THE EFFECT OF ALCOHOL CRAVING CONTROL PROGRAM ON ALCOHOL CONSUMPTION IN ALCOHOL DEPENDENTS

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ผลของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์

นางสาวสุนิศา สุขตระกูล

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาพยาบาลศาสตรดุษฎีบัณฑิต
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สุนิศา สุขตระกูล : ผลของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์. (THE EFFECT OF ALCOHOL CRAVING CONTROL PROGRAM ON ALCOHOL CONSUMPTION IN ALCOHOL DEPENDENTS) อ. ที่ปรึกษาวิทยานิพนธ์หลัก: รศ. ดร. จินตนา ยูนิพันธุ์, อ. ที่ปรึกษาวิทยานิพนธ์ร่วม รศ. ดร. วราภรณ์ ชัยวัฒน์, 159 หน้า.

การศึกษานี้มีวัตถุประสงค์เพื่อเปรียบเทียบการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์ระหว่างผู้เข้าร่วมโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์กับกลุ่มควบคุม โปรแกรมการพยาบาลนี้สร้างขึ้นเพื่อเพิ่มความสามารถในการควบคุมความอยากดื่มแอลกอฮอล์เพื่อลดการบริโภคแอลกอฮอล์ ประกอบด้วย 2 ระยะ คือ การตรวจสอบและการสะท้อนกลับเพื่อการตัดสินใจ (กิจกรรม 5 ครั้ง) และการปฏิบัติเพื่อควบคุมความอยากดื่มแอลกอฮอล์ (โทรศัพท์ 6 ครั้ง) ระยะเวลาในการดำเนินการ 3 เดือน การวิจัยเชิงทดลองนี้เป็นแบบการวัดก่อนและหลังโดยมีกลุ่มควบคุม กลุ่มตัวอย่างเป็นผู้ติดแอลกอฮอล์ที่เข้ารับการบำบัดรักษาในสถาบันยาเสพติดธัญญารักษ์จำนวน 61 ราย สุ่มเข้ากลุ่มทดลอง 32 ราย และกลุ่มควบคุม 29 ราย เครื่องมือที่ใช้ในการเก็บรวบรวมข้อมูลคือ แบบประเมินการบริโภคแอลกอฮอล์

ผลการศึกษาพบว่า ผลต่างของค่าเฉลี่ยของการบริโภคแอลกอฮอล์ในผู้ติดแอลกอฮอล์ที่เข้าร่วมโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์สูงกว่ากลุ่มควบคุมอย่างมีนัยสำคัญทางสถิติที่ระดับ .05 ผลการศึกษาครั้งนี้แสดงถึงประสิทธิภาพของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ในการลดการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์ซึ่งสามารถนำโปรแกรมนี้ไปใช้ในการปฏิบัติการพยาบาลได้

สาขาวิชา พยาบาลศาสตร์.... ลายมือชื่อนิสิต.....

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ลายมือชื่อ อ.ที่ปรึกษาวิทยานิพนธ์ร่วม.....

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The study purpose was to compare alcohol consumption in alcohol dependence between the Alcohol Craving Control Program (ACC Program) group and the control group. ACC Program was designed to improve alcohol craving control agency in order to decrease alcohol consumption. ACC Program composed of 2 phases, the investigation and reflection for decision (5 sessions) and the performance of productive craving control agency (6 telephone calls). The total length of the ACC Program was 3 months. Experimental pretest-posttest control group design was used. Subjects were 61 alcohol dependents admitted to the Thanyarak Institute on Drug Abuse which were randomly assigned to one intervention (n = 32) and one control group (n = 29). Data were collected by the Alcohol Consumption Assessment.

The finding revealed that the mean different score of the alcohol consumption in the intervention group was significantly higher than that of the control group, at .05 level. In conclusion, this study provided evidence for effectiveness of the ACC Program on alcohol consumption in alcohol dependents. It can be implemented in existing clinical nursing practice.

Field of Study : Nursing Science... Student's Signature Sunisa Suktrakul.

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CHAPTER I

INTRODUCTION

Background and Significance of the Study

Alcohol consumption is operating of the self-action (Sommers et al., 2003). The increasing and reducing to amount of consumption is a function of the drinker. Over alcohol consumption leads a significant burden of social and health harm to others as well as to the drinkers (Rehm et al., 2003). In Thailand, it is a leading cause of injury and disease. In 2004, the World Health Organization (WHO) identified the top 20 countries with the highest consumption for each beverage category; using the recorded adult per capita (APC) use in liters of pure alcohol for specific beverage type and Thailand ranked the sixth (6^{th}) (WHO, 2004a). Data from the Thailand National Survey in 2007 of tobacco used and alcohol consumption in population age over 15 years (51.2 million people) presented that 29.3% were consumed alcohol. In addition, males had consumed alcohol six times as much as females had (National Statistical of Thailand, 2010: online). In 2009, WHO reported evidence showing that alcohol consumption caused much more health burden for men than for women — the alcohol-attributable proportion of men's overall burden was about four times the proportion of women's (WHO, 2009). Due to the enormous affect of alcohol consumption in males to other as well as to themselves, this study was focus on male population.

On account of the increasing rate of persons' who had problems with alcohol consumption and related disease in globe, severe problem with lack of ability to decrease the consumption presented with over and/or continue consumption despite

adverse consequences had diagnosed as alcohol dependence (American Psychiatric Association [APA], 2000). Adverse consequences related to continued and/or increased consumption in alcohol dependents are physical and psychosocial consequence. Physical consequences included increased tolerance, withdrawal symptoms such as tremors, sweating, anxiety, vomiting, vitamin deficiencies, sexual impotence, and reproductive problems (Emanuele and Emanuele, 2001) and some physical illness such as high blood pressures (Cutis et al., 1997; Keil et al., 1997), stroke and heart failure (Abramson et al., 2001; Wilhelmsen et al., 2001; Walsh et al., 2002), cirrhosis (Corrao et al., 1999), and some cancers (Bagnardi et al., 2001). Recent analyses of alcohol-related illness from studies over the past 15 years indicates that individuals who over consume alcohol to the point of dependency are also more likely to meet criteria for bipolar disorder. While the prevalence of bipolar disorder is estimated at 1% in the general population, approximately 3% of alcohol dependents meet diagnostic criteria. Anxiety disorders are also more common in alcohol dependence population since the lifetime prevalence rate of anxiety disorders in alcohol dependents is approximately 9.4%, significantly higher than the reported 3.7% of alcohol dependents (Schuckit, 1996). Other studies suggest that the odds of having an affective disorder are 4 times higher, an anxiety disorder 3 times higher, and a drug use disorder 10 times higher among the alcohol dependents than those of the general population (Graeber et al., 2003). Chronic consumption can also damage the brain and lead to cognitive impairments such as dementia, difficulties with co-ordination and motor control, and sensory changes in the extremities (APA, 1994; WHO, 2001).

Psychosocial consequences are problems with work, law, family life, and society (Boyd and Mackey, 2000; Fisher et al., 2000; Perreira and Sloan, 2002; Ronnachai Kongsakol, 2005). An interesting social problem presented by WHO in the global status report on alcohol, a Thailand survey found that 62% of traffic accident victims had a positive blood alcohol concentration. Approximately, 45% of deaths from traffic accidents in Thailand are due to alcohol consumption (WHO, 2004a). Furthermore, the economic cost of hospitalization of alcohol-related illness per person per admission was estimated in 2004 to be over 25,000 baths which included medical treatment costs and indirect costs from lost earnings, decreased productivity of the patient and family, transportation costs, and other non-medical equipment and food (Thanyarak Institute on Drug Abuse, 2009: online).

The American Medical Association declares alcohol dependence is a serious health problem and chronic disease (McLellan et al., 2000). While receiving treatment, high recurrence still presented. The related data was shown by the Thanyarak Institute on Drug Abuse with 30-40% of the alcohol dependence patients were relapsed and readmitted more than one to fifteen times within a year of intervention completion (Thanyarak Institute on Drug Abuse, 2009: online). Results from previous studies supported that the relapse remain relatively high for significant periods of time after standard treatment, started with 2 weeks with slip as relapse within 8-24 weeks later (McLellan et al., 2000; Dennis, Scott, and Funk, 2003). Relapse situation was effected the exceed costs of healthcare (Bundit Sornpaisal et al., 2009). Noticeable, failed to follow up in the health center in many case can referred the relapse more than 70% (Thanyarak Institute on Drug Abuse, 2009: online). According to Orem (2001), a person living with chronic disease may have a limitation

of what he can do for himself and may limit his ability to reason, to make decisions, and to engage in activity to accomplish health and well-being. The specific requirements of care for him with this alteration of health should be arise. Under nurses' responsibility to care for the patients with the alteration of health in this sense new self-care required in alcohol dependents was to self-care action as decrease alcohol consumption. However, they still lack of self-care ability to decrease their consumption. Developing a new nursing intervention for the alcohol dependents to improve new self-care ability, self-care agency, was significant.

A large review of the literatures indicates that craving is the major factor to continue and/ or increase consumption in alcohol dependents (Marlatt, 1985; Tiffany, 1992; Niaura, 2000; Tiffany and Conklin, 2000; Aungkana Nadsasarn, 2005). The definition of craving is an urge that refers to wanting or desiring to consume alcohol (Monti, Rohesnow, and Hutchison, 2000). In 2005, a research by Aungkana Nadsasarn and others supports that craving is the major factor on continue and/or increase consumption in alcohol dependents. The top of cause of continued and increased consumption among 90 alcohol dependents who are readmitted in Central Institute on Drug Abuse in Chiang-Mai was craving (Aungkana Nadsasarn, 2005). Other interesting data of difficulty to decrease alcohol consumption related to crave in alcohol dependents presented by Thanyarak Institute on Drug Abuse (2006: online), the data showed the alcohol dependence patients readmitted with uncontrolled alcohol craving problem. Therefore, new self-care ability is required in alcohol dependents as craving control agency to accomplish new self-care action as decrease alcohol consumption. New nursing intervention was conducted by the researcher namely Alcohol Craving Control Program (ACC Program). For the process to improve the

ability to control alcohol craving related to Orem's (2001) perspective and according to Nursing Development Conference Group (1979) presented when self-care agency is show, fully developed , and operational, self-care is produced. The phase of deliberate action compose of 3 parts include the estimative and transitional operations involve individuals in action to acquire knowledge of themselves, of environmental conditions, of courses of action open to them, and of the effectiveness and desirability of these courses of action. Judgments are then formed regarding what can and should be done and a final decision is made about what to do (Orem, 2001: 259). The production operations begin with the decision for action regarding self-care. The person raises questions about how to proceed, what resources are needed, whether the actions can be performed correctly and effectively in the time required, where help can be acquired, or how results will be evaluated (Orem, 2001: 259-260).

Alcohol Craving Control Program was conducted in this study and guided by Orem's Self-Care Deficit Nursing Theory (2001). The purpose of this program was to improve alcohol craving control agency followed the phase of deliberate action that can effectively decrease alcohol consumption. Orem (2001) recommended nursing strategy to help the patients to engage in self-care in which the patient' s requirements for help are confined to decision making, behavior control, and acquiring knowledge and skills as supportive-educative system. Alcohol Craving Control Program followed supportive-educative system were included a combination of support, guidance, provision of developmental environment, and teaching particular knowledge and skills related to alcohol craving control. Supportive self-care action as decrease alcohol consumption with craving control in the real situation and support the

participants to make decision which skills should be continue and discontinue in real situation by continue contract with telephone call was significant in this study.

Objective of the Study

To compare alcohol consumption in alcohol dependents between the Alcohol Craving Control Program group and the control group.

Research Question

Are there significant differences of alcohol consumption in alcohol dependents between the intervention and control group before and after completed the program?

Research Hypothesis

Orem (2001) recommended nursing strategy to help the patients to engage in self-care in which the patient' s requirements for help are confined to decision making, behavior control, and acquiring knowledge and skills as supportive-educative system. Supportive-educative system was the nursing intervention that used in the program. ACC Program was included two phases. Phase one which was a combination of the parts 1 and parts 2 of deliberate action in self-care operation capabilities that are estimative-transitional operations and judgments as called investigation and reflection for decision to improve craving control agency phase. Nursing activities were included support, guidance, provision of developmental environment, and teaching particular knowledge and skills to control alcohol craving. Also, presentation, discussion and skills training were the methods used for each session then learning process would occur. Phase two which included the production operations part that the result of the self-care action should be evaluated as called performance of productive craving control agency phase. Nursing activity was

continued as telephone supported to work on craving control in real situation to effect on decreased alcohol consumption. After finished the program the alcohol dependents would have the ability to investigate knowledge in alcohol craving situation and cause of craving therefore they can make decision which skills should be improve and how to improve such skills to control craving so that learning process was occurred and the result of craving control agency to effect on decreased alcohol consumption.

The study hypothesis to be explored in this study was the alcohol dependents who were completed an ACC Program would have significantly decreased alcohol consumption than those received usual.

Scope of the Study

1. The population of this study was male patients' who diagnosed with alcohol dependence and already detoxified. This study is conducted at the detoxification ward in Thanyarak Institute on Drug Abuse.

2. Research design of this study was an intervention pretest-posttest control group design with subjects randomly assigned to an experimental or control group.

3. The independent variable was the Alcohol Craving Control Program and the dependent variable was alcohol consumption (which could be measured by using the Alcohol Consumption Assessment (ACA) conducted by the researcher).

Operational Definition

1. Alcohol Craving Control Program (ACC Program) means the nursing activity that work on improving alcohol craving control agency for male alcohol dependents which used Orem's Self-Care Deficit Nursing Theory (Orem, 2001) to guide this program. Teaching, guiding, and supporting techniques were used in each

session. Program was including 2 phases with 5 sessions and 6 phone calls after discharge. The details are as follows:

1.1 Phase I; Investigation and reflection for decision to improve craving control agency included 5 sessions:

1.1.1 Session 1 Cue management

Objectives: To investigate specific cue that cause the patients to crave and consume alcohol, taught the appropriate knowledge that could improve their craving control agency, support and motivation to plan for cue management that could improve their alcohol craving control in real situation after discharge.

1.1.2 Session 2 Negative affect of decrease consumption; Alcohol withdrawal management

Objectives: to provide knowledge and understanding about the negative effect that could occur while they had decreased their alcohol consumption as withdrawal symptoms and provided self-care plan for these symptoms.

1.1.3 Session 3 Negative affect of decrease consumption; Refusal skill and stress management

Objectives: Provide knowledge and understanding of refusal and stress management skills that the alcohol dependents could work with the appropriate situation.

1.1.4 Session 4 Positive affect of alcohol consumption; Emotional control and trip to stay sober

Objectives: To provide knowledge and understanding of emotional control and had the alternative activities to work instead of consume alcohol and guide the trip to stay sober in real life.

1.1.5 Session 5 Repetition self-care planning

Objectives: In the final session that arranged at the discharge day. To discussed and repeated all self-care plans to control all alcohol craving factors and to ready each self and sheer up willpower to continue self-care action as their plan in the booklet and also make appointment for 6 phone calls at the discharge day.

1.2 Phase II; Performance of productive craving control agency included 6 phone calls:

Telephone calls to support self-care action in week 1, 2, 3, 4, 6, and 8 after discharge. Supportive, motivation, continue education a warrant by the individual situations that focused on assignment in the “Alcohol Craving Control Booklet” and also motivate to decision which craving control action should be continue and should be develop or discontinue in real life were the aims of this phase.

