤဘၣ်ဒိနတၢ်ခွဲးတၢ်ယၢ်လၢတၢ်ကဒီးကူဆါယါဘျါသးအဂီၢ်ဘၣ်
, လၢတၢ်ဖိးတၢ်မၤစ့ၢ်ကိး ဒီး တၢ်အကုၢ်အဂၤတဖၣ်စ့ၢ်ကိးလီၤ.

နမ့ၢ်တၢ်ဟံၣ်လၢတၢ်ဟ့ၣ်ညါပူၤဒၣ်လဲၣ်,
နလဲၤဒီးကူဆါသးလၢတၢ်လီၢ်လၢဘၣ်တၢ်ဟံၣ်ဖျါထီၣ်လၢလံာ်ဆဲးဆဲးဖိလၢအဟ့ၣ်တၢ်ကစီၣ်သ့ဝဲ
လီၤ. နတၢ်မၤသကိးတၢ်သုတေသနအံၤ အိၣ်ညါလီၤအသးလၢနတၢ်ဆၢတံာ်လၢနသးအိၣ်.

- နအိၣ်ဒီးတၢ်သဘျၢလၢကဆၢတံာ်လၢကမၤသကိးတၢ်လၢတၢ်ဟ့ၣ်ညါပူၤသ့ဒီးတသ့ဘၣ်
စ့ၢ်ကိး
- နကတိၤသကိးတၢ်ဒီးနဟံၣ်ဖိသီဖိမ့ၢ်ဂ့ၤ,နကသံၣ်သရၣ်မ့ၢ်ဂ့ၤတချုးနဆၢတံာ်တၢ်သ့.နသံကွၢ်
တၢ်သံကွၢ်မနုၤဂ့ၤမနုၤဂ့ၤသ့စ့ၢ်ကိး;ပှၤဟ့ၣ်ညါတၢ်ဖိလၢကတဲနၢ်ပၢ်ဒီးဆဲးဖူးနတုၤလၢနနၢ်
ပၢ်အိၤပျီပျီဆဲးဆဲးန့ၣ်လီၤ.
- ဖဲနဆၢတံာ်လၢကမၤသကိးတၢ်ဟ့ၣ်ညါအံၤဝံၤအလီၢ်ခံ,နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢကထူး
ကွၢ်နသးဖဲလဲၣ်ဂ့ၤဖဲလဲၣ်ဂ့ၤသ့ဝဲဒၣ်န့ၣ်လီၤ.

3. တၢ်လၢပကြးသ့ၣ်ညါနၢ်ပၢ်ဒီးဒီးအတၢ်ရံၣ်တဖၣ်

တၢ်ဟ့ၣ်ညါအံၤကွၢ်ဟ့ၣ်သးအတၢ်ကီတၢ်ခဲလၢပှၤကီၢ်ပယီၤဖိလၢဟဲအိၣ်ဆိးလၢမဲၢ်စီး
ကီၢ်ဆၣ်တဖၣ်,လီၤဆီဒၣ်တၢ်တၢ်အိၣ်အါအိၣ်ဆိးဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအဘၣ်ထွဲဒီးPTSD.ပှၤဟဲ
အိၣ်ဆိးတဖၣ်လဲၤခီဖျိတၢ်ဘၣ်ဒိဘၣ်ထံးတချုးဟဲဒီးတၢ်ကီတၢ်ခဲဖဲဟဲဝံၤအလီၢ်ခံ,လၢအမၤဘၣ်

ဒီအဝဲသွာ်သးအတၢ်အိၣ်ဆူၣ်အိၣ်ချ့ဒီးတၢ်အိၣ်မူအိၣ်ဂဲၤ. ခဲအံၤ,
သးအတၢ်ကူစါတၢ်မၤလၢပုၤဟဲအိၣ်ဆိးအဂီၢ်အိၣ်စ့ၤ,
ဒီးတၢ်တၢ်တဖၣ်ဒ်အမ့ၢ်တၢ်ကဒီးန့ၢ်ဘၣ်တၢ်ကူဆါယါဘျါမ့ၢ်ဂ့ၤ,တၢ်ဆဲးတၢ်လၢအတၢ်လီၤဆီ
ဒီးထံကီၢ်လၢပဟဲအိၣ်တဘျီအံၤ,ဒီးလၢတၢ်ကဒီးသဒါနီၢ်သးတၢ်တုၢ်ဘၣ်ခိၣ်ဘၣ်စ့ၤဝဲအယိန့ၣ်
လီၤ.ဒ်သိးပကဒီးန့ၢ်ဘၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤလီၤတံၢ်လီၤဆဲးအဂီၢ်,တၢ်ဃုသ့ၣ်ညါအံၤကမၤစၢၤပုၤဒ်သိး
ပကနီၢ်ပၢၢ်တၢ်အိၣ်သးဒီး,လၢတၢ်ကဒီးအိၣ်ထီၣ်သန့ဒီးသဲးစးတဖၣ်လၢတၢ်ကမၤဂ့ၢ်ဒိၣ်ထီၣ်သးသ
မူအကံၢ်သစီဆူၣ်ပုၤကီၢ်ပယီၤဖိတဖၣ်အအိၣ်လီၤ.

4. ပုၤလၢအကြးဟံၣ်ဃုာ်နီၢ်ဂံၢ်နီၢ်ဒွဲးတဖၣ်

ပုၤတဂၤလၢလၢအဒိၣ်တုၢ်ခိၣ်ပုၤအိၣ်ဟဲလၢကီၢ်ပယီၤ, ပိၣ်ခွဲဒီးပိၣ်မုၢ်လၢအသးအိၣ်
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န့ၣ်ဒီးအဖီခိၣ်,ပုၤလၢအိၣ်ဒီးလံာ်လဲၣ်လၢကအိၣ်ကဒုလၢယီၤကီၢ်ပုၤအိၣ်မ့ၢ်ဂ့ၤတအိၣ်မ့ၢ်ဂ့ၤ,အိၣ်
ဆိးလၢမဲၣ်ဆိးကီၢ်ဆၣ်, လီၤဆီဒ်တၢ်လၢကရူၢ်လၢမဲၣ်ဆိး, မဲၣ်တီ, ဒီးထၣ်စဲးလူၣ်,
အစ့ၤကတၢ်ဃုလါ,
ဒီးအသးအိၣ်ဟံၣ်ဃုာ်လၢတၢ်ဃုသ့ၣ်ညါအပူၤပုၤမၤသကိးတၢ်ခဲလၢာ်360ဂၤကဘၣ်တၢ်သံကွၢ်
အီၤလၢပုၤဃုသ့ၣ်ညါတၢ်ဖိတဖၣ်.တၢ်ဂ့ၢ်တၢ်ကျိၤတဖၣ်ကဘၣ်တၢ်ထၢဖျိၣ်အီၤခီဖျိတၢ်တဲသကိး
တၢ်ထံၣ်လိာ်သးလၢပုၤဃုသ့ၣ်ညါကရူၢ်ဒီးပုၤမၤသကိးတၢ်တဖၣ်,ကသူဝဲတၢ်သံကွၢ်လံာ်ကွဲးလၢအ
ဘၣ်တၢ်ကတံာ်ကတီၤဃာ်အီၤတဖၣ်န့ၣ်လီၤ.

5. တၢ်ဃုသ့ၣ်ညါအတၢ်တိာ်ဟံၣ်တဖၣ်

- 1 လာကတယာ်ဘဉ်ဃးတၢ်အိၣ်အါအိၣ်စ့ၤဘဉ်ထွဲဒီးတၢ်ဆူးတၢ်ဆါဖဲလာတၢ်ဘဉ်ဒိဘဉ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)လာပုၤကီၢ်ပယီၤဖိလာဟဲအိၣ်ဆိးဖဲ မဲၣ်ဆိၣ်ကီၢ်ဆၢ, တးကီၢ်ရၣ်, ကီၢ်ကွီၣ်တဲၣ်
- 2 လာကသ့ၣ်ညါဘဉ်ဃးနီၤသးတၢ်အိၣ်ဆူၣ်အိၣ်ချ့ၤတၢ်အိၣ်တၢ်ဆိးဒီးပုၤဂီၢ်မုၢ်အတၢ်ဂ့ၢ်တၢ်ကျိၤလာအဘဉ်ထွဲဒီး PTSD တဖၣ်န့ၣ်လီၤ.
- 3 လာကမၤအါထီၣ်ဒီးဆိၣ်သုၣ်ထီၣ်တၢ်သိၣ်တၢ်သီလာအဘဉ်ထွဲဒီးနီၤသးလာပုၤခီကီၢ်ဖိတဖၣ်အဂီၢ်ဒီးကဖိၣ်လီၤစုၤမၤသကိးတၢ်ဒီးပုၤဘဉ်မူဘဉ်ဒါတဖၣ်န့ၣ်လီၤ.