2. Alcohol consumption means the number of the standard drink of the alcohol consumption in a week. The Alcohol Consumption Assessment (ACA) conducted by the researcher was used to measure alcohol consumption which included type of alcohol, frequency, and quantity of alcohol intake.

3. The usual care means the nursing activity for alcohol dependents included two individual and one family counseling by nurses at alcohol detoxification ward in Thanyarak Institute on Drug Abuse. Session one in individual counseling was investigated cause of alcohol consumption and problems with decreased consumption. Session two was taught to decrease alcohol consumption which included knowledge of alcohol consumption effect and related to improve self awareness to change their consumption. One family counseling at the discharge date was to support the family and to motivate them to help the patient to decrease alcohol consumption.

Expected Benefit

1. Providing the evidence on improving self-care to decrease alcohol consumption in alcohol dependents.

2. Providing the evidence to develop the guideline to decrease alcohol consumption in alcohol dependents for the health care center.

CHEPTER II

LITERATURE REVIEW

In order to study the effect of the Alcohol Craving Control Program on alcohol consumption in alcohol dependents, this chapter provided an integrative research review of empirical finding with the state of the summarization that related to each concept of interest which are organized in to two sections as following;

1. Alcohol consumption in alcohol dependents
    - 1.1 Impact of alcohol consumption in alcohol dependents
    - 1.2 Factors related to alcohol consumption in alcohol dependents
        - 1.2.1 Alcohol craving
        - 1.2.2 Alcohol craving measurement
    - 1.3 Alcohol consumption measurement
    - 1.4 Treatment to decrease alcohol consumption in alcohol dependents

2. The theoretical basis on Orem's Self-Care Deficit Nursing Theory in used to develop Alcohol Craving Control Program
    - 2.1 Self-care Deficit Nursing Theory
    - 2.2 Alcohol Craving Control Program

1. Alcohol consumption in alcohol dependents

The notion that alcohol consumption can become a chronic damaging self action was first postulated more than 200 years ago. Alcohol consumption is estimated to cause a net harm of 3.7% of all deaths, and 4.4% of the global burden of disease. Alcohol consumption caused much more health burden for men than for women — the alcohol-attributable proportion of men's overall burden was about four times the proportion of women's. For deaths, unintentional injuries were the most important category, followed by cardiovascular diseases and cancers. With regard to the burden of disease expressed in disability-adjusted life years (DALYs) lost, neuropsychiatric disorders, mainly made up of alcohol dependence, constitute the category with the highest alcohol consumption-attributable burden, with unintentional injury being the second most important category. The difference in ranking for deaths and DALYs reflects that while alcohol dependence are often very disabling, they are less often fatal than other disease categories (WHO, 2009).

Alcohol consumption knows as individual action that can quantified of alcohol intake in a variety of ways (Sommers et al., 2003). Alcohol consumption ranges from social drinking to abuse to dependence. Social drinking is defined as sometime consumption and limited the number of consumption, no more consumption than the standard drink (Appendix A) that provided men who consume no more than 2 drinks/day or no more than 4 drinks/week. Abuse is manifested by the recurrent consume of alcohol despite significant adverse consequences, including problems with work, law, personal health, family life, and social relationships (Boyd and Mackey, 2000; Fisher et al., 2000; Perreira and Sloan, 2002). Quantity and frequency of abusers provided men who consume more than 4 drinks/day or 8 drinks/week.

Alcohol dependence is the pattern of continue and increase consumption and often associated with physical and psychological consequences. Quantity and frequency of alcohol dependence provided men who consume more than 6 drinks/day or 14 drinks/week or more than 4 drinks/ occasion (Department of Mental Health, 2004; Dufour, 1999; NIAAA, 2003; NIAAA, 2005).

Focusing on alcohol consumption in alcohol dependents, in the 1940s, Jellinek framed the idea of over alcohol consumption till dependence, a serious health problem, with lack of ability to reduce consumption being its main symptom (Jellinek, 1960). According to the latest edition of the DSM-IV-TR (APA, 2000), focusing on continuous and increase consumption till dependence in alcohol dependence patients, defines the existence of at least three of the following seven symptoms within a 12-month period; 1) Tolerance, as defined by either a need for increased amounts of an alcohol consumption to achieve a desired effect or diminished effect with consume of the same quantity consumption. 2) Withdrawal, as characterized by specific withdrawal syndromes, or consume an alcohol in order to relieve or avoid withdrawal symptoms. 3) Consume an alcohol in larger amounts or over a longer period than was intended. 4) A persistent desire or unsuccessful efforts to reduce or control alcohol consumption. 5) A great deal of time spent obtaining, consuming and recovering from alcohol abuse. 6) Important social, occupational, or recreational activities are given up or reduced because of the alcohol consumption. 7) The alcohol continues to be consuming despite knowledge of resulting serious physical or psychological problems.

In essence, alcohol dependence refers to persons who lack of ability to decrease their consumption that present to compulsive, continued and/or increase

alcohol consumption despite adverse consequences; however the essence of the disease is the individual's attachment to alcohol and the distorted importance it assumes in his life (Miller and Goldsmith, 2001). Alcohol dependence seems to react in individual physical and psychosocial contexts. The details of alcohol consumption impact in alcohol dependents presented in the next section.

1.1 Impact of alcohol consumption in alcohol dependents

Alcohol consumption is an intoxicant affecting a wide range of structures and processes in the central nervous system which, interacting with personality characteristics, associated behavior and sociocultural expectations, are causal factors for intentional and unintentional injuries and harm to people other than the drinker (Rehm et al., 2003), including interpersonal violence (Gil-González, 2006), suicide (Cargiulo, 2007), homicide (Rehm, Patra, and Popova, 2006), crime (Richardson and Budd, 2003) and drink–driving fatalities (Cherpitel, et al., 2003) and a contributory factor for risky sexual behavior (Kalichman, et al., 2007), sexually transmitted diseases (Cook and Clark, 2005) and HIV infection (Fisher, Bang, and Kapiga, 2007). Alcohol consumption is a potent teratogen with a range of negative outcomes to the foetus, including low birth weight, cognitive deficiencies and foetal alcohol disorders (NIAAA, 2001: online). Alcohol consumption is neurotoxic to brain development, leading in adolescence to structural hippocampal changes (Faden and Goldman, 2005) and, in middle age, to reduced brain volume (Taki et al., 2006).

Consuming alcohol is a reinforcing properties and neuroadaptation in the brain (WHO, 2004b). It is an immunosuppressant, increasing the risk of communicable diseases (Gamble, Mason, and Nelson, 2006) including tuberculosis (Lönnroth, et al., 2008). Alcohol consumption is classified as a carcinogen by the International Agency

for Research on Cancer, increasing the risk of cancers of the oral cavity and pharynx, oesophagus, stomach, colon, rectum and breast in a linear dose– response relationship (Allen et al., 2009; Lyons, 2007). Acetaldehyde, which occurs in alcohol consumption as well as being produced in ethanol metabolism, is a potential pathway for cancer risk, with a global average of lifetime cancer risk from alcohol consumption of 7.6 in 10,000 (Lachenmeier, Kantares, and Rehm, 2009).

Alcohol consumption has a bi-form relationship with coronary heart disease. In low and apparently regular doses (as little as 10g every other day), consumed alcohol appears to be cardio-protective (Corrao, 2000), but at high doses, particularly when consumed in an irregular fashion, it is cardio-toxic (Bagardi et al., 2008). It should be noted that considerable concern remains about the extent to which the observed cardio-protection is due to systematic definition errors (Fillmore et al., 2007), drinking patterns and genetic factors (Djousse and Gaziano, 2008), and the extent to which the size of the protective effect is overestimated (Jackson, 2005).

In order to understand alcohol consumption reaction in alcohol dependents, Straussner and his college (1985) the first presented effect on the central nervous system. Alcohol is slow down, or sedate, the excitable brain tissues. Such sedation affects the brain centers that control speech, vision, coordination, and social judgment. The individual also experiences increased agitation and excitability when coming off alcohol—a withdrawal effect commonly known as a hangover. Individuals under the influence of alcohol or other central nervous system (CNS) depressants are likely to have poor judgment, which is often manifested in inappropriate and even destructive behavior. Whereas low doses of a CNS depressant, particularly alcohol, block the usual inhibitions, making the person appear to be relaxed or unreserved,

high doses slow down the heart rate and respiration, produce lethargy and stupor, and may result in death. Typical clinical features of alcohol withdrawal include the following (Becker, 2000). Sings of heightened autonomic nervous system activation, such as rapid heartbeat (i.e., tachycardia), elevated blood pressure, excessive sweating (i.e., diaphoresis), and shaking (i.e. tremor). Excessive activity of the CNS (i.e., CNS hyperexcitability) may culminate in motor seizures and hallucinations and delirium tremens in the most severe from of withdrawal. In addition to physical signs of withdrawal, a constellation of symptoms contributing to a state of distress and psychological discomfort constitute a significant component of the withdrawal syndrome (Schuckit et al, 1998). These symptoms include emotional changes such as irritability, agitation, anxiety, and dysphoria, as well as sleep disturbances, a sense of inability to experience pleasure (i.e., anhedonia), and frequent complaints about “achiness”, which possibly may reflect a reduced threshold for pain sensitivity. Many of these signs and symptoms, including those that reflect a negative-affect state (e.g., anxiety, distress, and anhedonia) also have been demonstrated in animal studies involving various models of dependence (Becker, 2000). Although many physical signs and symptoms of withdrawal typically abate within a few days, symptoms associated with psychological distress and dysphoria may linger for protracted periods of time (Martinotti et al., 2008). The persistence of these symptoms (e.g., anxiety, negative affect, altered reward set point manifesting as dysphoria and/or anhedonia) may constitute a significant motivational factor that leads to relapse to heavy consumption.

Furthermore, the last impact of alcohol consumption in persons with alcohol dependence include living with an alcohol dependence family member is typically full

of inconsistency and unpredictability, resulting in a chronic state of crisis. Legal and financial problems, serious illnesses, and various accidents are common occurrences that intrude on family life. When the alcohol dependence is a parent, dysfunctional cross-generational alliance and role reversal (i.e., children assume parental roles and responsibilities) are frequently seen (Straussner, 1994). Child neglect and, in more disturbed families, violence between parents, and child abuse, alcohol dependence is present in at least two-thirds of the families known to public child welfare agencies (Hampton, Senatore, and Gullotta, 1998). The sons of alcohol dependence fathers are four times more likely to become alcohol dependence, and the daughters of alcohol dependence parents are three times more likely to become alcohol dependence (Straussner, 1985). In sum, the alcohol dependence affects individuals, families, communities, and society as a whole.

1.2 Factors related to alcohol consumption in alcohol dependents

Factors related to consumption and engage to alcohol dependence include physical, psychological and social-environmental factors. Physical factors included age, gender, education, status, family systems, sociocultural (Jiraporn Thapnoo, 1997; Potiast, 1998; Avussada Chansantor, 1999; Poikolainen, 2000; Assansngkornchai et al., 2002; Schuckit, 2002; Greenfield et at., 2003; Pastor and Evans, 2003; Walton, et al., 2003; Kanittha Thaikla, 2005; Sangcharnchai, 2005), and individual's disease such as diagnosis of mental illness (e.g., bipolar disorder, schizophrenia), and antisocial behavior (Poikolainen, 2000; Schuckit, 2002; Tizabieal, et al., 2002). Psychological factors included high levels of stress, anxiety, low self-efficacy, lack of coping skill and positive alcohol expectancy. (Poikolainen, 2000; Stein, Goldman, and

Del Boca, 2000; Walton et al., 2003; Nurod, 2004;). Social-environmental factors included having friends or close partner who drinks. (Poikolainen, 2000; Donovan, 2004). All of these factors can come together in the specific time of individual and had presented pass the craving concept. In the last decade, many clinicians and researchers in alcohol dependence field believe that the concept of craving is central experienced by people with alcohol dependence (Anton, 1999; Drummond, et al., 2000; Monti et al., 2000). With the progress of the craving studies in the past, the detail of alcohol craving presented as follow.

1.2.1 Alcohol craving

Craving condition is seen as the key substrate of alcohol dependence and the driving force behind continued and/ or increased consume alcohol in spite of increasingly severe consequences (Larimer, Palmer, and Marlatt, 1999; Drummond et al., 2000; Schneider et al., 2001; Grusser, Morsen, and Flor, 2006; Hillemacher et al., 2006). Jellinek (1960) regarded craving for alcohol and relapse (or 'unsuccessful decrease consumption') as being related. In Jellinek's view, craving was in part due to a true physical demand for alcohol as a result of changes in cellular metabolism. Such belief in the central role of craving as the 'cause' of alcohol dependence had their roots in careful clinical observations.

The term 'craving' had been used in many different ways by different researchers. According to Webster's New World Dictionary (1996), the definition of craving as "a strong desire" and how persons with alcohol-related problems use the word to mean any desire or urge, even a weak one, to drinking. Monti and his college (2000) defined craving as an urge that refers to wanting or desiring alcohol. In this study, craving is taken to be 'the conscious experience of a desire or urge to drink

alcohol'. Cognitive social learning theory (CSLT), presented that how recovering alcoholics respond to conditioned alcohol associated stimuli will depend on their psychological expectations and coping skills. Marlatt and George (1998) distinguish craving, relatively sudden impulses to consume alcohol, from cravings, subjective desires to experience the effects of alcohol consumption.

The concepts of classical conditioning have had a major impact on theories of alcohol craving. Within classical conditioning, alcohol 'cues' are considered conditioned stimuli; that is, properties of people, places or things that have come to be reliably associated in space and time with the direct unconditioned effects of alcohol, and which come to evoke conditioned responses usually similar (but sometimes opposite) to the unconditioned alcohol effect, for example, salivation, alcohol craving, and alcohol seeking (Drummond et al., 2000). It is dominated by the negative effects of opponent processes, that craving has been observed, by clinicians, dependence patients alike, to be exceptionally strong and to recur frequently. The learning process is one whereby an individual learns through repeated experience that a particular behavioral response has predictable effects on a specific environmental goal (e.g. obtaining food or alcohol), and therefore is more likely to repeat the response again. Reinforcement is an operant conditioning process that involves the consistent presentation of a stimulus (positive reinforcer) or the consistent removal of a stimulus (negative reinforcer) contingent upon a particular response, which then tends to increase the probability that the response or behavior will be repeated. Consuming alcohol to experience hedonic reward or to alleviate negative symptoms of withdrawal are common interpretations of positive and negative reinforcement in alcohol studies.

Cues are thought to trigger a series of responses including craving to consume alcohol, positive outcome expectations for alcohol use, that is, for initial effects of alcohol. Depending on which affective circuit is activated, a somewhat different pattern of responses will emerge. For example, if negative affect is the precipitant, this is likely to trigger outcome expectations concerning alcohol-induced relief from distress. Physiological responses may include conditioned withdrawal symptoms or arousal associated with escape motivation. If positive affect is the precipitant, then outcome expectations are likely to involve anticipation of pleasurable experiences. The pattern of physiological adjustments may also prepare the individual to obtain the substance, and may reflect attention processes being directed toward alcohol-use cues (Drummond et al., 2000).