6. တၢ်ဃုသ့ၣ်ညါအက့ၢ်အဂီၢ်

တၢ်သံကွၢ်သံဒီးတဖၣ်ကမ့ၢ်မၢ်သကိးမဲၣ်တၢ်သံကွၢ်စံးဆၢ.ဒ်ပကသ့ၣ်ညါတၢ်ဂ့ၢ်လာအဘဉ်ထွဲဒီးတၢ်ဆူးတၢ်ဆါဖဲလာတၢ်ဘဉ်ဒိဘဉ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)လာပုၤကီၢ်ပယီၤဖိလာဟဲအိၣ်ဆိးဖဲ မဲၣ်ဆိၣ်ကီၢ်ဆၢ, တးကီၢ်ရၣ်, ကီၢ်ကွီၣ်တဲၣ်တဖၣ်န့ၣ်လီၤ.

7. တၢ်ဃုသ့ၣ်ညါအကျိၤအကွၢ်ဒီးတၢ်သံကွၢ်သံဒီးအဆၢကတီၢ်

ပုၤတဂၤလၢ်လၢ်လာအမ့ၢ်ပုၤကီၢ်ပယီၤဖိလာအသးအိၣ်18နံၣ်ဒီးအဖီခိၣ်တဖၣ်,အိၣ်ဆိးလာမဲၣ်ဆိး, မဲၣ်တီ, ဒီးထၣ်စဲးလူၣ်ကရၢ်, မၢ်ဆိးကီၢ်ဆၢ, ကီၢ်ကွီၣ်တဖၣ်န့ၣ်လီၤ. လာတၢ်ဃုသ့ၣ်ညါတဘျီအံၤ

ကသူတိဆာကတီ(၃၀)မံးနံးလီၤ.လၢနတၢ်ဟံးဖျိာ်မၤသကိးတၢ်အပူၤကမ့ၢ်တၢ်သံဒီးသံကွၢ်မၤသကိးမၤဒီးန့ၣ်န့ၣ်ကျိၤတဖၣ်ပကဖၣ်အိၤဘၣ်ဘၢလီၤ.

8. တၢ်ဘၣ်ယိာ်ဒီးတၢ်တူၢ်ဘၣ်တမ့ၢ်တလၢလၢတၢ်ယုသ့ၣ်ညါအပူၤ

လၢနတၢ်ဟံးဖျိာ်မၤသကိးတၢ်လၢတၢ်ယုသ့ၣ်ညါပူၤအံၤအိၣ်ဒီးတၢ်ဘၣ်ယိာ်ဒီးတၢ်တူၢ်ဘၣ်တမ့ၢ်တလၢစ့ၢ်ကိးလီၤ.ဖဲလၢတၢ်သံဒီးသံကွၢ်ဝံၤအလီၢ်ခံၤ,နကတူၢ်ဘၣ်တမ့ၢ်တလၢ,ဘၣ်ဆၣ်,ပကသံကွၢ်န့ၣ်လၢတၢ်သဒါအလီၢ်လီၤ.နတူၢ်ဘၣ်မ့ၢ်တမ့ၢ်ဘၣ်ဖဲလဲၣ်ဂ့ၤဖဲလဲၣ်ဂ့ၤလၢတၢ်သံကွၢ်အဆၢကကတီၢ်နထူးကွၢ်နသးသ့ဝဲလီၤ.နမ့ၢ်ပျံၤတၢ်ဒီးတူၢ်ဘၣ်တမ့ၢ်လၢတၢ်သံဒီးသံကွၢ်အဆၢကတီၢ်,ဒီးတၢ်ဆိကမိာ်လၢအပူၤကွၢ်မၤတမ့ၢ်နသးတဖၣ်မ့ၢ်ဟဲထီၣ်သတူၢ်ကလၢ,ပုၤမၤတၢ်ယုသ့ၣ်ညါအံၤမ့ၢ်ကသံၣ်သရၣ်လီၤအဃိနယုတၢ်ဟ့ၣ်ဖးလၢအအိၣ်သ့လီၤ.နမ့ၢ်ဘၣ်ကွၢ်ဆၢၣ်မဲၢ်နီၢ်သးအတၢ်ဂ့ၢ်ကိးဒီးကဘၣ်တၢ်လဲၤဆၢန့ၣ်ဆူမဲၢ်ဆီးတၢ်ဆါဟံၣ်မ့ၢ်တမ့ၢ်မဲၢ်တီတၢ်ဆါဟံၣ်သ့စ့ၢ်ကိးလီၤ.

9. တၢ်အဘျုးလၢကဟဲကဲထီၣ်လၢတၢ်မၤသကိးတၢ်လၢတၢ်ယုသ့ၣ်ညါ

တၢ်မၤသကိးတၢ်လၢတၢ်ယုသ့ၣ်ညါအံၤတဟ့ၣ်န့ၣ်တၢ်အဘျုးတၢ်ဖျိာ်နီၣ်တမံၤဘၣ်,ဘၣ်ဆၣ်ကမၤစၢၤပုၤလၢကမၤလၢထီၣ်ပွဲၤထီၣ်တၢ်ယုသ့ၣ်ညါအတၢ်တိာ်ဟံးတဖၣ်လီၤ.တၢ်ထံၣ်န့ၣ်တဖၣ်ကမၤအါထီၣ်ပတၢ်န့ၣ်ပၢၢ်ဘၣ်ဃးတၢ်အိၣ်အါအိၣ်စ့ၤဘၣ်ထွဲဒီးတၢ်ဆူးတၢ်ဆါဖဲလၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၢ်ခံၤ(PTSD).တၢ်သ့ၣ်ညါအံၤအရ့ၣ်လၢကသံၣ်သရၣ်တဖၣ်ဒီးပုၤဘၣ်မူဘၣ်ဒါတဖၣ်အဂီၢ်မ့ၢ်လၢအမၤစၢၤအဝဲသ့ၣ်လၢကန့ၢ်ပၢၢ်တၢ်ဂ့ၢ်ကိးတဖၣ်ဂ့ၤဒိၣ်ထီၣ်.ဒီးတၢ်ဂ့ၢ်တၢ်

ကျိအံ၊ကမၤစၢၤပုၤဘၣ်မူဘၣ်ဒါဒ်သီးကဒူးအိၣ်ထီၣ်တၢ်တီၢ်ကျဲၤအသီတခါခါဆူပုၤလၢအလိၣ်ဘၣ်ဝဲတၢ်ဆိၣ်ထွဲမၤစၢၤတဖၣ်အဂီၢ်လီၤ.

10. ကျဲအဂၤတဖၣ် လၢနမ့ၢ်ဃုထၢလၢတမၤသကိးတၢ်

တၢ်မၤသကိးတၢ်လၢတၢ်ဃုသ့ၣ်ညါအံၤမ့ၢ်ဝဲလၢတၢ်သ့ၣ်အိၣ်သးအိၣ်လီၤ,ဒီးနမ့ၢ်ဃုထၢလၢတမၤသကိးတၢ်သံဒီးသံကွၢ်တမၤဘၣ်ဒိနတၢ်ကူဆါယါဘျါ,တၢ်ဖဲးတၢ်မၤမ့ၢ်တမ့ၢ်တၢ်မၤအဂၤတဖၣ်ဘၣ်.နမ့ၢ်ဃုထၢလၢတမၤသကိးတၢ်ဘၣ်ဒီး,နဃုထီၣ်န့ၢ်သးအတၢ်မၤစၢၤဘၣ်ဃး PTSDလၢလံာ်ကွဲးဆဲးအပူၤသ့ဝဲလီၤ. တၢ်ညိကွၢ်တၢ်မၤသကိးတၢ်အံၤတဘၣ်ထွဲဒီးနတၢ်ခွဲးတၢ်ယၢ်ဘၣ်နီတမံၤဘၣ်.

11. တၢ်ဟံးစုနဲၣ်ကျဲလၢကမၤဘၣ်တၢ်အနေလၢကမၤအသးဖဲတၢ်သုတေသနအဆၢကတီၢ်

တၢ်အိၣ်သး	တၢ်ဟံးစုနဲၣ်ကျဲတဖၣ်
နမ့ၢ်ဆၢတံာ်လၢကထူးကွၢ်နသးဖဲတၢ်ဃုသ့ၣ်ညါအဆၢကတီၢ်	ပုၤမၤသကိးတၢ်တဖၣ်အိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢကထူးကွၢ်အသးလၢတၢ်ဃုသ့ၣ်ညါဖဲလဲၣ်ဂ့ၤဖဲလဲၣ်ဂ့ၤသ့လီၤ.နမ့ၢ်ဃုထၢလၢကထူးကွၢ်နသး,ဝံသးစူၤဒူးသ့ၣ်ညါဘၣ်တၢ်ဃုသ့ၣ်ညါတဖိလၢအစိအချုတက့ၢ်.နတၢ်ဆၢတံာ်လၢကထူးကွၢ်နသးကဘၣ်တၢ်ဟံးကဲအီၤ,ဒီးနဂ့ၢ်န

	ကျိတဖန်တင်ကဟ်အီၤဘံၣ်ဘံၣ်ဘၢ ဘၢဒီးတဟ်ဃုာ်အီၤလၢတၢ်ဃုသုၣ်ညါ အပူၤဘၣ်.
တၢ်ဂ့ၢ်တၢ်ကျိၤအသီမ့ၢ်အိၣ်ထီၣ်လၢတၢ်ဃုသုၣ် ညါအဆၢကတီၢ်ဒီးနီၣ်ကစၢ်တၢ်ဘံၣ်တၢ်ဘၢ	တၢ်ဂ့ၢ်ကျိၤအသီမ့ၢ်အိၣ်ထီၣ်ဖဲလၢတၢ် ဃုသုၣ်ညါအဆၢကတီၢ်ဒီးတၢ်ကဲထီၣ် သးတခါခါလၢကမၤဘၣ်ဒိန့ၤမ့ၢ်အိၣ်,ပှၤ ဃုသုၣ်ညါကတဲဘၣ်န့ၤသ့သ့ဘၣ်ဘၣ်. ဒီးနီၣ်အိၣ်ဒီးတၢ်ခွဲးတၢ်ယၤလၢလၢပွဲၤပွဲၤ လၢနကစဲးမၤကတၢ်တၢ်ဃုသုၣ်ညါမ့ တမ့ၢ်ပတုၣ်ကွၢ်အီၤ. နီၣ်ကစၢ်ဘံၣ်ဘၢမ့ၢ်တၢ်လၢအရ့ၣ်ခိၣ်က တၢ်လီၤ.

12. တၢ်အဘျုးလၢကဟ်ကဲထီၣ်သးဖဲလၢတၢ်တၢ်ဃုသုၣ်ညါဝံၤအလီၢ်ခံ

ဖဲလၢတၢ်ဃုသုၣ်ညါအဆၢကတီၢ်ဝံၤအလီၢ်ခံ,တၢ်ဘၣ်ဘျုးလီၤလီၤဆူပှၤလၢအဒီးတၢ်သံ
ကွၢ်တအိၣ်နီၣ်တမံၤဘၣ်.ဘၣ်ဆၣ်ပှၤဃုသုၣ်ညါကဒုးသ့ၣ်ညါက့ၤန့ၤတၢ်အဆၢဖဲလၢတၢ်မၤကွၢ်ဝံၤ
အလီၢ်ခံန့ၣ်လီၤ

တၢ်လၢာ်ဘၣ်လၢာ်စ့ၤလၢပုၤမၤသးကိးတၢ်ကဘၣ်ဟ့ၣ်လၢတၢ်တၢ်ဃုသ့ၣ်ညါအံၤအပူၤတအိၣ်ဘၣ်.

16.တၢ်အံၤထွဲကွၢ်ထွဲဒီးလၢာ်န့ၣ်ကျဲတဖၣ်ဆူပုၤလၢဒီးတၢ်သံကွၢ်တဖၣ်မ့ၢ်တုၢ်ဘၣ်ဒီးဟဲဒီဖျိသး လၢတၢ်ဃုသ့ၣ်ညါအပူၤ

ပုၤတၢ်ကၤမ့ၢ်လဲၤဒီဖျိတၢ်ပျံၤတၢ်ဖုးမ့ၢ်တမ့ၢ်သးကိးအါထီၣ်ဒီဖျိတၢ်သံကွၢ်သံဒီးအပူၤ, လၢအမၤသ့ၣ်နီၣ်ထီၣ်က့ၤတၢ်သ့ၣ်နီၣ်ထီၣ်က့ၤလၢတအဲၣ်ဒီးဘၣ်, ပုၤဃုသ့ၣ်ညါတၢ်ဖိတဖၣ်ကမၤစၢၤအီၤလၢကထံၣ်လိာ်သးဒီးတၢ်ကွၢ်ထွဲဒီးတၢ်မၤစၢၤလၢအကြးအဘၣ်ဝဲန့ၣ်လီၤ.

တၢ်အစိကတၢ်မ့ၢ်ဝဲ, လၢတၢ်ကတဲသကိးတၢ်တအိၣ်ဒီးတၢ်ဟံၣ်ထံနီၤဖးဘၣ်. ဖဲလၢတၢ်မၤကွၢ်အဆၢကတီၢ်တၢ်အစၢၤလၢအအါသ့ၣ်တဖၣ်ကြးလၢတၢ်ကဘၣ်ဃုသ့ၣ်ညါအါထီၣ်အီၤဒီးတၢ်တဆၢတံၢ်အီၤဒ်အမ့ၢ်တၢ်ဆူးတၢ်ဆါဖဲလၢတၢ်ဘၣ်ဒိဘၣ်ထံးကဲထီၣ်သးဝံၤလီၤခံ(PTSD)ဘၣ်. ဖဲလၢပုၤဒီးသံကွၢ်တၢ်တၢ်လၢလၢပုၤတၢ်ဖုးမ့ၢ်တမ့ၢ်သးကိးအါထီၣ်ဒီး, ဒ်ပုၤဃုသ့ၣ်ညါတၢ်တၢ်ဒ်အမ့ၢ်ကသံၣ်သရၤဒီးအိၣ်ဒီးလံာ်အုၣ်သးလၢနီၤသးတၢ်အိၣ်တၢ်အိၣ်ဆူၣ်အိၣ်ချ့အသိးပုၤဒီးသံကွၢ်တၢ်တၢ်လၢလၢဒီးန့ၣ်တၢ်ဟ့ၣ်ကူၣ်ဟ့ၣ်ဖးသ့လီၤ.

ဆူညါတပတီၢ်, ဒ်သိးကဒီးန့ၣ်ဘၣ်ပတီၢ်ထီတၢ်အံၤထွဲကွၢ်မ့ၢ်စ့ၤကိးတၢ်အရဲဒိၣ်စ့ၤကိးလီၤ.

ဒီးတၢ်ကသူဝဲCAPS-5(Clinician Administered PTSD Scale)ဒ်သိးကဟံၣ်ဂၢၢ်ဟံၣ်ကျဲၤတၢ်ဆူးတၢ်ဆါလီၤ. ဒီးပုၤတၢ်လၢလၢလၢတၢ်ပနီၣ်အိၣ်တဖၣ်ကြးလၢကဘၣ်ဒီးန့ၣ်ဘၣ်တၢ်အံၤထွဲကွၢ်ထွဲလၢမဲၢ်ဆိးတၢ်ဆါဟံၣ်မ့ၢ်တမ့ၢ်မဲၢ်တီၢ်တၢ်ဆါဟံၣ်လီၤ.

ပုၤမၤသကိးတၢ်ခဲလၢ်ကဒိးန့ၢ်ဘၣ်လံာ်ကွဲးဆဲးတဘျီလၢအဘၣ်တၢ်ကတဲာ်ကတီၤအီၤ
လၢကမၤအါထီၣ်အဝဲသ့ၣ်တၢ်န့ၢ်ပၢၢ်ဘၣ်ဃး PTSD ဒီးသးအတၢ်အိၣ်ဆူၣ်အိၣ်ချ့အဲၣ်
အနေအကၤတဖၣ်.