Once either of the positive or negative affect circuits is activated, hypothesize that there will occur an interaction with cognitive– behavioral coping efforts and attributions. So for example, if the cluster of craving, outcome and physiological reactions is intense, then this will undermine existing coping skills and contribute to attributions that this state is uncontrollable, stable and caused by personal factors (e.g. age, status, education, income, family system). However, to the extent that cognitive–behavioral coping can be brought to bear, and to the extent that causal attributions for the state are congruent with personal control, then the system will be dampened and the probability of alcohol consumption will decrease. Perceives ability is thought to be centrally interactive with reactions to cues and coping efforts, such that efficacy inhibits craving and outcome expectations and increases the likelihood of coping and, reciprocally, craving and outcome expectations decrease confidence (Drummond et al., 2000).

In laboratory and field settings, Litt et al. (2000) demonstrated that craving for alcohol have severe alcohol dependence and grater mood disturbance (especially anger and anxiety). In laboratory setting, negative mood and alcohol cues increased alcohol craving (Cooney et al., 1997). Two investigative groups noted that stress played an important role in alcohol craving and relapse (Sinha, 2001; Breese et al., 2005). Malcolm et al. (2000) showed that alcohol craving and previous multiple detoxifications were correlated.

In 1998, Weinstein and his colleges (Weinstein et al., 1998) conducted intervention to study factors that makes alcohol dependence early in abstinence crave for alcohol. The studied has compared the three major induction procedures of exposure to consume alcohol (alcoholic and nonalcoholic by holding a drink and smell it), imagery of situations that elicit alcohol craving (compared with neutral situations), and recall of autobiographical memories of craving for alcohol (compared with neutral memories). Researchers predicted that, in each of the three procedures (exposure, imagery, and autobiographical memory), the exposure to alcohol-related condition would result in increases in subjective ratings of craving and urges and autonomic measures of heart rate and systolic blood pressure, compared with the neutral condition. Researchers further hypothesized that imagery and autobiographical recall of craving will be equally effective as exposure to alcoholic drinks at eliciting self-reported urges. Finally predicted that imagery and autobiographical recall of craving will be equally effective as exposure to alcohol at eliciting physiological urge indices. The results of the studied supported the hypothesis all three factors were significant induced craving in subjects.

In 2000, Monti and his colleges (Monti et al., 2000). had summarized the relation of factors appear to increase alcohol consumption when experiencing craving include: a) factors that increase the motivation to consume alcohol, such as positive expectancies about alcohol, negative emotions and certain physiological states (e.g., low levels of certain chemicals in the brain), b) factors that decrease the awareness of danger, such as lack of knowledge on cause and effect of alcohol, overconfidence or maladaptive beliefs about the riskiness of a situation as well as physiological states that decrease general awareness (e.g., overtiredness), c) factors that decrease the effectiveness of coping, such as in adequate coping skills, or highly complex situations. The authors suggested clinicians should be help patients recognize that craving are a danger sign they should be have ability to control by improve some specific skills.

Investigate specific factors that influence craving in alcohol dependence patients in this study and help them to manage those factors to control craving that affected on their alcohol consumption. A review of the literature guided the researcher to summarize the three factors that related to alcohol craving in this study included cue that can stimuli the alcohol dependents to crave, negative affect of decrease alcohol consumption as withdrawal symptom that can caused their craving to consume to relief from distress, and positive affect of alcohol consumption that can made them pleasure.

1.2.2 Alcohol craving measurement

This section presented the review of alcohol craving measurement. Clinically, use of craving ratings during therapy may enable clinicians to better tailor treatment to individual patient needs (Flannery et al., 2001). The assessment of

cravings has improved significantly over the past 10 years. Previously, single-item analogue measures were used to assess craving. However, concerns about single-item measures of such a complex construct led to the development and rigorous testing of several multidimensional measures of craving. Modell and his colleges (Modell et al., 1992) adapted the Yale–Brown Obsessive Compulsive Scale (Y-BOCS) to measure cravings for alcohol in a sample of heavy drinkers. Later, Anton and others (1995) revised the Yale–Brown Obsessive Compulsive Scale–Heavy Drinking into the Obsessive Compulsive Drinking Scale (OCDS), a 14-item self-report measure with subscales for alcohol-related obsessions and compulsions. Anton and others (1995) reported that the OCDS was easy to administer and had good reliability and validity. The OCDS has been subjected to a substantial psychometric analysis in clinical research studies. At first it was thought that the OCDS measured only obsessive and compulsive dimensions of alcohol cravings (Anton et al., 1995); however, several factor analytic studies have suggested three or four factors (Kranzler et al., 1999; Roberts et al., 1999) that include resistance and control impairment describes the lack of success in the control of alcohol consumption, obsession describes the distress of anxiety caused by a preoccupation with alcohol-associated ideas or impulses, and interference describes the degree of interference with social or work functioning. Studies of construct validity have shown significant relationships between total OCDS scores and measures of alcohol problem severity (Kranzler et al., 1999; Roberts et al., 1999). Studies have shown that OCDS scores change over the course of treatment and reflect respondents' consuming status (Anton et al., 1995; Kranzler et al., 1999; Roberts et al., 1999).

1.3 Alcohol consumption measurement

This section reviewed the instrument in used to measure alcohol consumption. Instrument to measure alcohol consumption-related problems usually involves asking the patient questions about consumption through structured interviews of self-report questionnaires. Several alcohol questionnaires have been tested and validated in clinical setting, including brief, structured interviews that contain questions on the quantity and frequency of consuming; questionnaires that can be self-administered or used in an interview by health professional. This instrument should have high sensitivity and specificity (Israle et al., 1996).

Interviews: Quantity-Frequency Questions. Currently, the standard of practice for most clinicians is to ask patients how much and how often they consumed alcohol. To make the responses to these “quantity - frequency” questions uniform. The level of alcohol consumption that poses a risk for developing alcohol-related problems differs for men and women (National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2005). Quantity and frequency questions allow the clinician to estimate a patient’s risk directly. They are also easy to score and can be included as part of an office visit with minimum cost and effort. Examples of quantity and frequency questions include the following:

- On average, how many days per week do you consume alcohol?
- On a typical day when you consume, how many drinks do you have?
- What is the maximum number of drinks you had on any given occasion during the last month?

Such questions generally have high sensitivity in detecting persons who consume above recommended limits. However, some patients may understate

their consuming, especially if they are alcohol dependence or are intoxicated at the time of the interview.

Most of the questionnaires focus on the consequences of patients' consuming and their perceptions of their consuming behavior. Commonly used questionnaires were reviewed by NIAA in 2000 (NIAA, 2000a) whose effectiveness has been examined include the following:

• The CAGE instrument, which consists of four questions about the patient's consuming and family or friend s' reactions to it; one or more "yes" answers indicate an increased risk of alcohol-related problems in both men and women.

• The Alcohol Use Disorders Identification Test (AUDIT), which was developed from a World Health Organization (WHO) collaborative project. It consists of 10 questions regarding the patients' alcohol consumption, consuming behavior, and alcohol - related problems over the past year. The AUDIT's sensitivity varies, however, depending on the study population and the cutoff score used. Further more, the AUDIT may be less effective for detecting alcohol problems among people who barely meet the criteria for at-risk consuming. Finally, the length of the AUDIT may make its administration cumbersome for some physicians or patients. It may be more useful for assessing patients after a possible problem has been detected by other methods.

• The Health Screening Survey and the Health Screening Questionnaire , which include questions about alcohol consumption as well as other health questions (e.g., on smoking, weight, exercise, and depression). Both instruments have adequate sensitivity and specificity.

• The Primary Care Evaluation of Mental Disorders (PRIME-MD), a relatively new instrument that includes the four CAGE questions and two questions on alcohol consumption. The PRIME-MD also can be used through telephone-assisted computer administration.

• The Alcohol Use Disorders Identification Test Consumption (AUDIT-C) consists of the first three questions of the AUDIT (Saunders et al., 1993), deemed the AUDIT-C because it is based solely on items reflecting alcohol consumption, has come into increasing use as an alternative to other brief screeners for alcohol consumption problems. Many researchers had tested the effectiveness of this instrument and the results showed an excellent screening for alcohol consumption related to misuse or alcohol use disorder (Knight et al., 2003; Reinert and Allen, 2002; Kokotailo et al., 2004).

Many alcohol consumption measurements were found which developed for many objectives in used such as screening tools and also investigated severity of consumption. In this study which the objective to measure alcohol consumption to compare the change before and after received the intervention the researcher developed the new Alcohol Consumption Assessment (ACA) that included 3 questions as type of alcohol consumption, frequency of consumption for one week, and quantity of alcohol intake per time and calculated into the standard drink that for evaluation outcome in this study.

1.4 Treatment to decrease alcohol consumption in alcohol dependents

This section presented the literature reviewed about the treatment to decrease alcohol consumption in alcohol dependents. The detail as follow:

1.4.1 Alcohol detoxification

Alcohol detoxification is the first step in treatment. The definition of detoxification is as follows: "A treatment for alcohol dependence intended to rid the body of the alcohol, and the physiological and mental readjustment that accompanies the process." This definition refers to the physical withdrawal symptoms of alcohol dependence, as well as the psychological symptoms experienced while in alcohol detoxification. Persons with alcohol dependence require detoxification before beginning treatment and recovery. When alcohol residuals remain in the body, cravings will continue and recovery from alcohol dependence will be very difficult to achieve. Attempting to detoxification from alcohol without the proper professional help is extremely dangerous. It can result in serious physical, psychological, and emotional consequences which can include death (Peele, 1987).

The goal of alcohol detoxification is to rid the body of toxins accumulated by alcohol. The first step of detoxification is withdrawal symptom. Alcohol withdrawal is "the act or process of ceasing to consume alcohol." Once an individual has discontinued consuming physical and behavioral withdrawal symptoms may follow. Alcohol detoxification is a process that helps diminish the uncomfortable symptoms of alcohol withdrawal. Alcohol detoxification is performed in many different ways depending on where the patients decide to receive treatment. Most alcohol detoxification centers simply provide treatment to avoid physical withdrawal to alcohol. A quality drug detoxification program will not only to provide the individual with counseling during detoxification but help with the physical withdrawal and the psychological root cause of the individual’s problem, so as to decrease the chances of relapse (Peele, 1987).

Usual care in alcohol dependents at Thanyarak Institute on Drug Abuse started with detoxification ward. As the setting in this research, usual care in this setting was presented in this part.

1.4.1.1 Alcohol detoxification in Thanyarak Institute on Drug Abuse

Alcohol detoxification ward is the setting for first admitted for all alcohol dependence. The treatment and caring can be viewed in three separate stages:

1. Medical Detoxification: A medical doctor was needed to supervise patients' medical withdrawal from alcohol, ensuring patient complete this phase safely and with minimal complications. Medical detoxification can take no more than 2 weeks.

2. Physical Detoxification: Once patient body is no longer dependent on alcohol, patient was needed to work on building up their physical health. A nutritionist could helpful during this phase. This health care center offer the food court and allowed the patients' to buy other foodstuff that can help to enabling them to develop a balanced diet and help them through the rest of the alcohol detoxification process. Exercise was also included in this step nurses had responsibility to promote all this activity together with the patients.

3. Psychological Detoxification: Detoxification can be extremely difficult on the patients' emotional health, which is why most treatment centers offer counseling during detoxification. Because alcohol has become an integral part of patients' mental, emotional and social life. The usual care of this center provided 2 individual and one family counseling with alcohol consumption

problem by nurses for the patients. Provided education, suggestion and support were used in this step.

1.4.2 Psychological treatment

A broad range of psychological treatments and philosophies are currently used to treat alcohol dependence, including social skills training motivational enhancement, behavior contracting, cognitive therapy, marital and family therapy, aversion therapy, and relaxation training. These varied approaches have different levels of scientific support for their effectiveness. The task for the scientific community is to evaluate the various approaches and determine which strategies offer the best chances of successful outcome, with the understanding that some types of treatment may have better results for certain types of patients (Miller, Wilbourne, and Hetema, 2003; UKATT Research Team, 2005a; b; Raistrick, Heather, and Godfrey, 2006) with evidence of effects for behavioral therapies, where a systematic review of 17 studies found a combined effect size of 0.33 (SE=0.08) for reduced alcohol consumption and alcohol-related difficulties (Walters, 2000). There is evidence that matching individuals with alcohol dependence to specified treatment does not improve outcome (Babor et al., 2003). Although Project MATCH found a significant positive impact of treatment and no differences in outcome between 12-step facilitation therapies designed to help patients become engaged in the fellowship of Alcoholics Anonymous, a 12-session cognitive behavioral therapy designed to teach patients coping skills to prevent a relapse into drinking, and a motivational enhancement therapy designed to increase motivation for and commitment to change (Babor et al., 2003), the mesa-grand study found evidence of ineffectiveness of 12-step facilitation from 6 studies and of ineffectiveness of Alcoholics Anonymous from

7 studies (Miller, Wilbourne, and Hetema, 2003). An additional systematic review of 8 studies found no studies that unequivocally demonstrated the effectiveness of Alcoholics Anonymous or 12-step facilitation approaches for reducing alcohol dependence or alcohol-related problems (Ferri, Amato, and Davoli, 2006).

Brief interventions are time-limited counseling strategies that are especially useful in busy, high volume health care practices, where physicians are often pressed for time and have multiple priorities. These techniques can be used to reduce alcohol consumption in patients who consumed above the recommended levels but who are not alcohol dependent. They may also be helpful in motivating patients with alcohol dependence to seek specialized alcohol treatment (Welsh, 2000). Research supported this presented by Gentiello et al. (1999) studied among the patients for whom the intervention was completed, alcohol consumption was decreased significantly at 12 months compared with the control group. The difference was most pronounced in patients with mild-to-moderate consumption problems, whereas no benefit was seen in patients with severe consumption problems.

Kumlarn (2004) studied group cognitive behavioral therapy on alcohol consumption in 20 patients with alcohol dependence in Thailand. The intervention included motivation to decrease or stop consumption, analysis factors related to consume alcohol, and cognitive and behavior change with plane for change within 5 sessions in 1 week. Results evaluated in 2 months showed 9 cases could stop consumption over times and 11 cases could decrease their consumption. Interesting between follow-up in 2 weeks after completed intervention the participants presented first slip in more than a half of case.

Plangklang and Singkakul (2006) studied the effect of motivation interviewing intervention in 80 alcohol dependence patients who received motivation interviewing program within 3 sessions to decrease alcohol consumption in 3 months follow-up. Data presented 37.5% stopped consumption, 42.5% relapsed and 20% failed the follow-up.

Alcohol consumption viewed as learned behaviors that are acquired through experience. If alcohol provides certain desired results (i.e., good feelings, reduced tension, etc.) on repeated occasions, it may become the preferred way of achieving those results, particularly in the absence of other ways of meeting those desired ends. From this perspective, the primary tasks of treatment are to (1) identify the specific needs that patients are being used to meet, and (2) develop skills that provide alternative ways of meeting those needs (Kadden, 2002). Most patients in treatment will have tried either on their own or in previous treatment to abstain from alcohol or moderate their consumption. Asking patients to describe past relapses may provide important clues to future high-risk situations and deficit in skills to cope with that. Nurses and patients can classify the descriptions of past relapse into the categories previously presented in order to determine the situational or personal factors that had the greatest impact. It is also useful to determine the patient's attitude toward these past 'failures' to remain abstinent of to consume moderately, because many patients develop negative attitudes toward future change attempts, based on attributions that they have a deficit in willpower or self-control. Reframing of past relapse will be necessary to reduce the patient's fear of the prospect of yet another failure. Nurses can encourage the patient to attribute past relapse as due to a lack of skill or effort, not to immutable internal factors.

A number of knowledge and skills training in psychological treatment related to decrease alcohol consumption are available. The overview of these knowledge and skills presented below.

1.4.3.1 Cue exposure

One behavioral model of alcohol dependence is predicated on the associative learning principle that originally, neutral stimuli that regularly precede alcohol consumption can, with repeated pairings, become capable of eliciting conditioned responses that may prompt further alcohol consumption (Niaura et al., 1988). Some adherents of approach invoke a model based entirely on Pavlovian (respondent) conditioning, in which conditioned stimuli directly elicit alcohol consumption, whereas others invoke a two-stage process in which conditioned stimuli elicit interoceptive responses, which serve as discriminative stimuli that set the occasion for, and increase the likelihood of, alcohol consumption (Pomerleau et al., 1983). Both version of the model entail assumptions about alcohol dependence's reactivity to environmental cues and the relationship of that reactivity to subsequent alcohol consumption. Consequently, researchers have examined the relationship of alcohol cues to behavioral, physiological, and cognitive responses, the relationship of those responses to subsequent alcohol consumption, and the clinical efficacy of cue exposure as a treatment procedure (Dummond, Cooper, and Glautier, 1990; Rohsenow et al., 1991). A recent meta-analysis of 41 cue reactivity studies indicated that self-reported craving can be elicited by cue exposure (Carter and Tiffany, 1999). In a study focused on training moderate alcohol consumption, Sitharthan and others (1997) compared the cue exposure (with priming doses of alcohol) to a cognitive-behavioral intervention. They found cue exposure to be superior at a 6-month follow-

up in terms of consumption frequency and quantity. They speculated that the priming dose of alcohol may have enhanced generalization of the effects of cue exposure to participants' natural environments.

Litt and others (2000) examined alcohol consumption antecedents that occur in the natural environment, on the assumption that some of the critical variables that elicit alcohol consumption have not been captured in the laboratory. They compared cue-elicited craving in the laboratory with craving that occurred in participants' natural environments, through the use of hand-held computers. Cravings elicited in the laboratory via cue exposure were not predictive of subsequent consumption, but craving recorded in the field were, tending to grow prior to consume and to decline afterwards. These findings provide early evidence for the possible benefit of field studies employing experience-sampling methodology as a means of identifying and studying factors that control alcohol consumption behavior. Stasiewicz and others (1997) recommend caution in using emotional arousal cues. They found that greater exposure to negative emotional cues was associated with greater craving to consume and negative emotional responses. Another factor that may impact responsively to alcohol cues is clients' perception of actually being able to consume the alcohol used as the cue. Laberg (1990) demonstrated that the most successful way to elicit craving in the laboratory was to inform participants that they were allowed to consume the alcohol that was shown to them in the cue-exposure paradigm.

In 2001, Rohsenow and his colleges demonstrated the study to test the effective of cue exposure with coping skills training (CET) and communication skills training (CST) for alcohol dependence: 6 and 12 months

outcome in 100 patients diagnosed. Patients who received either CET or CST had fewer heavy consumption days in the first 6 months than control patients. In the second 6 months, CET continues to result in fewer heavy consumption days among lapsers and increased with CST to decrease quality of alcohol consumed. CET also resulted in greater reports of use of coping strategies during the follow-up, and many of the craving-specific strategies taught in CET were associated with reduced alcohol consumption (Rohsenow et al., 2001).

1.4.3.2 Withdrawal symptoms

Following chronic alcohol consumption, the removal of alcohol reliably produces a constellation of withdrawal symptoms, some of which increase the motivation to seek and consume alcohol (i.e., have motivational significance). Although alcohol withdrawal symptoms vary in severity according to the history of the individual, they are qualitatively similar across species. The physiological aspects of withdrawal in humans and rodents usually last up to 48 hours following termination of alcohol consumption and include convulsions, motor abnormalities, and autonomic disturbances (e.g., sweating, higher heart rate, and restlessness) (WHO, 2004b). Additionally, withdrawal is associated with a negative-affective state characterized by anxiety, dysphoria, and irritability that typically develops during early stages of withdrawal but can be very long lasting. Perhaps the most reliable of these disturbances across species is an increase in anxiety (Valdez et al., 2002). In this sense, inform knowledge about this symptom and motivate adherence with medication and also advice for self-care prevention when some symptom were presented such as depth breathing, relaxation, rest in open air can made them feel better (Tabakoff and Hoffman, 1996).

1.4.3.3 Emotional

Emotional arousal itself could elicit craving to consume alcohol. In the Cooney and others (1997) studied, the craving to consume alcohol that was aroused by cue exposure plus emotional arousal did predict time to relapse. Some patients may experience difficulty expressing their emotional, feeling, or communicating effectively and sensitivity with their relative, especially where there is considerable conflict and tension as a result of alcohol consumption. This can be a bar to intimacy, both emotional and sexual. Patients are taught about self-disclosing their emotions, sharing their positive feeling, and the importance of expressing negative feeling (in an appropriate way) to prevent things from building up. They may also be taught listening skills, which are an essential component of an intimate relationship. Patients practice these skills in simulated draw from their recent past in which they felt angry, anxious, or sad with love ones (Cooney et al., 1997).

1.4.3.4 Stress management

As presented in the earlier both genetic and environmental factors play significant roles in determining alcohol consumption. Stress is one of environmental factor that may influence the initiation and continuation of heavy consumption. For instance, in study with human, increased levels of anxiety and stress were associated both with high alcohol consumption and with relapse to heavy consumption by abstinent alcohol (Kushner et al., 1990). Similarly, De Wit (1996) found that stressful life events, as well as onetime (i.e., acute) reexposure to alcohol, caused abstinent alcoholics to experience increased alcohol craving and to relapse to consume.

Stress is a very common antecedent to alcohol consumption. Patients are taught about the warning signs of stress, both external and internal signs, so they can identify them early and begin to manage them before stress grows strong and becomes harder to control. To the degree that stress causes unpleasant physical sensation and associated dysphoric mood, it is a high-risk situation for uncontrolled alcohol consumption. Skills for managing stress include the use of clam-down phases, identify aspects of a situation that are provoking stress, and considering options that might help to resolve the situation. Relaxation techniques include muscle relaxation, imaginary, or deep-breathing. These skills can be modeled by the provider and then role-played by the patients. Negative thinking is related to stress. Patients are taught to recognize various types of negative thinking habits that may occur automatically. Skills for managing negative thoughts include substituting positive thoughts of feeling, thought stopping, and positive self-talk. Exercises give patients in identifying their negative thinking and negative self-talk, and provide an opportunity for them to prepare alternative, substitute response (Healther and Stockwell, 2004).

1.4.3.5 Pleasant activities

Patients may discover a void in their lives as free time become available one they are no longer so occupied with acquiring, using, and recovering from the effects of alcohol. They may also find that they are leading an unbalanced lifestyle in which they fulfill numerous obligations, with little if any time devoted to recreation or self-fulfillment. A pleasant activities plan is intended to help patients prepare enjoyable, low-risk ways of fulfill the free time that will be opened

up, and achieve a better balance between their obligations and more enjoyable or self-fulfill activities (Heater and Stockwell, 2004).

1.4.3.6 Drinking refusal

Knowing how to cope with offers to consume alcohol is an important skill for the majority of chemically dependents patients because such offers are fairly common. Patients are taught to say “no” convincingly without giving a double message, to suggest an alternative activity that does not involve substance use, to change the subject to a different topic of conversation, and if the other person persists, to ask him not to offer alcohol any more. With considerable practice of this skill, patients should be able to respond quickly and convincingly when these situations arise. Role-play of refusal scenes progress from ones that are easy to handle, building to more persistent offers that are difficult to refuse. People often feel discomfort when refusing other peoples’ requests for favors, and therefore may tend not to do so. However, failure to refuse to do something they really don’t want to do can leave them feeling imposed upon, self-critical, resentful, or anger, any of which may serve as cure for craving or consumption. Patients are taught to refuse unwanted requests by first acknowledging the requesting person’s position and feeling, and to then make a firm, clear statement of refusal. They are also taught to consider whether or not a compromise might be appropriate under the circumstance (Heater and Stockwell, 2004).

1.4.3.7 Balance blood sugar

One of the things that can easily induce a craving for alcohol is low blood sugar. The craving comes about because the body associates alcohol consumption with lots of quickly available carbohydrates. So the one thing

that needs to do when the patients are cutting down the alcohol intake is keep blood sugar levels fairly balanced. Next time when get a craving for alcohol, eat something instead that can leaded to feel how quickly that craving disappears (Bright eye, 2010: online).

1.4.3.8 Reminder cards

Just as a reminder cards is used to automate the patient's emergency response to a lapse, reminder cards are designed to help patients deal with intense cravings at a time when they may have trouble generating adaptive thoughts and self-care actions (Heater and Stockwell, 2004). A sample card included 'stop drinking, stop poverty-stricken', and 'sheer up Dad, I know you can'.

1.4.3.9 Coping with lapses

The occurrence of a lapse, while not a catastrophe, cannot be viewed as a totally harmless event. It is a moment of crisis that combines both danger and opportunity, with the most dangerous period immediately following the slip (Heater and Stockwell, 2004). There are several recommended strategies to employ whenever a lapse occurs. The following strategies for self-care with lapse are presented by Marlatt and Gordon in1985.

1. Stop, look and listen. The first thing to do when a lapse occurs is to stop the ongoing flow of events and to look and listen to what is happening. The lapse is a warning signal indicating that patients are in danger.

2. Keep calm. The first reaction to a lapse may be one of felling guilty and blaming oneself for what has happened. This is a normal reaction and is to be expected. Motivated patients to allow this reaction to arise and to pass

away just like an ocean wave that builds in strength, peaks at a crest, and then ebbs away.

3. Renew patient's commitment. After a lapse, the most difficult problem to deal with is motivation. Patients may feel like giving up. Supportive them to think back over the reasons why they decided to change self-care behavior in the first place. Renew the commitment.

4. Review the situation leading up to lapse. Support the patients don't yield to the tendency to blame themselves for what happened. Instead, look at the slip as a specific unique event. Ask the patients the following questions. What events led up to the slip? Were there any early warning signals that preceded the lapse? What was the nature of the high-risk situation that triggered the slip?

5. Implement self-care planning. First get rid off all alcohol of other stimuli associated with consumption. Second, motivate to remove from the high-risk situation if at all possible.

6. Ask for help. Support them to make it easy if they find that they need help: ask for it. Communicated to other relative who are present to help in any way they can if the participants are alone, feel free to call to nurse and seek out their assistance and support.

After the lapse has occurred, the patients should be reassured that nurses or their relative will not censure or blame him for the mistake, as often occurs in traditional programs. Instead, patients should receive compassion and understanding, along with encouragement to learn everything possible about how to deal with similar situations in the future through a thorough debriefing of the lapse and its consequences. Patients are taught to review the details of the events and

thoughts that led to the high-risk situation, to develop and practice new self-care responses that are likely to be more effective in future situations, and to reframe their reactions to the slip as an error that is correctable with effort on their part and not as a sign of failure or moral weakness (Marlatt, 1985).

Whatever happened, the continued vulnerability to relapse still exhibited. Vulnerability to relapse remains relatively high for significant periods of time after standard treatment protocols, started with 2 weeks later with slip and relapse within 8-24 weeks have ended (McLellan et al., 2000; Dennis, Scott, and Funk, 2003). Better management requires longer periods of continued contract with the patients (McLellan et al., 2005). Over the past 20 years, many successful and creative intervention and also telephone counseling programs have been documented to continued contract with patients. Early adopters of telephone counseling demonstrated high satisfactions rated among patients and providers. Most intervention and also telephone counseling programs documents increased efficiency, decreased readmissions and emergency room visits. Key component of the telephone counseling are to educate and support patient and the number one goal is to generate good, quality outcomes. Educate and support patients to participate in monitoring their health state and make lifestyle modifications to get better health. (Britton et al., 1999).

2. The theoretical basis on Orem's Self-Care Deficit Nursing Theory in used to develop the Alcohol Craving Control Program:

2.1 Self-Care Deficit Nursing Theory

The Self-Care Deficit Nursing Theory (Orem, 2001) is based on a model of practical science with theoretic and practical components, models of human assistance in societies, practical insight into situation as a necessary basis for creativity and change, model of result-producing practical endeavor and deliberate human action. The theory consists of four concepts about persons under the care of nurses, two nurse-related concepts, and three interrelated theories (the Theory of Self-Care, the Theory of Self-Care Deficit, and the Theory of Nursing Systems). Concepts in the general theory include, self-care, self-care agency, therapeutic self-care demand, self-care deficit, nursing agency, and nursing systems. The theory describes and explains the individuals have the acquired ability to care for themselves, termed self-care agency. The type and kind of self-care needed is determined by general health requirements, developmental requirements, and requirements as a result of illness. Collectively these sets of self-care needs are the therapeutic self-care demand. When an individual's self-care agency is less than the therapeutic self-care demand, a self-care deficit arises. When a self-care deficit is present, there is a need for nursing intervention.

The comprehensive development of the self-care concepts enhances the usefulness of the Self-Care Deficit Nursing Theory as a guide to nursing practice situations involving individuals across the life span who are experiencing health or illness, and to nurse-client situations aimed at health promotion, health restoration, or health maintenance. According to this theory, nurses use their specialized capabilities

to create a helping system in situations where persons are deemed to have an existent or potential self-care deficit. Decisions about what type of nursing system is appropriate in a given nursing practice situation rests with the answer to the question, “who can and should perform the self-care operations?” (Orem, 2001: 350). When the answer is the nurse, a wholly compensatory system of helping is appropriate. When it is concluded that the patient can and should perform all self-care actions, the nurses assumes a supportive-educative role and designs a nursing system accordingly. Orem states that in nursing practice the relation of the concepts of basic conditioning factors, therapeutic self-care demand, self-care agency, self-care, and nursing system should be consideration and understood.

2.1.1 Basic conditioning factors

In 1974, the Nursing Development Conference Group [NDCG] define a basic conditioning factors as “have as their referents existent human conditions or ongoing series of events that exercise an active influence on identifiable human abilities (self-care agency), and human requirements (self-care requirements) with in a time frame or affect the means that can be used to meet requirements”. The number of basic conditioning factors, the magnitudes of which are changing rapidly, will increase the complexity of nursing practice situations (NDCG, 1979: 171).

Know relationships between a conditioning factor and these human operations and requirement can be expressed as a conditional proposition. According to Orem’s theory (2001) the basic conditioning factors can be organized into four sets as follow; *the first set* describes the person who is nursed. The factors in the set include age; gender; environmental features; family system factors including status, patient’s position in the family, and information about other family members, with

relevant details about residence and relationship with the patient; sociocultural factors including education, occupation, experience or life experience; socioeconomic factors including resources currently available or potentially available. *The second set* has only one factor, that is, the pattern of living of the patient. Information sought included usual and repetitively performed daily activities, including self-care measures performed daily; activities perform at other intervals of time, including recreational activities and self-care measures; amount of time spent alone and with others; adjustments in pattern of living imposed by health state and health care system factors; and responsibilities for other persons, a household, pets, a garden, or a business farm. *The third set* of factors includes health state and health care system factors. Health state conceptualizes as having anatomic, physiologic, and psychologic features. *The fourth set* includes the factors of developmental state in its relation to the existence and the meeting of developmental self-care requisites under known environmental conditions (Orem, 2001: 326).