လံာ်ကွဲးဆဲးအံၤကဟံးဃုာ်တၢ်ပနီၣ်ဒီးတၢ်နီၣ်ထီၣ်နီၣ်ဖး,တၢ်မၤနၤတၢ်ကျဲလၢကမၤဘၣ်သးအတၢ်
အိၣ်ဆူၣ်အိၣ်ချ့တၢ်ဂ့ၢ်တၢ်ကျိၤတဖၣ်,ဒီးတၢ်ဟ့ၣ်ကူၣ်လၢကထံၣ်လိာ်သးအဂီၢ်တၢ်ဂ့ၢ်တၢ်ကျိၤလၢ
တၢ်အလီၢ်အကျဲ, ဒ်သိး မဲၣ်တၢ်တၢ်ကူၣ်စါလီၢ် ဒီးမဲၣ်ဆီၣ်တၢ်ဆါဟံၣ်.

17. ပုၤလၢကထံၣ်လိာ်သးအဂီၢ်ဖဲအိၣ်ဒီးတၢ်သံကွၢ်မ့တမ့ၢ်တၢ်ဘၣ်ကိၢ်ဘၣ်ဂီၤ

နမ့ၢ်အိၣ်ဒီးတၢ်သံကွၢ်သံဒီးဘၣ်ဃးတၢ်ဃုသ့ၣ်ညါအံၤမံနကစဲးကျိးသံကွၢ်ပုၤဃုသ့ၣ်ညါ
ဒ်တၢ်စဲးကျိးနီၢ်ဂံၢ်လၢလၢအံၤအသိးလီၤ.

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နမ့်အိန်ဒီးတင်သံကွပ်ဘဉ်ယးနတခွဲးတင်ယာ်, နစဲးကျိးသံကွပ် Mae Fah Luang

ဖုန်စီမိ

တင်ယုသုဉ်ညါကရသုဝဲလီ (AS), 4th floor, tel. (053) 917-170 to 1 မုတမု (053) 916-551,

fax. (053) 917-170, မုတမု e-mail: [rec.hu-](mailto:rec.hu-man@mfu.ac.th)

man@mfu.ac.th သုဝဲဒ်သီးနကသုဉ်ညါလီတင်ခွဲးနယာ် ဒီး ဘဉ်တင်သုဝဲ

ဟီဉ်ခိဉ်ဘိမုပတိတ်ထီတင်ယုသုဉ်ညါလံာ်နဲဉ်ကျဲနုဉ်လီ.

လံာ်တင်ပျဲ

ယ၊ _____, ယဆာတ်လီယသးလာယကဒီးသံကွပ်ယသးလာ

တင်အိဉ်အိဉ်စုဒီးတင်ဂုလအဘဉ်ထွဲဒီးတင်ဆူးတင်ဆါဖဲလတင်ဘဉ်ဒိဘဉ်ထံးကဲထီဉ်သး

ဝံလီခံ(PTSD)လာပုကီပယီဖဲလဟဲအိဉ်ဆိးဖဲမဲဉ်ဆိဉ်ကီဆဉ်, တးကီရုဉ်, ကီကီဉ်တဲဉ်တင်

ယုသုဉ်ညါအံလီ. ယဒီးန့ဘဉ်တင်ဂုတင်ကျိလီတင်လီဆဲး, လာယကသံကွပ်တင်အဂီစုကီး

လီ. ဒီးယဒီးန့ဘဉ်တင်ဆာကတိတ်လာလပုလပုလာယကဖးလံာ်နုပာ်ယသးလာတင်ဂုတင်ကျိ

တဖဉ်ဒီးယဆာတ်လီယသးလာယကဟ်ဃုာ်လာတင်ယုသုဉ်ညါအံအပူလီ.

ယအိဉ်ဒီးခွဲးယာ်လာကထုးကွံာ်ယသးလာတင်ယုသုဉ်ညါအံဒီးတင်လာကကဲထီဉ်တင်ကီ

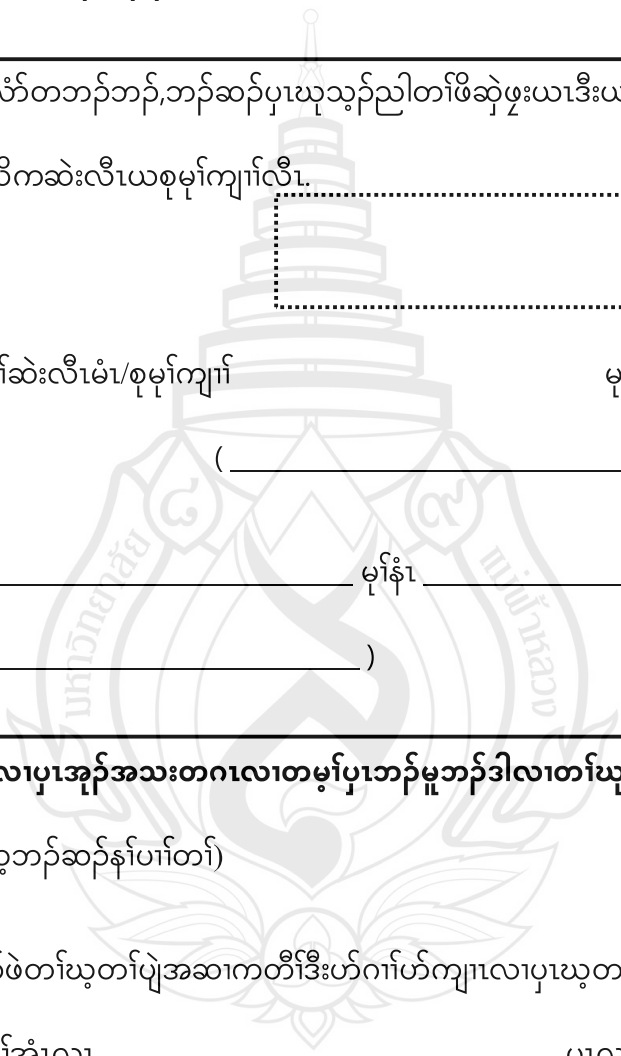
တင်ခဲလာယဂီတအိဉ်နီတမံဘဉ်.

ယတညိကွံာ်တင်ခွဲးတင်ယာ်မနုဂုမနုဂုလာယဒီးန့ဘဉ်လာတင်သိဉ်တင်သီအဖီလာ, ဒီး

ဖဲဆဲးလီမံဝံအလီခံ, ယကဒီးန့ဘဉ်လံာ်တင်ဂုတင်ကျိဒီးလံာ်တင်ပျဲတဘဉ်လီ.

ပုၤမၤသကိးတၢ်ဆဲးလီၤမံၤ _____ မုၢ်နံၤ _____
(_____)

(လၢပုၤဖးလံာ်တသ့ဘဉ်ဆဉ်န့ၢ်ပၢၢ်တၢ်)

ယဖးလံာ်တဘဉ်ဘဉ်,ဘဉ်ဆဉ်ပုၤဃုသ့ၣ်ညါတၢ်ဖိဆဲးဖးယၤဒီးယန့ၢ်ပၢၢ်အီၤဂ့ၤဂ့ၤလီၤ.	
လၢတၢ်န့ၣ်အယိကဆဲးလီၤယစုမုၢ်ကျါၣ်လီၤ.	
	
ပုၤမၤသကိးတၢ်ဆဲးလီၤမံၤ/စုမုၢ်ကျါၣ်	မုၢ်နံၤ _____
(_____)	
ပုၤဃုတၢ်ပျဲ _____	မုၢ်နံၤ _____
(_____)	

တၢ်အုၣ်အသးလၢပုၤအုၣ်အသးတဂၤလၢတမ့ၢ်ပုၤဘဉ်မူဘဉ်ဒါလၢတၢ်ဃုသ့ၣ်ညါ(ပုၤမၤသကိး
တၢ်ဖးလံာ်တသ့ဘဉ်ဆဉ်န့ၢ်ပၢၢ်တၢ်)

ယအိၣ်ဖဲတၢ်ဃုတၢ်ပျဲအဆၢကတီၢ်ဒီးဟံၣ်ဂၢၢ်ဟံၣ်ကျါၣ်လၢပုၤဃုတၢ်ပျဲအံၤ ဖး /

မၤဖျါလံာ်တၢ်ဂ့ၢ်အံၤလၢ _____ .ပုၤလၢဘဉ်တၢ်ကတိၤအီၤအ

ဖီခိၣ်အံၤအိၣ်ဒီးတၢ်ခွဲးတၢ်ယၢ်လၢကသံကွၢ်တၢ်ဒီးဆၢတဲာ်လၢကမၤသကိးတၢ်လၢတၢ်သးအိၣ်ဒီး

န့ၢ်ပၢၢ်တၢ်ဂ့ၢ်တၢ်ကျါၣ်လၢလံာ်အံၤအပူၤလီၤတံာ်လီၤဆဲးလီၤ.