Analysis of statement by Orem revealed that all of the basic conditioning factors may not be relevant in every situation. For example, factors such as health state and health care system factor condition the therapeutic self-care demand through the emergence of new requisites, while the individual is willing to consider (Orem, 1995: 204). Orem (1995: 175) identified the factors of sociocultural orientation, health state, and resources as directly affecting self-care agency. Orem has further identified health state and patterns of living as significant to the health-deviation self-care requisites (Orem, 1995: 287).

Over the past decade, nurse researchers have studied the influence of basic conditioning factors, singularly and in combination, on individuals' self-care

abilities. The socioeconomic status and age of coronary bypass patients were found by Senten (1991) to each have a significant negative relationship with their well-being; in addition, their socioeconomic status explained 3% of the variance in well-being. Occupational prestige, social support, and health state in radiotherapy clients together were found to explain 48% of the variance in self-care (Hanucharurnkul, 1989). Duration of illness as health state factor and educational level were found to be related to self-care agency (Ailinger and Dear, 1993). West (2001) investigated the influence of clinical variations in the level of depression, conceptualized as a health-state factor, on the self-care abilities of young American women. This study reported the level of depression was the dominant predictor of the quality of the self-care abilities of her sample. In a study with Dutch psychiatric patients, Brouns (1991) also reported that variation in mental health state significantly influenced patients' self-care abilities. In both studies a positive relationship between health state and self-care agency was revealed.

Metcalfe (1996) studied the relation of therapeutic self-care demand, self-care agency, and the self-care actions of individuals with chronic obstructive lung disease. Health state was found to offer significant explanation of variations in the self-care actions of this population. Knowledge of these factors provides for a more complete understanding of persons, imperative for better understanding the individual patient.

2.1.2 Therapeutic self-care demand

Therapeutic self-care demand is a conceptual element composed of self-care requisites and the method and operations to meet the required care. Orem's definition of the therapeutic self-care demand is "a structure of formulated and

expressed courses of action or care measures that must be performed to generate action processes, using the technologies selected to meet—that is, fulfill—the regulatory goals (functional or developmental) of known existent and emerging self-care requisites of individuals" (Orem, 2001: 223). The purpose of engaging in deliberate self-care actions are expressed as goals termed self-care requisites (Orem, 2001). The detail of self-care requisites are as follow;

2.1.3 Self-care requisites

Self-care requisites are the required actions though which individuals regulate factors that affect their human functioning and human development (Orem, 2001). There are three types of self-care requisites identified; universal, health-deviation related, and developmental requisites.

Universal requisites are common to all human beings. They are concerned with life processes and their purpose is to maintain human structure and functioning and to promote general well-being. They include adequate air, food and water; elimination; a balance between activity and rest; a balance between solitude and social interaction; prevention of hazards to life, functioning and well-being; and promotion of normal human functioning in terms of human potential, human limitations, and human desire to be normal (Orem, 2001: 225).

Health-deviation self-care requisites refer to needs related to illness, injury, or disability. These requisites arise from both the disease or injury state and the measures used in diagnosis of treatment. Their purpose is to prevent, control, or manage health problems. There are six categories of health-deviation self-care requisites included; seeking appropriate medical assistance, being aware of and attending to effects of health-deviations, carrying out prescribed medical measures,

attending to uncomfortable or deleterious effects of medical care measures, modifying the self-concept (and self-image) in accepting specific health state that need specific health care, and learning to live with the effects of illness and side effect of treatment measures in daily leaving that promotes continued personal development (Orem, 2001: 235).

The third type of self-care requisite is developmental. Development requisites relate to either particular periods in the life cycle or to conditions that could adversely affect human development (Orem, 2001: 230). The summation of care measures needed in order to meet all of the self-care requisites is termed by Orem as the therapeutic self-care demand.

According to the NDCG (1979) identification of component parts of therapeutic self-care demand that are common to a population assist in the organization of care for persons with specific diseases who have demands in common. In nursing practice, one of the nurse's major responsibilities is to determine a patient's therapeutic self-care demand in order to asses the adequacy of self-care agency.

2.1.4 Self-care agency

Self-care agency is a fundamental personal factor necessary in the practice of self-care. Agency is "the duty or function of an agent (person), the state of being in action or of exercising power, operation" (Webster's New Universal Unabridged Dictionary, 1996). In Orem's (2001: 254), self-care agency is the complex acquired capability to meet one's continuing requirements for care of self that regulates life processes, maintains or promotes integrity of human structure and functioning and human development, and promotes well-being. Orem defined agency as "the specific powers of individuals. These powers are associated with the nature of

maturing and mature persons to take action voluntarily and deliberately in the achievement of desired ends and goals".

The capability to engage in self-care is also conceptualized as having from and content. Self-care agency is conceptualized as including the ability to attend to specific things and to understand their characteristics and meaning of the characteristics, the ability to apprehend the need to change or regulate the things observed, the ability to acquire knowledge of appropriate courses of action for regulation, the ability to decide what to do, and the ability to act to achieve change or regulation. The content of self-care agency derives from its proper object, meeting self-care requisites, whatever those requisites are at specific moments (Orem, 2001: 256).

The detail of a three-part structure of the concept of self-care agency was developed by Orem (2001) as follow:

1) Foundational capabilities and dispositions include common human foundation for engagement in deliberate action.

2) Power components, the self-care agency power components dimension is the human capabilities that are empowering for engagement in the operations of self-care. There are ten power components believed necessary for the person to be able to engage in self-care action. These components are: 1) ability to sustain attention for self-care and attend to internal and external conditions and factors that influence self-care; 2) ability to use physical energy to initiate and sustain self-care activity; 3) control of body position while performing self-care; 4) reasoning about self-care needs; 5) motivation for self-care as it relates to well-being; 6) decision-making ability about care of self and the ability to operationally one's

decisions; 7) ability to understand, retain, and use knowledge about self-care such as from patient teaching; 8) a combination of various cognitive, perceptual, and interpersonal skills that enhance self-care; 9) ability to prioritize self-care actions to achieve self-care; and 10) ability to integrate a consistent pattern of self-care into one's social and physical environment (Orem, 2001: 265).

3) The part of self-care operational and dispositions can be divided into estimative, transitional, and production phases of deliberate action. Estimative type are operations of inquiry that seek both empirical and technical knowledge for purposes of knowing and understanding what is, what can be, and what should be brought about with respect to taking care of self. Transitional type include reflecting, judging, and deciding with respect to self-care matters are grounded in what individuals know about the self-care situation, their experiences and their knowledge about self-care requisites and measures for meeting them, as well as their values, self-concepts, and willingness. Productive type is doing operations to achieve practical results demanding preparation for and performance of self-care measures, monitoring performance as well as their effects and results, and making judgments and decisions about subsequent actions (Orem, 2001: 264)

All or some of the ten power components may be an activated to perform self-care operations. Three elements—knowledge, skill, and motivation—are integral constituents of the power components and are necessary for self-care (Orem.2001). Knowledge has been demonstrated by several investigators as a correlate of self-care agency (Aish, 1993).

2.1.5 Motivating self-care

Within the Self-Care Deficit Theory of Nursing, motivating self-care can be viewed from two perspectives. The first is the performance of the estimative, transitional, and productive type of self-care to meet therapeutic self-care demands. The second related to actions persons engage in to develop of refine their capabilities to perform self-care operations. The foregoing exposition of motivation leads us to stipulate that motivation is operational in all the stages of deliberate action. It is most clear-cut in the transitional phase where persons make decisions to practice specific forms of self-care to meet particularized self-care requisites or to take action to regulate the experience or development of their self-care agency. Four conditions that may encourage action tendencies for self-care are presented by Renpenning and Taylor in Self-Care Theory in Nursing book in 2003 and the detail as follow.

1. Persons should organize their knowledge about their particularized self-care requisites and the meaning of meeting these requisites for life, health, and well-being.

2. Persons should lay out the sets of actions and their proper sequences for meeting each particularized self-care requisite and attach to each the essential materials and environmental conditions, the times of performance, the duration of performance, and the labor required.

3. Persons should be able to estimate the discomfort or pain and the stress associated with prescribed courses of self-care.

4. Persons should be able to locate prescribed self-care within their hierarchies of value.

Nurses should be aware motivating self-care is a matter internal to persons who are confronted with self-care requisites to be understood and met and with the development of the requisite knowledge and skills.

2.1.6 Self-Care

Orem defines self-care as “action of mature and maturing person who have the powers and who have developed or developing capabilities to use appropriate, reliable and valid measure to regulate their own functioning and development in stable or changing environment. Self-care is the deliberate use of valid means to control or regulate internal and external factors that affect the smooth activity of a person’s own functional and developmental processes or contribute to a person’s personal well-being. Self-care is the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being” (Orem, 2001: 43). It is a direct and deliberate action in response to the person’s therapeutic self-care demand. Self-care is envisioned by Orem to be represented by an action-system or a dynamic process. This action-system is activated in a series of deliberate action sequences required for meeting requisites for self-care. Deliberate action, within the Self-Care Deficit Theory of Nursing is described as purposeful, goal-or result-seeking activity always self-initiated, self-directed, and controlled in regard to presenting conditions and circumstance (Orem, 2001). Deliberate action is activated by an internal power called agency. To operational self-care, the individual must be able to initiate and persevere. This ability is framed within the belief that the person must “have specific requisite knowledge and skills…, be sufficiently motivated to initiate and continue efforts until results are achieved…, be committed to meeting particular demands for care…, able to execute movements required…, and

have energy and a sense of well-being sufficient to initiate and sustain self-care effort (Orem, 2001: 275-276). Study to operate self-care presented by Miaskowski et al. in 2004 with randomized clinical trail of the effectiveness of a self-care intervention to improve cancer pain management. Subjects were 93 oncology outpatients with pain from bone metastasis who received the PRO-SELF program compared with the patients in usual care. The outcome demonstrated that after completed the program subjects had changed in self-care behavior and the achieve maximal changed had presented at 8 weeks later.

Several studies based on Orem's Self-Care Deficit Nursing Theory in chronic illness patients and their self-care were conducted by Hanucharurnkul and others (1997) studied to develop the model for promoting self-care among diabetic patients to control the level of glycosylated hemoglobin (HbA1c), increase perceived self-care agency and participants' satisfaction with care. Purposive sampling was used to select 30 adults with uncontrolled non-insulin dependent diabetes mellitus in out-patient diabetic clinic, one provincial hospital. Self-care agency was promoted by educative-supportive nursing system by individual and group meeting once a month for four consecutive months. Results of the study revealed that after entering the program for four months, the level of self-care agency development for most of the patients were increased, the level of HbA1c decreased and satisfaction with care increased significant compared to before entering the program (all $p < 0.001$).

Cutler (2001) presented symptom management of patients with mood disorder, such as depression and bipolar disorder, influences quality of life and relapse. This study describes a result of symptom recognition and management. A purposive sample of 45 subjects was studied. Step-wise multiple regression analyses

of self-care agency with symptom management resulted in self-care agency explaining 37% of the variance in symptom management at 2 months post hospitalization. Patients with mood disorders have long-term vulnerability for relapse after hospital stabilization. The study confirmed Orem's self-care theory can be useful for professional nurses to assist patients in estimating self-care ability and areas of self-care, such as symptom management, to promote autonomy and ongoing follow-up of treatment and to reduce recidivism in patients treated for mood disorder.

Cebeci and Celik (2006) demonstrated the results of discharge training counseling increase self-care ability and reduce post discharge problem in coronary artery bypass graft patients. Quasi-experimental was used in 57 patients. Data showed that interventions group had higher mean self-care score than in usual care.

2.1.7 Nursing system

Orem (2001) indicated that nursing is appropriate when the patient requires assistance in meeting needs related to self-care. Orem views nursing as a system which is intended to benefit patients who require nursing. Several propositions are suggested as guides for the development of theory related to nursing system. One of these central ideas about nursing is that nurses as patients work together to produce allocate the roles of each in providing for self-care and regulating self-care agency. The nursing system is constituted by the actions of nurses and the actions of patients that regulate patients' self-care agency and meet patients' needs for self-care. Another proposition related to nursing system is that nurses determine patients' need for self-care, select processes or technologies for meeting this need, and formulate required courses of nursing action. Nurses also assess patients' self-care agency by estimating

the potential of patients to engage or to refrain from engaging in required self-care, and their capacity to develop abilities to engage in care now or in the future.

Orem (2001: 350) presented three basic variations in nursing system are recognized: 1) wholly compensatory nursing systems, 2) partly compensatory nursing systems, and 3) supportive-educative nursing systems. This typology of nursing systems is associated with the question: Who can or should perform those self-care operations that require movement in space and controlled manipulation? If the answer is the nurse, the system of nursing is wholly compensatory because a nurse should be compensating for a patient's total inability for engaging in self-care activities that require controlled ambulation and manipulative movement. If the answer is that the patient can perform some but not all self-care actions requiring controlled ambulation and manipulative movement, then the nursing systems should be considered partly compensatory. If the answer is that the patient can and should perform all self-care actions requiring controlled ambulation and manipulative movement wile engaged in self-care agency development, the nursing system should be of the supportive-educative type.

In this study, alcohol dependence patients are able to perform or can and should learn to perform required measures of externally or internally orientated therapeutic self-care but cannot to do so without assistance that supportive-educative systems were selected.

Supportive-educative system is the valid helping techniques include combinations of support, guidance, provision of a developmental environment, and teaching. It is the only systems in which a patient's requirements for help are confined to decision making, behavior control, and acquiring knowledge and skills. There are a

number of variations of this system. In the first, a patient can perform care measures but needs guidance and support. Teaching is required in the second variation. In the third, providing a development environment is the preferred method of helping. The fourth variation is in the situation in which the patient is competent in self-care but requires periodic guidance that he is able to seek: in this variation, the nurse's role is primarily consultative (Orem, 2001: 354).

Integration all this knowledge to develop the program presented in the next section.

2.2 Alcohol Craving Control Program

In this study, alcohol dependents had significant lack of ability to control alcohol craving, which influenced on their self-care as decrease alcohol consumption. Determined from Self-care Deficit Nursing Theory and empirical literature, the following basic conditioning factors-age, marital status, level of education, type of occupation, and income-were selected for inclusion in this study.

The organization of a three-part structure of the concept of self-care agency in alcohol dependence focus on the phase of deliberate action, operational capabilities was the main focus in this study.

Operational capabilities; for the process to improve the ability to control alcohol craving, related to Orem's (2001) perspective the self-care operation capabilities compose of estimative type include investigate knowledge in alcohol craving situation and cause of craving therefore make decision which skills should be improve as the transitional type and then follow by the productive type include the way to improve that skills then learning process will be occur and the result of that should be evaluate.

Related to NDCG (1979) declared nursing assessment of self-care agency can occur at any one of the three dimensions. When self-care agency is present, fully developed, and operational, self-care produced. In this study selected self-care operational was the major focus.

Alcohol Craving Control Program was a nursing activity that work to improve alcohol craving control agency and to effect on self-care action as decrease alcohol consumption. Supportive-educative systems used in this program included combinations of support, guidance, provision of a developmental environment, and teaching. Process included 2 phase: 1) Investigation and reflection for decision to improve craving control agency. The details included cue management, negative affect of decrease consumption as alcohol withdrawal management, refusal skill and stress management, and positive affect of alcohol consumption as emotional control. 2) Performance of productive craving control agency that support the patients to work on alcohol craving control to decrease their alcohol consumption in the real situation by telephone. Guidance to make decision which action was work and should be continue and which one should be discontinue was included in this phase.