ပုၤအုၣ်အသးအတၢ်ကွဲးမံၤ _____ မုၢ်နံၤ _____

(_____)



APPENDIX G

QUESTIONNAIRE (ENGLISH VERSION)

Title – Prevalence and factors associated with Post Traumatic Stress Disorder(PTSD)
among Myanmar migrants in Mae Sot, Tak province, Thailand

Questionnaires

Community.....

Research Code.....

Interviewer.....

Date.....

Part 1 : Demographic characteristics

Part 2 : Psychological factors

Part 3 : Social factors

Part 1. Demographic characteristics

1. Gender

1. Male ☐

2. Female ☐

2. Age..... Years

3. Marital Status

1. Single ☐

2. Married ☐

3. Widow ☐

4. Divorce ☐

5. Separate ☐

4. Religion

1. Buddhism ☐

2. Christian ☐

3. Islam ☐

4. Other ☐ (please specify)

5. Ethnicity

1. Karen ☐

2. Mon ☐

3. Burmese ☐

4. Shan ☐

5. Kachin ☐

6. Other ☐

(please specify)

6. Which state/region in Myanmar are you originally from?

7. Education

1. Illiterate ☐

2. Primary school ☐

3. Middle school ☐

4. High School ☐

5. Graduate ☐



8. Are you employed?

1. Yes ☐

2. No ☐

9. What is your occupation?

1. Factory Labor ☐

2. Domestic worker ☐

3. Agriculture ☐

4. Shop front seller ☐

5. Construction ☐

6. Other ☐ (please specify)

10. Monthly incomeThai Baht per participant.

11. Place of residence

1. Rent dormitory ☐

2. In work compound ☐

3. Shared housing ☐

4. Other ☐ (please specify)

12. How many family members are staying together?.....

13. How long have you stayed in Thailand?

14. 7. Do you face difficulties communicating in the local language when seeking healthcare services?

1. Yes ☐

2. No ☐

15. What is your legal status?

1. Documented ☐

2. Undocumented ☐

16. Where do you usually go when you need health care services?

1. Hospital ☐

2. Community Center ☐

3. Private clinics ☐

4. Buy medicine from pharmacy ☐

5. No/Do nothing ☐

6. Other ☐ (please specify)

17. Do you have health insurance?

1. Yes ☐

2. No ☐

If Yes, what kind of insurance do you have?

1. Social Security Scheme ☐

2. Migrant Health Insurance Scheme ☐

3. M-Fund ☐

4. Others ☐ (please specify)

Part 2. Psychological factors

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

01 MAY 2025

APPROVED

1. In the past months, have you ever used

The substances listed	No	Yes
1. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)		
2. Alcoholic beverages (beer, wine, spirits, etc.)		
3. Cannabis (marijuana, pot, grass, hash, etc.)		
4. Cocaine (coke, crack, etc.)		
5. Amphetamine-type stimulants (speed, meth, ecstasy, etc.)		
6. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
7. Sedatives or sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.)		
8. Hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.)		
9. Opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.)		
10. Other – specify:		

2. Which of the following types of events have you experienced in your life? Please select

Types of events	No	Yes
1. Physical assault	☐	☐
2. Sexual assault	☐	☐
3. War and arms conflict	☐	☐
4. Others (please specify)	☐	☐
Total traumatic events exposure		



Part 3. Social factors

1. Do you feel safe in your neighborhood?

1. Yes ☐

2. No ☐

If "No", what is your safety concern?.....

2. Do you feel excluded from social activities in your community?

1. Yes ☐

2. No ☐

3. Have you ever felt unfairly treated in your host country?

1. Yes ☐

2. No ☐

If "Yes", would you like to share more details about your experience of discrimination?

.....

4. The multidimensional scale of perceived social support (MSPSS)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very Strongly Disagree

Circle the "2" if you Strongly Disagree

Circle the "3" if you Mildly Disagree

Circle the "4" if you are Neutral

Circle the "5" if you Mildly Agree

Circle the "6" if you Strongly Agree

Circle the "7" if you Very Strongly Agree

	1	2	3	4	5	6	7
1. There is a special person who is around when I am in need.							
2. There is a special person with whom I can share joys and sorrows.	☐	☐	☐	☐	☐	☐	☐
3. My family really tries to help me.	☐	☐	☐	☐	☐	☐	☐
4. I get the emotional help & support I need from my family.	☐	☐	☐	☐	☐	☐	☐

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5. I have a special person who is a real source of comfort to me.	☐	☐	☐	☐	☐	☐	☐
6. My friends really try to help me.	☐	☐	☐	☐	☐	☐	☐
7. I can count on my friends when things go wrong.	☐	☐	☐	☐	☐	☐	☐
8. I can talk about my problems with my family.	☐	☐	☐	☐	☐	☐	☐
9. I have friends with whom I can share my joys and sorrows.	☐	☐	☐	☐	☐	☐	☐
10. There is a special person in my life who cares about my feelings.	☐	☐	☐	☐	☐	☐	☐
11. My family is willing to help me make decisions.	☐	☐	☐	☐	☐	☐	☐
12. I can talk about my problems with my friends.	☐	☐	☐	☐	☐	☐	☐

PTSD Checklist for DSM-5 (PCL-5)

Version date: 29 August 2023

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013).

The PTSD Checklist for DSM-5 (PCL-5) – Standard [Measurement instrument]

Available from <https://www.ptsd.va.gov/>

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully



and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event: _____

In the past month, how much were you bothered by:	Not at all =0	A little bit =1	Moderately = 2	Quite a bit = 3	Extremely = 4
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	☐	☐	☐	☐	☐

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6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐

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11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being "superalert" or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐

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APPENDIX H

QUESTIONNAIRE (MYANMAR VERSION)

မေးခွန်းမေးမြန်းချက်

နေထိုင်ရာအသိုင်းအဝိုင်း.....

သုတေသနကုဒ်.....

လူတွေမေးမြန်းသူ.....

ရက်စွဲ.....

အပိုင်း ၁။ လူမှု-စရိုက်လက္ခဏာများ

၁။ ကျားမအမျိုးအစား

၁။ အမျိုးသား ☐

၂။ မိန်းမ ☐

၂။ အသက်အရွယ် နှစ်

၃။ အိမ်ထောင်ရေးအခြေအနေ

၁။ လူလွတ်□

၂။ အိမ်ထောင်သည်□

၃။ မုဆိုးဖို/မ□

၄။ ကွာရှင်း□

၅။ သီးခြား□

၄။ ဘာသာတရား

၁။ ဗုဒ္ဓဘာသာ□

၂။ ခရစ်ရုပ်□

၃။ အစ္စလာမ်□

၄။ အခြား□ (ထပ်မံဖော်ပြရန်)

၅။ လူမျိုးစု

၁။ ကရင်□

၂။ မွန်□

၃။ ဗမာ□

၄။ ရှမ်း□

၅။ ကချင်□

၆။ အခြား□

(ထပ်မံဖော်ပြရန်)

၆။ မြန်မာနိုင်ငံ ဘယ်ပြည်နယ်/ ဒေသကလာတာလဲ။

၇။ ပညာရေး

၁။ ကျောင်းမနေဖူး□

၂။ မူလတန်းကျောင်း□

၃။ အလယ်တန်းကျောင်း□

၄။ အထက်တန်းကျောင်း□

၅။ ဘွဲ့ရ□

၈။ သင် ယခုအလုပ်လုပ်နေသလား။

၁။ ဟုတ်တယ်□

၂။ မဟုတ်ဘူး□

၉။ သင် ဘာအလုပ် လုပ်ပါသလဲ။

၁။ စက်ရုံအလုပ်သမား□

၂။ အိမ်တွင်းအလုပ်သမား□

၃။ စိုက်ပျိုးရေး □

၄။ ဈေးဆိုင်ရောင်းသူ□

၅။ ဆောက်လုပ်ရေး□

၆။ အခြား□

(ထပ်မံဖော်ပြရန်)

၁၀။ လစဉ်ဝင်ငွေ တစ် ဦး လျှင် (ထိုင်း ဘတ်)။

၁၁။ နေထိုင်ရာနေရာ

၁။ အဆောင်ငှား□

၂။ အလုပ်အဆောက်အအုံ□

၃။ စုပေါင်း နေအိမ်□

၄။ အခြား□ (ထပ်မံဖော်ပြရန်)

၁၂။ သင့်မိသားစုနဲ့အတူ နေထိုင်နေပါသလား။

၁။ ဟုတ်တယ်□

၂။ မဟုတ်ဘူး□

မှန်ပါက မိသားစုဝင် ဘယ်နှစ်ယောက် အတူတကွနေထိုင်နေကြတာလဲ.....

၁၃။ ထိုင်းမှာနေတာ ဘယ်လောက်ကြာပြီလဲ။

၁၄။ ကျန်းမာရေးစောင့်ရှောက်မှု ဝန်ဆောင်မှုများရှာဖွေရာတွင် ဘာသာစကားဖြင့်

ဆက်သွယ်ရေး အခက်အခဲများ ရင်ဆိုင်ရပါသလား။

၁။ ဟုတ်တယ်□

၂။ မဟုတ်ဘူး□

၁၅။ သင့်နေထိုင်ရာအထောက်အထား။

၁။ မှတ်တမ်းဝင်

၂။ စာရွက်စာတမ်းမပါဘဲ

၁၆။ ကျန်းမာရေးစောင့်ရှောက်မှု ဝန်ဆောင်မှုလိုအပ်တဲ့အခါ ဘယ်ကို သွားလေ့ရှိသလဲ။

၁။ ဆေးရုံ

၂။ ဒေသန္တရ ဆေးခန်း

၃။ ပုဂ္ဂလိကဆေးခန်းများ

၄။ ဆေးဆိုင်မှ ဆေးဝယ်ယူခြင်း

၅။ ဘာမှမလုပ်ပါ

၆။ အခြား (ထပ်မံဖော်ပြရန်)

၁၇။ ကျန်းမာရေးအာမခံ ရှိပါသလား။

၁။ ရှိတယ်

၂။ မရှိဘူး

ရှိတယ်ဆိုရင် ဘယ်လိုအာမခံမျိုးရှိသလဲ။

၁။ လူမှုရေးဖူလုံရေး စီမံကိန်း

၂။ ပြောင်းရွှေ့လာသူ ကျန်းမာရေးအာမခံ အစီအစဉ်

၃။ M-Fund

၄။ တခြား (ထပ်မံဖော်ပြရန်)

အပိုင်း ၂။ စိတ်ပညာဆိုင်ရာ အချက်အလက်များ

၁။ လွန်ခဲ့တဲ့လအတွင်းမှာ သုံးခဲ့ဖူးတဲ့ စာရင်းပြုစုထားသော ပစ္စည်းများ	မသုံး ပါ	သုံး သည်
--	-------------	-------------

၁။ ဆေးရွက်ကြီး ထုတ်ကုန်များ (စီးကရက်၊ ဆေးရွက်ကြီး၊ ဆေးရွက်ကြီးစားခြင်း၊ ဆီဂါ စသည်တို့။)	☐	☐
၂။ အရက်ယမကာ (ဘီယာ၊ ဝိုင်၊ အရက်ပြန် စသည်)	☐	☐
၃။ ကန်နဗစ် (ဆေးခြောက်၊ ပြောင်း၊ မြက်၊ ဟက်ရှ် စသည်။)	☐	☐
၄။ ကိုကင်း (ကိုကင်း၊ စသည်)။	☐	☐
၅။ Amphetamine-အမျိုးအစား (ရာဘာ၊ အက်စ်တက်စီ စသည်)	☐	☐
၆။ Inhalants (nitrous, Getrol, ဓာတ်ဆီ၊ တင်နာ စသည်။)	☐	☐
၇။ Sedatives (သို့) အိပ်စေသော ဆေးလုံးများ (Diazepam, alprazolam, flunitrazepam, flunitrazepam, midazolam စသည်)။	☐	☐
၈။ ဟာလူစီနိုဂျင် (LSD, LSD, acid, Mushrooms, လွင့်မြောခြင်း၊ ကေတာမင်း စသည်)။	☐	☐
၉။ Opioids (ဟီရိုအင်း၊ မော်ဖင်း၊ မီတာဒိုင်း၊ ဘူပရင်နော်ဖိန်း၊ ကိုဒင်း စသည်)။	☐	☐
၁၀။ အခြား -	☐	☐

၂။ သင့်ဘဝတွင် အောက်ပါ ဘယ်အဖြစ်အပျက်တွေကို သင်ကြုံတွေ့ခဲ့ရသလဲ။ ကျေးဇူးပြု၍ ရွေးချယ်ပါ။

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အဖြစ်အပျက်အမျိုးအစားများ	မဟုတ် ဘူး	ဟုတ် တယ်
၁။ ကိုယ်ထိလက်ရောက် ကျူးလွန်ခံရမှု	☐	☐
၂။ လိင်ပိုင်းဆိုင်ရာစော်ကားမှု	☐	☐
၃။ စစ်ပွဲနဲ့ လက်နက်ပဋိပက္ခ	☐	☐
၄။ အခြား	☐	☐
စိတ်ထိခိုက်ဖွယ် အဖြစ်အပျက်စုစုပေါင်း		

အပိုင်း ၃။ လူမှုရေးအချက်အလက်များ

၁။ သင့်ရပ်ကွက်မှာ လုံခြုံတယ်လို့ ခံစားရသလား။

၁။ ဟုတ်ပါတယ် ☐

၂။ မဟုတ်ဘူး ☐

"မဟုတ်ဘူး"ဆိုရင် သင့်ရဲ့ လုံခြုံရေးနဲ့ ပတ်သက်နေတာ ဘာလဲ?.....

၂။ အိမ်ရှင်နိုင်ငံမှာ မတရားဆက်ဆံခံရဖူးသလား။

၁။ ဟုတ်တယ် ☐

၂။ မဟုတ်ဘူး ☐

"ဟုတ်တယ်" ဆိုရင် ခွဲခြားဆက်ဆံမှု အတွေ့အကြုံနဲ့ ပတ်သက်ပြီး

အသေးစိတ်အချက်အလက်တွေကို ဝေမျှချင်လား။

.....

၃။ မိသားစုက ကျွန်တော်/ကျွန်မကို ကူညီပေးဖို့ တကယ်ကြိုးစားတယ်။	☐	☐	☐	☐	☐	☐	☐
၄။ မိသားစုဆီက လိုအပ်တဲ့ စိတ်ပိုင်းဆိုင်ရာ အကူအညီနဲ့ အားပေးထောက်ပံ့မှု ရရှိပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၅။ နှစ်သိမ့်မှုအစစ်အမှန်ပေးတဲ့ ယုံကြည်ရသူတစ်ယောက်ရှိပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၆။ သူငယ်ချင်းတွေက ကျွန်တော်/ကျွန်မကို တကယ်ကူညီပေးဖို့ ကြိုးစားကြတယ်။	☐	☐	☐	☐	☐	☐	☐
၇။ ပြဿနာတွေဖြစ်တဲ့အခါ မိတ်ဆွေတွေကို တိုင်ပင်အားကိုးနိုင်ပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၈။ မိသားစုကို ပြဿနာတွေအကြောင်း ပြောပြနိုင်ပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၉။ ပျော်ရွှင်မှုတွေနဲ့ ဝမ်းနည်းမှုတွေကို ပြောပြနိုင်တဲ့ မိတ်ဆွေတွေ ရှိပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၁၀။ ကျွန်တော့်ဘဝမှာ ကျွန်မရဲ့ခံစားချက်တွေကို ဂရုစိုက်တဲ့ ယုံကြည်ရသူတစ်ယောက် ရှိပါတယ်။	☐	☐	☐	☐	☐	☐	☐
၁၁။ မိသားစုက ဆုံးဖြတ်ချက်ချရာတွင် တလိုတလားကူညီပေးတယ်။	☐	☐	☐	☐	☐	☒	☐

၁၂။ သူငယ်ချင်းတွေကို ပြဿနာတွေအကြောင်း ပြောပြနိုင်ပါတယ်။	☐	☐	☐	☐	☐	☐	☐
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PTSD Checklist for DSM-5 (PCL-5)

ဗားရှင်း ရက်စွဲ - ၂၉ ဩဂုတ် ၂၀၂၃

Reference: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013).