This review of the literature has covered concepts from Orem's Self-care Deficit Nursing Theory which relate to self-care and the scientific basis for improve alcohol craving control agency was reviewed.

Theoretical Framework:

This study used major concepts from Orem's Self-Care Deficit Nursing Theory (2001). The theory describes and explains the individuals have acquired ability to care for themselves. The type and kind of self-care needed is determined by requirement as a result of illness, as alcohol dependence. Collectively these sets of self-care need to decrease consumption as include the craving control agency. Alcohol dependents have some factors that influence to lack of ability to control alcohol craving that effect to consume alcohol then there is a need for nursing intervention. Helping alcohol dependence patients can and should perform self-care actions, decrease alcohol consumption, a supportive-educative intervention as Alcohol Craving Control Program should be appropriate. The conceptual framework was presented in figure 1

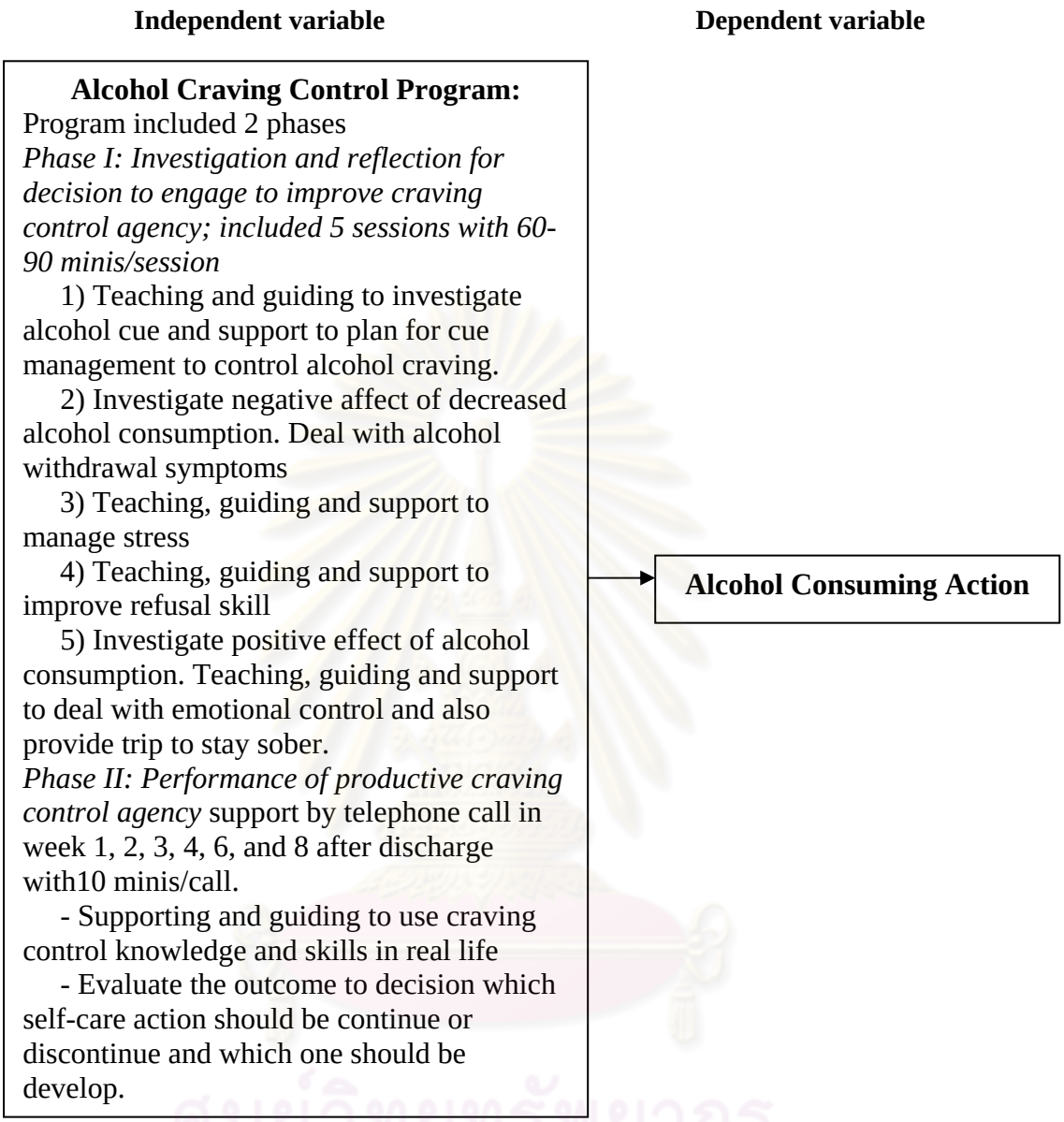


Figure 1 Conceptual framework

CHAPTER III

RESEARCH METHODOLOGY

In this chapter, methodological aspect, including the research design, population and sampling, setting, instruments, data collection, protection of the human rights and data analysis were discussed.

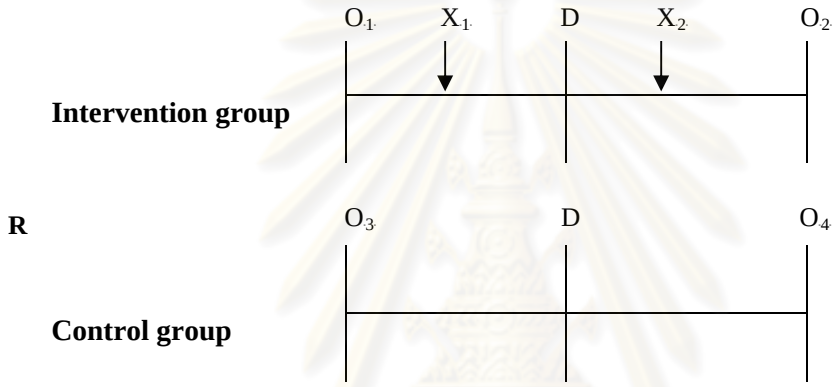
Research Designs

In order to examine the effective of a nursing intervention to support alcohol dependence patients to improve alcohol craving control agency in order to decrease their alcohol consumption, this clinical study was used an experimental pretest-posttest control group design with subjects randomly assigned to an intervention or control group. In this type of design, internal validity is the key issue (Brink and Wood, 1989). It must be possible to assume that changes in the dependent variable are actually due to the manipulated independent variable and not to other differences between groups of subjects. To minimize extraneous difference between groups, subjects were randomly assigned to intervention and control group (Aronson et al., 1990).

In the pretest-posttest control group design, data were analyzed to determine how much change occurred between time 1 and time 2 for both intervention and control group and whether the change was greater in the Alcohol Craving Control Program (ACC Program) or control group. Samples are being studied over time, so controlling for maturation is possible by examining change over time in the control

group. Since the control group did not receive the intervention, any changes over time are likely to be due to maturation (Woods and Catanzaro, 1988).

The outcome were measured the alcohol consumption by The Alcohol Consumption Assessment (ACA) measured before intervention as time 1, and time 2 at 8 weeks after discharge in the intervention group and control group. Only the intervention group were received the telephone called 6 times after discharge.



R	refer to random assignment in order to select samples into the intervention and control group
O_1, O_3	refer to the pre-intervention and pre-test
X_1	refer to the Alcohol Craving Control Program
D	refer to discharge date either intervention and control group
X_2	refer to 6 telephone calls
O_2	refer to posttest about 8 weeks after discharge
O_4	refer to posttest about 8weeks after discharge

Figure 2 Research design

Summary of activity while contracted with the subjects in both groups were presented in the table.

Table 1 Timetable of Contract with Subjects

Time	Activity	Groups	Measures
1. Pre-intervention	Preparation session in hospital	Control	- ACA
		Intervention	- ACA
			- OCDS
2. Intervention	Alcohol Craving Control Program	Intervention	
3. Within 2 months following discharge from hospital	Telephone call to each subject 6 calls in week 1, 2, 3, 4, 6, and 8	Intervention	
4. Evaluation at week 8 after discharge	Follow-up in hospital	Control	- ACA
		Intervention	- ACA
			- OCDS

Population and Sampling

The populations in this study were male persons' age between 20 to 60 years with alcohol dependence diagnosis by the DSM-IV-TR (2000) criteria who are admitted to alcohol detoxification.

Samples of the Study

1. Sample size

According to Polit and Hungler (1997), suggested that 20-30 cases in each group are sufficient for the comparison purpose. It was important that attrition be anticipated and that sample size be increased to accommodate potential "drop out". It is not likely that many will drop out but reasons for this might include members of the study group not available to continue the follow-up at the health care center as presented in the previous study the drop out were between 40-60%. To accommodate

these possibilities the sample size would be increased by 40%. There fore, the final sample size was 70 samples that randomized to 35 samples in each group.

2. Sampling procedures

The simple random sampling was used to obtain qualifies participants in this study. The following steps were used to recruit the samples.

Inclusion & exclusion criteria

Inclusion criteria in this study included;

1. Male alcohol dependence patients who presented for DSM-IV-TR (2000) criteria,

2. Age between 20 to 60 years because of the maturity and power to decision in ethical issue and learning process

3. at 1 week after detoxification

4. Free of withdrawal symptoms and mental health problem

5. able to read Thai

6. willing to participate in this study and agree to continue participate by telephone during the time of the study

7. The Thai Mini-Mental State Examination score 23 or over for exclude problem with cognitive impairment that can effect on self-care learning (Aish, 1993).

The exclusion criteria for this study were;

1. The participants who had mental health problem and any medical condition between the interventions which could significantly effect their health state were excluded.

This section explained the procedure of random assignment the subjects to groups and procedure in the intervention and control groups. The researcher were approach the patients by individual who met the study criteria. Potential subjects were informed of the study purpose and procedures and asked to sign an informed consent form. After consenting to the program, they were randomly assigned to either ACC Program or a control group using a simple computerized and made before the procedure by using sealed envelopes with numbers previously assigned by random number list of GraphPad Software program. This technique minimizes the possibility of imbalance among potentially confounding variables and achieves better balance between the intervention and control group assignment (Shadish, Cook, and Campbell, 2002). One would assume equivalence between groups based on randomization and sample size. The numbers were placed in a sealed enveloped. The subjects were asked to take an envelope and were assigned to the group that their enveloped dictates. After that the subjects were completed demographic data sheet and ACT for baseline data. Subjects in intervention group also completed OCDS and given appointment to start the program.

Seventy alcohol dependents who met the inclusion criteria were approached to participate. For the initial data correction, total 70 cases were approached to participate in this study, 35 cases were random assigned to the control group. One case was readmitted between the follow-up phase and 5 cases were failed to maintain follow-up after discharged from the hospital.

The samples in ACC Program group included 35 cases, but 1 case was failed to maintain follow-up and 2 cases were unable to complete throughout the follow-up phase because they got to work. The total number of sample in this study

was 61 cases which was 32 cases in ACC Program group and 29 cases in control group. The sampling procedures presented in figure 3.

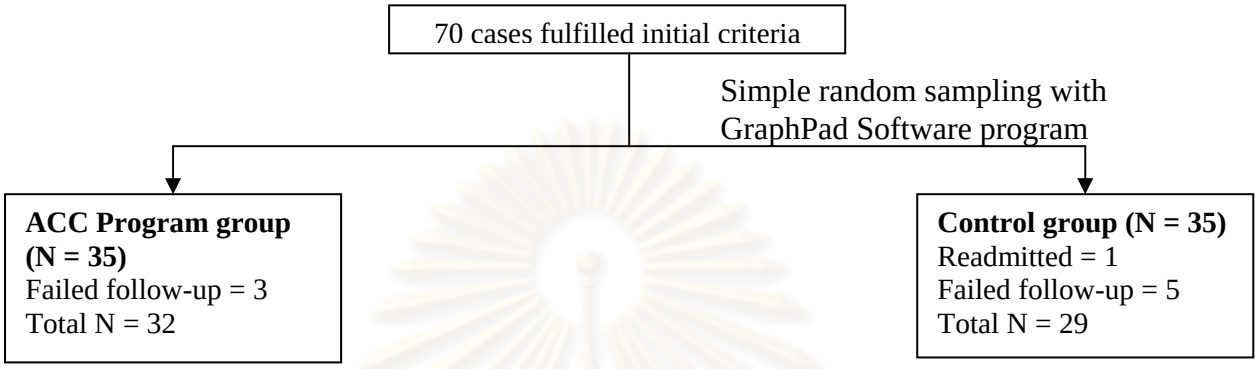


Figure 3 The details of sampling procedures

Protection of Right of Human Subjects

The study proposal was submitted to the Ethic Committee, Thanyarak Institute on Drug Abuse, for approval prior to data collection and permission. The potential subjects who meet the study criteria were informed of the purpose, procedure, benefits, and risks of the study. The subjects were informed that the process of data collection were taken around one hour and were involved supportive self-care action by telephone and also answering three questionnaires. They could refuse to answer any specific questions which make them feel uncomfortable. The subjects were assured that they could terminate their participation at any time. They were assured that their willingness to participate in the study had no implications for the health care services that they were received. Their decision to discontinue participating in the study was not affect their relationship with health care providers or their access to any services available at the hospital. Confidentiality of data collection was ensured both during data collection and after collection.

Setting

This study was conducted in the alcohol detoxification ward and follow-up at the outpatient department of Thanyarak Institute on Drug Abuse, Patumtanee, Thailand. The intervention was conducted in the activity room of alcohol detoxification ward which is one of the male inpatient units for alcohol dependence in Thanyarak Institute on Drug Abuse. The evaluation of alcohol consumption at week 8 after discharge had been occurred at either outpatient department at the date of physician's appointment.

Instrumentations

There were three types of instrumentation. The first type was Alcohol Craving Control Program guided by Orem's Self-Care Deficit Nursing Theory (2001). The second was the data collection instrument. The third was the additional tool for investigated craving control agency in the intervention group.

1. Alcohol Craving Control Program

The researcher developed the Alcohol Craving Control Program by using Orem's Self-Care Deficit Nursing Theory (2001) as a theoretical framework for understanding patients' self-care requisite, self-care agency, self-care action, phase to deliberate action and nursing intervention. However, the development of the Alcohol Craving Control Program comprised of 4 phases;

1) The assessment of patients' self-care requisite, self-care agency, and self-care action

This phase focused on the review literature to understand self-care requisite and self-care agency in alcohol dependent in Thai and other country both of

eastern and western. Results of the literature review revealed that the significant self-care requisite in persons with alcohol dependence was lack of ability to decrease alcohol consumption. Reviewed factors related to continue and/or increase consumption found craving was the most interesting. Problem with uncontrolled craving caused the alcohol dependence to uncontrolled consumption. Self-care agency required alcohol craving control agency that could effect on action to decreased alcohol consumption.