The PTSD Checklist for DSM-5 (PCL-5) – Standard [Measurement instrument]

Available from <https://www.ptsd.va.gov/>

ညွှန်ကြားချက်များ– တစ်ခါတစ်ရံအလွန်စိတ်ဖိစီးမှုဖြစ်စေသော အခါ တုံ့ပြန်တတ်သည့်

ပြဿနာများစာရင်းဖြစ်သည်။ သင်၏အဆိုးဆုံးဖြစ်ရပ်ကို စိတ်စွဲမှတ်ထားပါ။

ပြဿနာတစ်ခုစီကို ဂရုတစိုက်ဖတ်ရှုပြီးနောက် လွန်ခဲ့သောလက ထိုပြဿနာကြောင့်

သင်မည်မျှစိတ်အနှောင့်အယှက်ဖြစ်ခဲ့ကြောင်း ဖော်ပြရန် နံပါတ်တစ်ခုကိုရွေးချယ်ပါ။

အဆိုးဆုံးဖြစ်ရပ်– _____

လွန်ခဲ့တဲ့လတုန်းက ခင်ဗျားတို့	လုံးဝ	နည်း	တော်	နည်း	အလွန်
ဘယ်လောက်	မ	နည်း	သင့်ရုံ	နည်း	အကျွံ
စိတ်အနှောင့်အယှက်ဖြစ်ခဲ့တာလဲ။	ဟုတ်	လေး = ၁	= ၂	များ	= ၄
	= ၀			= ၃	
၁။ စိတ်အနှောင့်အယှက်ဖြစ်စေရပြီး	☐	☐	☐	☐	☐

စိတ်ဖိစီးမှုကိုထပ်တလဲလဲ၊ ဖြစ်စေတဲ့ အတွေ့အကြုံရှိလား။					
၂။ စိတ်အနှောင့်အယှက်ဖြစ်စေတဲ့ အိပ်မက်တွေ ထပ်ခါတလဲလဲမက်လား။	☐	☐	☐	☐	☐
၃။ ရုတ်တရက် စိတ်ဖိစီးမှုခံစားနေရသလို အရင်ကအရာက အမှန်တကယ် ပြန်ဖြစ်နေသလို (တကယ် ထိုနေရာသို့ ပြန်ရောက်နေသလို)ခံစားရလား။	☐	☐	☐	☐	☐
၄။ တစ်စုံတစ်ခုကို သင့်က ပြန်လည်သတိရစေတဲ့အခါ စိတ်ဖိစီးမှုဖြစ်ရတာရှိလား။	☐	☐	☐	☐	☐
၅။ တစ်စုံတစ်ခုခုကြုံရတဲ့အခါ စိတ်လှုပ်ရှားမှုဖြစ်ခြင်း (ဥပမာ၊ နှလုံးခုန်ခြင်း၊ အသက်ရှူမြန်ခြင်း၊ ချွေးထွက်ခြင်း။)	☐	☐	☐	☐	☐
၆။ ပြန်မလိုချင်တဲ့ အမှတ်တရတွေ၊ အတွေးတွေ ဒါမှမဟုတ် ခံစားချက်တွေရှိလား။	☐	☐	☐	☐	☐

၇။ စိတ်ဖိစီးမှုဖြစ်စေတဲ့ အခြေနေတွေကို ရှောင်ခြင်း (ဥပမာ၊ လူတွေ၊ နေရာတွေ၊ စကားပြောဆိုမှုတွေ၊ လှုပ်ရှားမှုတွေ၊ အရာဝတ္ထုတွေလား ဒါမှမဟုတ် အခြေအနေတွေလား။)	☐	☐	☐	☐	☐
၈။ စိတ်ဖိစီးစေတဲ့ အကြောင်းအရာ ကိစ္စရပ်တွေကို သတိရဖို့ အခက်အခဲ ရှိလား။	☐	☐	☐	☐	☐
၉။ ကိုယ့်ကိုယ်ကို မကောင်းမြင်နေတာမျိုးရှိနေလား။ တခြားလူကို ဒါမှမဟုတ် လောကကို(ဥပမာအနေနဲ့ - ကိုယ်က ဆိုးတယ်၊ အကြီးအကျယ် မှားနေတာ၊ လူတစ်ဦးကိုမှ မယုံကြည်စိတ်မချနိုင်ပြီး လုံးဝအန္တရာယ်ရှိနေတယ်လို့ခံစားနေရတာ)။	☐	☐	☐	☐	☐
၁၀။ စိတ်ဖိစီးမှုအတွက် ၊ ဖြစ်ခဲ့တာတွေအတွက် ကိုယ့်ကိုယ်ကိုယ်	☐	☐	☐	☐	☐

ဒါမှမဟုတ် တခြားသူတစ်ယောက်ကို အပြစ်တင်ခြင်း။					
၁၁။ အပျက်သဘောခံစားချက်တွေရှိလား (ကြောက်ရွံ့ခြင်း၊ ထိတ်လန့်ခြင်း၊ ဒေါသအစရှိတဲ့ ရှိခြင်း၊ အပြစ်ရှိသလိုခံစားရခြင်း ဒါမှမဟုတ် ရှက်ခြင်း)။	☐	☐	☐	☐	☐
၁၂။ သင့်ကိုပျော်စေသော လုပ်ဆောင်မှုတွေကို စိတ်ဝင်စားမှု လျော့နည်းသွားလား။	☐	☐	☐	☐	☐
၁၃။ တခြားသူတွေနဲ့ သီးခြားဖြစ်နေသလိုခံစားရလား။	☐	☐	☐	☐	☐
၁၄။ အပြုသဘောဆောင်တဲ့ ခံစားချက်တွေ ခံစားရဖို့ အခက်အခဲရှိလား(ဥပမာ၊ ပျော်ရွှင်မှုမခံစားနိုင်ခြင်း သို့မဟုတ် ခင်ဗျားနဲ့ ရင်းနှီးတဲ့လူတွေဆီက မေတ္တာပြည့်ဝသောခံစားချက်များမရှိခြင်း)။	☐	☐	☐	☐	☐

၁၅။ စိတ်အနှောင့်အယှက်ဖြစ်စေတဲ့ အပြုအမူ၊ ဒေါသပေါက်ကွဲလွယ်တာ ဒါမှမဟုတ် ပြင်းပြင်းထန်ထန် ပြုမူမိတာ။	☐	☐	☐	☐	☐
၁၆။ အန္တရာယ်များလွန်းတာ ဒါမှမဟုတ် သင့်ကိုထိခိုက်နိုင်စေနိုင်တဲ့ အရာတွေကို လုပ်ဆောင်ခြင်းရှိလား။	☐	☐	☐	☐	☐
၁၇။ "လိုတာထက်ပို သတိထားမိလွန်းနေတာ" ဒါမှမဟုတ် စောင့်ကြည့်မိနေတာ ဒါမှမဟုတ် ကိုယ်ကိုယ်ဂရုစိုက်လွန်တာမျိုးရှိလား။	☐	☐	☐	☐	☐
၁၈။ အလွယ်တကူ စိတ်ရှုပ်တာ ဒါမှမဟုတ် ထိတ်လန့်သွားတာမျိုးရှိလား။	☐	☐	☐	☐	☐
၁၉။ အာရုံစိုက်ရတဲ့ကိစ္စတွေမှာ အခက်အခဲတွေ ကြုံနေရလား။	☐	☐	☐	☐	☐
၂၀။ အိပ်ပျော်ဖို့ ခက်ခက်ခဲခဲကြိုးစားနေရလား။	☐	☐	☐	☐	☐

APPENDIX I

BROCHURE (ENGLISH VERSION)

Version 2 Date 9.4.2025

Brochure PTSD_Englishversion



4.09.2025

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

01 MAY 2025

APPROVED

If you think you are experiencing the above symptoms
You can visit the following places for consulting and treatment.

1. Mae Tao clinic
Address: 702, Moo 1, Tha Sai Luad, Mae Sot, Tak, 63110, Thailand



2. Mae Sot Hospital
Address: 75/76, Sriphetsi Road, Mae Sot District, Tak Province

Dr. Arkar Mann Kyaw
M.B.B.S(MDY)
Master of Public Health in Border Health Management,
Mae Fah Luang University,
Chiang Rai, Thailand

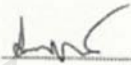
Contact:
+66-927089331
drarkarmanhkyaw@phdgmpl.com
6651804003@kumduan.mae.ac.th

POST TRAUMATIC STRESS DISORDER(PTSD)

THINGS WORTH KNOWING ABOUT



Are you experiencing stress due to past traumatic experiences?


9.04.2025

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

01 MAY 2025

APPROVED

APPENDIX J

BROCHURE (BURMESE VERSION)

အထက်ပါ လက္ခဏာများရှိနေသည်ဟု ထင်ပါက

အောက်ဖော်ပြပါနေရာများသို့ သွားရောက်၍ ဆွေးနွေးကုသတိုင်ပင်နိုင်ပါသည်။

၁။မယ်တော်ဆေးခန်း

Address: 702, Moo 1, Tha Sai Luad, Mae Sot, Tak, 63110, Thailand



၂။မဲဆောက်ဆေးရုံကြီး

Address: 75/16 Sriphanit Road, Mae Sot District, Tak Province.

ဒေါက်တာအာကာမန်းကျော်
M.B.B.S(MDY)

Master of Public Health in Border Health Management,
Mae Fah Luang University,
Chiang Rai, Thailand

ဆက်သွယ်ရန်

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6651804003@lamduanumfua.ac.th

စိတ်ဒဏ်ရာကြောင့် စိတ်ဖိစီးမှုရောဂါ(PTSD)

အကြောင်း သိကောင်းစရာများ



သင့်မှာ ယခင်ကဖြစ်ခဲ့တဲ့ စိတ်ဒဏ်ရာတွေကြောင့် စိတ်ဖိစီးမှုတွေ ရှိနေပါသလား?

သင့်မှာ ဒီလို လက္ခဏာ တွေရှိနေပြီလား?

စိတ်ပိုင်းဆိုင်ရာလက္ခဏာများ

စိတ်ထိခိုက်စေသော
အတိတ်ဖြစ်ရပ်များကို ပြန်ပြန်
အိပ်မက်ဆွဲယူနေခြင်း၊
စိတ်ခံစားမှုမရှိခြင်း၊
အာရုံစူးစိုက်မှုခက်ခဲခြင်းနှင့်
အပြစ်ရှိသလိုခံစားနေရခြင်း သို့မဟုတ်
လူအများနှင့် စကားမပြောလိုခြင်း၊
ရှက်ကြောက်နေခြင်းများ ဖြစ်နိုင်ပါသည်။

တစ်ခါတစ်ရံ အန္တရာယ်ပေါ်လာမည်ဟု
ခံစားနေရခြင်း သို့မဟုတ် ရုတ်တရက်ဖြစ်
ပျက်မည့်အရာတစ်ခုခုတစ်ခုခုအတွက်
အလွန်အမင်း သတိထားမိနေခြင်းကိုလည်း
ခံစားရနိုင်ပါသည်။

ရုပ်ပိုင်းဆိုင်ရာလက္ခဏာများ

နာကျင်ခြင်းကိုခံနိုင်ရည်
ခံနိုင်ရည်မရှိခြင်း၊
စိုးရိမ်လန့်လန့်ခြင်းနှင့်
အလွယ်တကူ ကြောက်လန့်တတ်မှုများ
ဖြစ်နိုင်ပါသည်။

ဒီလိုလက္ခဏာတွေရှိနေရင် ဘာဆက်လုပ်မလဲ ?

တိုင်ပင်ဆွေးနွေးပါ

မိမိယုံကြည်သော မိသားစုဝင် သို့မဟုတ်
သူငယ်ချင်းမိတ်ဆွေတစ်ယောက်ယောက်ကို
ဖွင့်ဟတိုင်ပင်ပါ။
ထို့နောက် လမ်းညွှန်သူ သို့မဟုတ် ဆရာဝန်
ထံသို့ သွားသင့်ပါသည်။

စိတ်ဒဏ်ရာကြောင့် စိတ်ဖိစီးမှုရောဂါ (PTSD) ဆိုတာ

ဘာလဲ ?

စိတ်ဒဏ်ရာကြောင့် စိတ်ဖိစီးမှုရောဂါ (PTSD) ဆိုတာ
စိတ်ကုန်းမာရေအခြေအနေ တစ်ခုဖြစ်ပြီး၊
ထိခိုက်မှု ဖြစ်ရပ်များကို ကြုံတွေ့ရခြင်း သို့မဟုတ်
ပြင်တို့စားရပြီးနောက် ဖြစ်ပေါ်လာခြင်း ဖြစ်သည်။

ထိုဖြစ်ရပ်များတွင်
သဘာဝဘေးအန္တရာယ်များ၊
ကြီးမားသည့် မတော်တဆမှုများ၊
စစ်ပွဲများ၊
ကိုယ်တိုင်လက်ရောက်ကျူးလွန်မှုများ သို့မဟုတ်
အသက်အန္တရာယ်အနောက်အယုက်ဖြစ်စေသော
အခြေအနေများ၊
လိင်ပိုင်းဆိုင်ရာ စော်ကားခံရမှုများ
ပါဝင်သည်။

APPENDIX K

VALIDITY ASSESSMENT OF QUESTIONNAIRE

The validity of the questionnaire was rigorously assessed by three experts utilizing the Item-Objective Congruence (IOC) method. The questionnaire has been thoughtfully structured into three distinct sections: demographic factors, psychological factors, and social factors.

Expert 1

Asst.Prof.Dr.Maliwan Rueankam

Institution: Dean of Faculty of Physical Therapy, Mahidol University

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Expert 2

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Expert 3

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Part 1: Questionnaires on Demographic Factors

Items	Expert 1's opinion score			Expert 2's opinion score			Expert 3's opinion score			Total score	Average	Remarks
	-1	0	+1	-1	0	+1	-1	0	+1			
1			✓			✓			✓	3	3/3=1	Good
2			✓			✓			✓	3	3/3=1	Good
3			✓			✓			✓	3	3/3=1	Good
4			✓			✓			✓	3	3/3=1	Good
5			✓			✓			✓	3	3/3=1	Good
6			✓			✓			✓	3	3/3=1	Good
7			✓			✓			✓	3	3/3=1	Good
8			✓			✓			✓	3	3/3=1	Good
9			✓			✓			✓	3	3/3=1	Good
10			✓			✓			✓	3	3/3=1	Good
11			✓			✓			✓	3	3/3=1	Good
12			✓			✓			✓	3	3/3=1	Good
13			✓			✓			✓	3	3/3=1	Good
14			✓			✓			✓	3	3/3=1	Good
15			✓			✓			✓	3	3/3=1	Good
16		✓				✓			✓	3	2/3=0.7	Good
17			✓			✓			✓	3	3/3=1	Good

Where;

$$IOC = \frac{1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 1 + 0.7 + 1 + 1}{17}$$

$$IOC = 0.98$$

Remark

Question number 1 was revised according to the expert's suggestion.

Question number 16 was revised according to the expert's comment



Part 2. Questionnaires on psychological factors

Items	Expert 1's opinion score			Expert 2's opinion score			Expert 3's Opinion score			Total Score	IOC	Result
	-1	0	+1	-1	0	+1	-1	0	+1			
1		✓				✓			✓	2	2/3=0.7	Good
2			✓			✓			✓	3	3/3=1	Good

Where;

$$IOC = \frac{0.7 + 1}{2}$$

$$IOC = 0.85$$

Part 3: Questionnaires on social factors

Items	Expert 1's opinion score			Expert 2's opinion score			Expert 3's Opinion score			Total Score	IOC	Result
	-1	0	+1	-1	0	+1	-1	0	+1			
1			✓			✓			✓	3	3/3=1	Good
2			✓			✓			✓	3	3/3=1	Good
3			✓			✓			✓	3	3/3=1	Good
4			✓			✓			✓	3	3/3=1	Good

Where;

$$IOC = \frac{1 + 1 + 1 + 1}{4}$$

$$IOC = 1$$

CURRICULUM VITAE

NAME Arkar Mann Kyaw

EDUCATION BACKGROUND

2016 Bachelor of Medicine, Bachelor of Surgery
University of Medicine, Mandalay, Myanmar

WORK EXPERIENCE

2018-2022 Sale Executive
Servier Pharmaceutical Company, Myanmar

2017- 2018 Medical Officer
Private hospitals in Mandalay

2016-2017 Medical Officer
Mandalay General Hospital, Myanmar

CERTIFICATES

2025 Managing Mental Health

2025 Introduction to PTSD: Treating Trauma and Managing Symptoms