2) The program development phase

The researcher developed this program based on Orem's Self-Care Deficit Nursing Theory (2001) that provided self-care operation as the developed capabilities of individual to engage in self-care. Literature reviewed to understand the design of this nursing intervention, many researchers who conducted the intervention had integrated phase 1 and 2 of the self-care operation (estimative-transitional and judgment operation) into the first phase and concluded these 2 phase could ongoing in the process (Hanucharurnkul et al., 1997; Cutler, 2001; Miaskowski et al., 2004; Cebeci and Celik, 2006). The knowledge of the specific skills the work on alcohol craving control were reviewed in this phase. ACC Program comprises of 2 phases: Phase I Investigation and reflection for decision to engage to improve self-care agency: consists of 5 sessions with 60-90 minutes per session and each session are applied throughout 3 times per week during the 2 weeks for each participant. Detail included cue management, alcohol withdrawal management, refusal skill and stress management, emotional control and trip to stay sober; Phase II Performance of productive self-care agency (productive operation): 6 telephone calls with 10 minutes per call after discharge to support alcohol craving control to effect on decrease alcohol

consumption in real situation. The detail of program were included the goals of each session, materials, content, strategies and detailed guidelines for patients training, handouts, and exercise assignments. The supportive-educative nursing systems included a combination of support, guidance, provision of developmental environment, and teach particular knowledge and skills were the help methods in the program. ACC Program had 2 manual. One for nursing activities and other for patients as called Alcohol Craving Control booklet.

3) Modification phase

The program was reviewed by three experts for content validity. The first expert was a specialist in mental health and psychiatric nurse, especially caring experience with alcohol dependence patients. The second expert was a nursing instructor who had experience taking care of patient with Orem's Self-Care Deficit Nursing Theory. The third expert was a physician who was an expert in alcohol dependence care. Suggestion to add inclusion criteria which non cognitive impairment by Mini-Mental State Examination with scores over 23. Rewrite some session with the easy words and reform some patients' assignment in the booklet to table style. The manual was revised according to the three experts' recommendations.

4) Program trial phase

The revised an ACC Program was try out on the 5 persons with alcohol dependence (who was not part of the sample for the main study) that had similar characteristic of the participant in the study. The procedure was the same as that used in the main study. Each subjects participated all sessions, filled out the handouts, and exercise assignments. The results of try out were the preparation session was very important in order to build the trust. After completed the program almost of the

samples had the difference length of stay to discharge that could affected self-care learning, motivating and self-care action plan. Other recommended were some letters in worksheet were too difficult to read and some were too small. Suggestions from the experts and the results of try-out indicated that the researcher should modify the protocol of the program by added the last session, session 5, that repeated all action plan to control their alcohol craving and to ready each self in reality and sheer up willpower to continue self-care action and also make appointment for 6 phone calls. This activity was worked at the discharge day.

The protocol of the Alcohol Craving Control Program

The total of the program comprises of 2 phases: Phase I Investigation and reflection for decision to engage to improve self-care agency: consists of 5 sessions; Phase II Performance of productive self-care agency: 6 telephone calls. The details of ACC Program are shown as follows:

Preparation session

Objectives: To trust building, investigation alcohol craving and alcohol consumption problems, motivation and supportive to improve ability to get new self-care action.

Approach the samples individually in the activity room of alcohol detoxification ward. When the samples assented to participate in this study, provided the samples to understand their problem and provided to understand that they had new self-care requisites required to decrease alcohol consumption and a new ability required to effect on their alcohol was alcohol craving control. The details of this session were as follow;

At the beginning, provide the Alcohol Craving Control Booklet for all samples and the activity were followed this booklet. Started with taught about the standard drink (Appendix A) and safe drink then guided the patients to understand their consumption problem, effect on health and life, and motivated to improve new ability in order to decrease alcohol consumption. After that, informed about factors related increased consumption and related them to their past experience. Supported to understand uncontrolled craving was a major problem. Taught about alcohol craving as follow;

Cravings are strong, uncontrollable urges to consume alcohol that drive the dependency to once again consuming alcohol. To get an idea of what alcohol cravings are like, think of a time when you went for a long time without eating a meal and you were really hungry. Hunger is a mental and physical sensation that is triggered when the body needs food for nutrients and energy. The craving for food, driven at a physical level, stimulates memories of eating food, which is followed by a strong desire or compulsion to consume food. Usually when a person is very hungry, they will think about their favorite foods; if they get hungry enough, they can sometimes even smell and taste certain foods. If a person goes long enough without food, compelling thoughts of eating plus a growling stomach and shakiness due to not having eaten will become so great, making the person so uncomfortable, that they will drop whatever it is they are doing and arrange to get food and eat it. As soon as the food is consumed, the hunger pangs stop and the person feels good about satisfying their hunger. Alcohol craving is similar, but the desire to consume alcohol is much stronger and more intense. An alcohol dependence who is craving alcohol will feel like life itself is dependent on getting and taking their preferred alcohol. They will do

and say almost anything to consume alcohol to handle their intense cravings. Once they satisfy the craving, they feel relief until the alcohol wears off and the craving returns.

Discussion about past experience related to alcohol craving and alcohol consumption and factors related to alcohol craving. Guided to know about alcohol craving and consumption problems and motivated to improve self-care ability as craving control. After that, the researcher made appointment with samples to start session 1 of the intervention at 2 days later.

Phase I; Investigation and reflection for decision to engage to improve craving control agency

Session 1 Cue management

Objectives: To investigate specific cur that cause the patients to crave and consume alcohol, taught the appropriate knowledge that could improved their craving control agency, supported and motivated to plan for cue management that could improved their alcohol craving control in real situation after discharge.

Provide knowledge and understanding about cue that could evoke alcohol craving, guided the samples to investigated specific cue that effect on their craving by used alcohol cue assessing form. Teaching and guiding to manage alcohol cue and also included support and motivation to decision which cue management should be appropriate then wrote down his plan into the cue management planning from in the booklet.

Session 2 Negative affect of decrease consumption; Alcohol withdrawal management

Objectives: Provide knowledge and understanding about the negative affect that could occurred while they had decreased their alcohol consumption as withdrawal symptoms.

Discussion about the past withdrawal symptoms and their old self-care experience. Providing the knowledge about the withdrawal symptoms and taught how to prevent and first aid for that symptoms related to their experience. Encourage the samples to decision and wrote down their plan into the booklet and then gave them a reinforcement to work on their self-care plan in the real situation.

Session 3 Negative affect of decrease consumption; Refusal skill and stress management

Objectives: Provide knowledge and understanding of refusal and stress management skills that the alcohol dependence could work with the appropriate situation.

Taught, guided, and supported the samples to improve refusal and stress management skills which provided role-play and practiced these skills. For stress management, provided the samples to investigate their stress by the Stress Questionnaire and motivated them to use this instrument in real life as they needed. Then supported and motivated to decision which self-care plan should be appropriate to act in their real situation and encouraged them to write down their plan into the booklet.

Session 4 Positive affect of alcohol consumption; Emotional control and trip to stay sober

Objectives: To provide knowledge and understanding of emotional control and had the alternative activities to work instead of consume alcohol and also guide the trip to stay sober in real life.

Discussed about the emotional control problems that lead them to crave and consume alcohol. Teaching and practiced emotional control and provided information of trip to stay sober for the samples. Guiding, and supporting them to decision and plan to manage their emotion that can lead him to crave and consume. The researcher encouraged the samples to write down their plan into the booklet.

Session 5 Repeat self-care plan;

Objectives: In the final session that arranged at the discharge day. To discussed and repeated all plans to control alcohol craving and to ready each self and sheer up willpower to continue self-care action as their plan in the booklet and also make appointment for 6 phone calls.

Phase II Performance of productive craving control agency;

Telephone calls included week 1, 2, 3, 4, 6, and 8 after discharge. Support, motivation, continue education a warrant followed their alcohol craving control in the Alcohol Craving Control Booklet by the individual situations and also motivated to decision which self-care action should continued and should developed or discontinued in real life were the aims of this phase.

The summarization of the program showed in the table 2.

Table 2 The summarization of the Alcohol Craving Control Program process

Session/ Objective	Contents	Helping Method	Session & Time
Preparation session;			
Obj; Trust building, investigate alcohol consumption problems, motivation to improve self-care action	- Trust building - Introduction to the program - Investigate internal & external factors influence alcohol craving and consumption - Discuss about past experience related to alcohol craving and alcohol consumption	- Individual sharing - Teaching, guiding, and supporting - Encourage to completing ACT, factors related to alcohol crave questionnaire and OCDS	- 60 minutes
Phase I. ***Investigation and reflection for decision to engage to improve craving control agency***			
1. Cue management			
Obj; ▪ investigate alcohol craving cue & consumption ▪ Inform environmental management ▪ provide decision making for cue management	- Deal with alcohol craving by investigate alcohol cues or high-risk situation that influence them to consume alcohol - Environmental management knowledge that fit for control alcohol consumption in daily living	- Teaching, guiding and supporting - Encourage to complete cue assessment, and cue management plan	- 2 days after the preparation session - 60 minutes
2. Negative affect of decrease consumption; Alcohol withdrawal management			
Obj; ▪ inform alcohol	- Alcohol knowledge &	- Teaching,	- 2 days after

Table 2 The summarization of the Alcohol Craving Control Program process (con't)

Session/ Objective	Contents	Method	Session & Time
knowledge & effect of alcohol consumption ▪ Inform alcohol withdrawal management ▪ Provide decision making for withdrawal caring	effect of alcohol consumption ▪ Inform negative affect related to decrease consumption that can influence alcohol craving (e.g., withdrawal symptoms) - Preventing and caring withdrawal symptoms	guiding and supporting - Encourage to complete alcohol withdrawal management plan	session 1 - 60 minutes
3. Negative affect of decrease consumption; Refusal skill and stress management **Obj;** ▪ Inform refusal skills & stress management ▪ Provide decision making for refusal skill & stress management	▪ Refusal skill and Stress management	- Teaching, guiding and supporting refusal and relaxation and also encourage role-play and practice that skills - Encourage to complete stress questionnaire & all self-care plan	- 2 days after session 2 - 90 minutes
4. Positive affect of alcohol consumption; Emotional control and trip to stay sober **Obj;** ▪ Inform emotional	▪ Emotional control &	- Teaching,	- 2 days after

Table 2 The summarization of the Alcohol Craving Control Program process (con't)

Session/ Objective	Contents	Method	Session & Time
control technique ▪ Inform trips to stay sober ▪ Provide decision making for emotional control and technique to stay sober ▪ Motivate continue craving in the real situation.	trips to stay sober	guiding and supporting - Encourage to complete the emotional control plan	session 3 - 60 minutes
5. Repeat self-care plan **Obj;** ▪ Discussion to repeat all action plan to control ▪ To ready each self in reality and sheer up willpower to continue self-care action ▪ Make appointment for 6 phone calls.	▪ All craving control action ▪ Make appointment for phone call	- Teaching, guiding and supporting - Encourage to made a time table for 6 phone calls	- the discharge day - 60 minutes
Phase II. ***Performance of productive craving control agency*** in real life by telephone **Obj;** ▪ investigate the difficulty to control craving ▪ Supportive and motivate to practice all craving control skills in real situation ▪ Motivate to decision which self-care action should be continue and should be develop or discontinue	▪ Craving control activities ▪ Alcohol consumption behavior	- Support and motivation	- 6 telephone calls with 10 minutes per call - In week 1, 2, 3, 4, 6, and 8 after completed the program

The samples in control group were received usual care as the nursing activity included two individual and one family counseling by nurses at alcohol detoxification ward in Thanyarak Institute on Drug Abuse. Session one in individual counseling was investigated cause of alcohol consumption and problems with decreased consumption. Session two was taught to decrease alcohol consumption which included knowledge of alcohol consumption effect and related to improve self awareness to change their consumption. One family counseling at the discharge date was to support the family and to motivate them to help the patient to decrease alcohol consumption.

2. Instruments for data collection

Two questionnaires were used in this study. Details of the instrument as follow:

1. The demographic data sheets included age, marital status, education level, occupation, and income by the researcher.

2. The Alcohol Consumption Assessment (ACA) was developed by the researcher used to measure the number of standard drink for the alcohol consumption in a week. Persons with alcohol dependence were asked 2 questions, type and quantity of alcohol consumption each day during the pass 7 days, and the total number of standard drink was then calculated.

3. Instrument of additional analysis

To investigate alcohol craving control agency at pretest and posttest after completed the program in the intervention group was the Obsessive Compulsive Drinking Scale (OCDS) (Anton, Moak, and Latham, 1995) and the detail as follow;

OCDS was developed to reflect obsessionality and compulsivity related to craving and alcohol consumption behavior. This instrument has been show to be

sensitive to, and specific for the obsessive and compulsive characteristics of drinking-related thought, urges to drink, and the ability to resist those thought and urges in alcohol abusing and alcohol dependent populations. In this study, craving was taken to be ‘the conscious experience of a desire or urge to consume alcohol’ that can be measured by the OCDS. The OCDS had very acceptable test-retest reliability and good internal consistency (Anton et al., 1995). This instrument is a global measure in which patients are asked to rate their craving over a period of 1 or 2 weeks (but no less than 1 day). The 14 items of OCDS contains with 3 items measured; resistance/control impairment describes the lack of success in the control of alcohol consumption, obsession describes the distress of anxiety caused by a preoccupation with alcohol-associated ideas or impulses, and interference describes the degree of interference with social or work functioning. Studied on 60 alcohol dependent patients’ test-retest correlation for the OCDS total score was 0.96. The internal consistency of the items in the OCDS was high (0.86). It is useful in monitoring individuals in treatment, and increasing scores may predict the increasing rate of alcohol consumption and relapse after treatment. OCDS for this study was modified with cut off 2 question related to measure quantity and frequency of alcohol consumption in the resistance/control impairment subscale that the same as measure in Alcohol Consumption Test. The total number of the modified scale is 12.

Back-translation was used in this study for OCDS. This is highly recommended by experts on cross-cultural research because it is the key to estimating semantic equivalent (Maneesriwongul and Dixon, 2004). This method requires a minimum of two independent translators. The first translator produces the target language version from the original. The second translator uses the target language

version to produce the instrument in the original language. Each translator works independently and no consultation among them is allowed. Processed of this method included the following steps: (1) Forward translation (English language into Thai language, first translator); (2) The OCDS Thai version was translated back to English by the second translator; (3) The researcher consulted with both translators to identify reasons for any discrepancies and inconsistencies can be adjusted. (4) The modify OCDS Thai version was consulted the three experts in alcohol consumption area for content validity. Items content validity index (I-CVI) of scales was 0.8-1. A pilot-test was subsequently conducted with a convenience sample of 30 male alcohol dependence patients to test reliability. Cronbach's alpha coefficient was .76.

Data Analysis

The Statistical Package for Social Sciences (SPSS) version 13 was used to analyze the data. The assigned study number for each subject was used for data entry to ensure the anonymity of subjects. Data was double check to identify errors.

Frequency distribution and percentages were conducted to describe demographic of the subjects in both groups. Independent t-test was used to compare the difference between the dependent variable between the intervention and the control group. Pair t-test was used to compare the score of the investigation craving control agency in the intervention group. The Alpha was set at .05.

CHAPTER IV

RESEARCH RESULTS

The purpose of the study was to determine the effect of the alcohol craving control program on alcohol consumption in alcohol dependents. The research findings were presented in three parts as followed:

Part 1: The descriptive analysis of the demographic characteristics of the samples

Part 2: The results of hypotheses testing with the description of the dependent variables.

Part 3: Additional analysis

Part 1: The descriptive analysis of the demographic characteristics of the samples

The demographic characteristic of the samples in the intervention and control group are presented. The 61 alcohol dependence ranged in age from 20 to 59 years, 45.8% alcohol dependence were 30 to 39 years old (M = 34.72, S.D. = 7.785). 45.9% were married, 59.0% were completed secondary school education, 45.9% worked as day laborer, 54.1% had a monthly income between 5,000 to 10,000 Bath, and 75.4% had consumed white-spirit. Using Chi-square and student t-test, differences of all these characteristics were not found between the intervention and control group. Categorical demographic characteristics are shown in table 3.

Table 3 Demographic characteristics of the intervention and control groups

Characteristics	Control group N=29 Number (%)	Intervention group N=32 Number (%)	Total N=61 Number (%)	χ^2	df	*p*
Education				.69	2	.41
Elementary school	7(24.1)	8(25.0)	15(24.6)			
Secondary school	19(65.5)	17(53.1)	36(59.0)			
Vocational education	3(10.3)	7(21.9)	10(16.4)			
Marital Status				1.11	3	.29
Single	13(44.8)	11(34.4)	24(39.3)			
Married	14(48.3)	14(43.8)	28(45.9)			
Divorced	2(6.9)	-	2(3.3)			
Separated	-	7(21.9)	7(11.5)			
Occupation				.92	4	.34
Unemployed	7(24.1)	8(25.0)	15(24.6)			
Day laborer	15(51.7)	13(40.6)	28(45.9)			
Merchant	5(17.2)	8(25.0)	13(21.3)			
Farmer	2(6.9)	2(6.3)	4(6.6)			
Government employer	-	1(3.1)	1(1.6)			
Alcohol				.17	3	.68
White-spirit	21(72.4)	25(78.1)	46(75.4)			
Red-Spirit	3(10.3)	1(3.1)	4(6.6)			
Boil-spirit	3(10.3)	3(9.4)	6(9.8)			
Beer	2(6.9)	3(9.4)	5(8.2)			
Income (Bath)				3.50	3	.32
None	7(24.1)	6(18.8)	13(21.3)			
<5,000	5(17.2)	2(6.3)	7(11.5)			
>5,000-10,000	15(51.7)	18(56.3)	33(54.1)			
>10,000	2(6.9)	6(18.8)	8(13.1)			

Table 3 Demographic characteristics of the intervention and control groups (con't)

Characteristics	Control group N=29	Intervention group N=32	Total N=61	χ^2	df	*p*
	Number (%)	Number (%)	Number (%)			
Age Group				.89	59	.19
20-29	8(27.5)	10(31.3)	18(29.5)			
30-39	13(44.6)	15(47)	28(45.8)			
40-49	6(20.4)	5(15.6)	11(17.9)			
50-59	2(6.8)	2(6.2)	4(6.5)			
Average age	Mean = 35.66	Mean = 33.8	Mean = 34.72			
	S.D. = 7.475	S.D. = 8.079	S.D. = 7.785			

Part 2: The results of hypothesis testing with the description of the dependent variables.

Hypothesis: Alcohol dependents who were completed an ACC Program would have significantly decreased alcohol consumption than those received usual care over the time of the study.

To answer Hypothesis, independent t-test was performed. Independent t-test is used to test between-groups differences, when the samples differ with respect to other extraneous variables. Means and distributions underlying the independent t-test:

(1) The independent variable is categorical and contains two groups. The dependent variable should be continuous. The independent variable in this study was group assignment. In this study, they were assigned to either the intervention or the control group.

(2) The distribution of the dependent variable is normal. The student t-test indicated that the distribution was normal on alcohol consumption that included alcohol consumption scores for the intervention group and control group (p = .44).

(3) Homogeneity of variance: the Levene's test demonstrated equality of variance (p = .17) in alcohol consumption.

The three assumptions underlying independent t-test were not violated. Independent t-test was used to compare alcohol consumption between the intervention group and control group at pretest and posttest. The table 4 revealed that the mean score of alcohol consumption between 2 groups at pretest was not significant difference at pretest and at posttest was statistically difference at the level of .05.

Table 4 The comparison of alcohol consumption between intervention and control group at pretest and posttest

ACA scores	**Pretest**		**Posttest**		**t**	**df**	***p*-value**
	Mean	**S.D.**	**Mean**	**S.D.**			
Control group (n = 29)	173.53	61.69	114.69	87.46	.14	59	.44
Intervention group (n = 32)	171.09	69.83	19.52	60.42	4.98	59	.00

Part 3: Additional analysis

In this study, the additional analysis was to observe the improvement of alcohol consumption and craving control agency. Alcohol consumption was measured at week 2, 4, and 8 after discharge. The table 5 presented the alcohol consumption scores in both group at pretest, week 2, week, 4 and week 8 after discharge.

Table 5 The comparison of ACA scores between intervention and control group

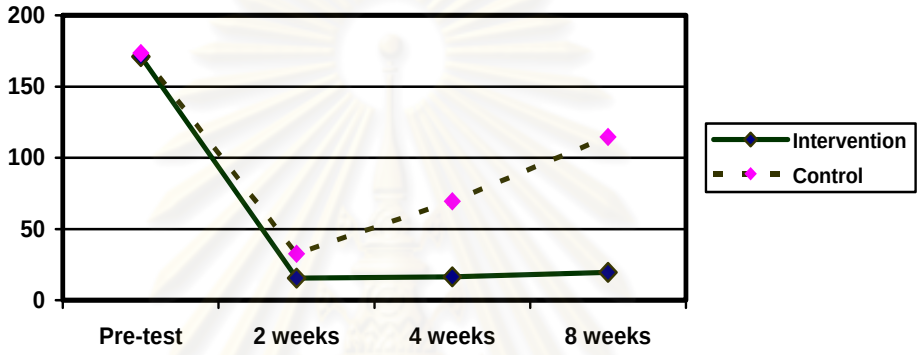
ACA scores	Control Group		Intervention Group		t	df	*p*-value
	Mean	S.D.	Mean	S.D.			
Pretest	173.53	61.69	171.09	69.83	.14	59	.44
2 weeks	32.68	45.87	15.50	33.29	1.68	59	.04
4 weeks	69.40	58.76	16.36	18.02	4.86	59	.00
8 weeks	114.69	87.46	19.52	60.42	4.98	59	.00

From table 5, the descriptive statistic of the alcohol consumption in the intervention group between the telephone support in phase 2 presented mean rates at pretest before intervention were 171.09 (S.D. = 69.83), had decreased after discharge at 2 weeks to 15.13 (S.D. = 33.29), had slightly increased at 4 weeks to 16.36 (S.D = 18.02), and had increased at 8 weeks to 19.51 (S.D. = 60.42) after discharge.

As for control group, there were also at before intervention the alcohol consumption were 173.53 (S.D. = 61.69), had decreased after discharge at 2 weeks to 32.68 (S.D. = 45.87), and had increased at 4 weeks to 69.40 (S.D. = 58.76), and also still increased at 8 weeks to 114.69 (S.D. = 87.46) after discharge. The mean scores of alcohol consumption at pretest between 2 groups was not significant difference at the

level .05. While at week 2, week 4 and week 8 after discharge the mean scores had significantly difference at .05 level.

The plots of the comparison of alcohol consumption, ACA scores, between pretest, 2 weeks, 4 weeks, and 8 weeks, after discharge in the intervention and control groups presented in Figure 4.



Graph 1 Plots of the comparison of alcohol consumption between pretest, 2 weeks, 4 weeks, and 8 weeks after discharge in 2 groups

After discharged till follow-up at 2 weeks ACA scores had decreased in both groups, at 4 weeks follow-up in the control group had increased but in the intervention group had decreased. At 8 weeks in the intervention group had slightly increased while in the control group ACA scores presented very high increased.

To observe the improvement of alcohol craving control agency measured by the OCDS at pretest and posttest after completed the ACC Program in the intervention group. Pair dependent t-test was used. This test was used when the samples are dependent; that is, when there is only one sample that has been tested twice or when there are two samples that have been matched or “paired”. The pair was either one person’s pretest or posttest scores or between pairs of persons matched into

meaningful groups (Munro, 2000). OCDS was included 3 items, resistance/control impairment, obsession, and interference.

Table 6 The comparison of alcohol craving control agency at pretest and posttest in intervention group

OCDS scores	Pretest		Posttest		t	df	*p*-value
	Mean	S.D.	Mean	S.D.			
Intervention group (n = 32)	28.59	8.78	9.28	7.54	10.10	31	.00

From Table 6 revealed that OCDS scores in the intervention group had statistical difference in all items at the level .05.

CHAPTER V

DISCUSSION, IMPLICATION AND RECOMMENDATION

This chapter presents the summary of the study, a discussion of the research finding. It explores the effect of the Alcohol Craving Control Program between control and intervention group on alcohol consumption in alcohol dependents. In addition, the implications for nursing practice, nursing education, and recommendations for future research are described.

Summary of the study

The Alcohol Craving Control Program aims to improve craving control agency that can effected on decreased alcohol consumption in alcohol dependents was constructed by applying the Orem's Self-care Deficit Nursing Theory. The program was including 2 phases with 5 sessions and also 6 phone calls after discharge. Phase I with 5 sessions were an investigation and reflection for decision to improve craving control agency. Details included 1) cue management; 2) negative affect of decrease consumption included alcohol withdrawal management, refusal skill and stress management; 3) positive affect of alcohol consumption included emotional control and also trip to stay sober had provided with teaching, guiding, and supporting techniques. Typically 60-90 minutes per session and 10 minutes per call were done. Phase II was performance of productive craving control agency included supportive alcohol craving control in real life by telephone. The phone calls were proactive, once a week in 1st month and 2 weeks for 1 call in 2nd month, and focused on assignment in the "Alcohol Craving Control Booklet".

The results of the study demonstrated by an evaluation of the outcome that quantified alcohol consumption at 8 weeks after discharge, alcohol dependents who completed ACC Program had significantly decreased mean scores of alcohol consumption better than ones who did not participated in the program ($p < .05$).

Furthermore, the analysis of results also presented that after participation in ACC Program, the mean score of craving control agency which measured by OCDS had significant lower or better control than before participation in the program ($p < .05$) at mean of difference was 19.31 (S.D. = 7.140; see Table 8). It can be concluded that the alcohol dependents who participated in the ACC Program had significant decrease alcohol consumption and can maintain long term self-care action than ones who did not participated in the program. The following finding discussion is presents.

Discussion

The effect of Alcohol Craving Control Program

The research hypothesis, ‘alcohol dependence patients who were completed an ACC Program would have significantly decreased alcohol consumption than those received usual care’ was supported.

Based on Orem’s Self-Care Deficit Nursing Theory (2001) indicated to provide the samples to understand their problem and their self-care requisites. In this case, persons with alcohol dependence had new self-care requisites required to decrease alcohol consumption and a new ability required is alcohol craving control agency. The finding that alcohol craving control agency increased in the intervention group suggested that the effect of the nursing action was partly related to its influence on self-care agency. This occurred in spite of the fact that the intervention focused on only one specific aspect of self-care agency. Furthermore, Orem had recommended nursing strategy to help the patients to engage in self-care in which the patient’ s requirements for help are confined to decision making, behavior control, and acquiring knowledge and skills as supportive-educative system. Supportive-educative system was the nursing intervention that guided in ACC Program. Follow the phase of deliberate action, self-care operation, the participants started with phase 1 in the program as estimative type included investigated internal and external factors that caused them to crave and consume alcohol. Asking patients to describe past relapse (as presented in the result all patients had experience with intended to stop consumption) provided important clues. Motivated to be aware and improved ability to manage all factors with similar situation in the future developed and practiced new self-care responses that can get more effective (Marlatt, 1985).

Follow the transitional type including reflecting, judging, and deciding to manage factors related alcohol craving to improve craving control agency and then affected on decreased alcohol consumption was confirmed in this studied. Worked on cue management, the result of the study presented investigated and planed to manage cue in real situation can reduce alcohol craving and consumption (see Appendix B). These were congruent with Rohsenow and others. (2001) who proposed that alcohol consumption was reduced by use of cue management strategies.

Increased knowledge about the effect of alcohol consumption by investigated knowledge and also informed more in the items that they lack such as presented the participants to know about effect of alcohol consumption on their individuals such as central nervous system, withdrawal symptoms, craving process and feedback them to understand the relation of their problem with other was caused by alcohol consumption for instance, told them about the studied by Litt and others (2000) presented persons with alcohol dependence had grater mood disturbance (i.e., anger, anxiety) and then it can bring about the conflict with other and lead them to crave and get more consumption. In Cooney and others (1997) offered the relation of cue and emotional were aroused the craving to consume alcohol.

Withdrawal symptoms were experienced with all participants in this study (see Appendix B). Drummond and others (2000) presented to alleviate negative symptoms of withdrawal that increased alcohol craving and consumption. Teaching and guiding to prevent and care for withdrawal symptoms were the significant strategies as presented in the results of the study.

Stress management was the choice that provided for the participants because stress is one of external factor that influenced the initiation and continuation of

craving and consumption (De Wit, 1996, Kushner et al., 1990). Skills for managing stress that the participants were used include clam-down, deep-breathing, and count the number. For positive self-talk, the researcher provide the words to use as ‘anything happened it must be good’ for remind the participants and they responds it worked when they felt bad and stress.

Emotional control was effective when the alcohol dependence faced with the destructive effects of their alcohol consumption on their life. All cases accepted consumption made them relax and felt good. Finding other activity that made them felt the same was the choice. Some participants selected tree planting, house work, or artificial. Motivated them to confidence that they can felt happy by themselves though non alcohol. Emotion controlled with consciousness and used number count technique was done (see Appendix B).

Practice skills to say ‘NO’ with offer to consume alcohol is provided in this study as presented in Heater & Stockwell in 2004 training to refusal without giving a double message, to suggest an alternative activity that does not involve substance use, to change the subject to a different topic of conversation, and if the other person persists, to ask him not to offer alcohol any more. Patients should be able to respond quickly and convincingly when these situations arise. In this study, participants had responded role-playing helped them to easy to refuse offer to consume.

Trip to stay sober in the detail of balance blood sugar, early dinner and get more carbohydrates, these techniques had accepted. All participants presented when they got full they did not craved. As presented in the online alcohol & addiction counseling (Bright eye, 2010: online), one things that can easily induce a craving for

alcohol is low blood sugar. They suggested next time when get a craving for alcohol, eat something instead that can leaded to feel how quickly that craving disappears.

Reminder cards were presented effective in Heater and Stockwell (2004) studied. They used the reminder cards as the automate the patient's emergency response to a lapse, reminder cards are designed to help patients deal with intense cravings at a time when they may have trouble generating adaptive thoughts and self-care actions. Results of this study confirmed this concept.

Interesting in improved alcohol craving control agency to get new self-care action that decreased alcohol consumption was supported self-care action in real situation by telephone. The phone calls were proactive, once a week in 1st month and 2 weeks for 1 call in 2nd month, and focused on assignment in the "Alcohol Craving Control Manual for Patients" booklet. The results of this study agreed that patients need booster self-care and motivation to self-care action. The continued vulnerability to relapse still exhibited. Vulnerability to relapse remains relatively high for significant periods of time after standard treatment protocols, started with 2 weeks later with slip and relapse within 8-24 weeks have ended (McLellan et al., 2000; Dennis, Scott, and Funk, 2003). McLellan and others (2005) suggested better management requires longer periods of continued contract with the patients. Most intervention and also telephone counseling programs documents increased efficiency, decreased readmissions and emergency room visits. Key component of the telephone counseling are to educate and support patient and the number one goal is to generate good, quality outcomes. Educate and support patients to participate in monitoring their health state and make lifestyle modifications to get better health. (Britton et al., 1999). In this study, between the supportive self-care actions phase by telephone some

participant had problems with got some sip. The researcher aware about the patients should be reassured that nurses or their relative will not censure or blame him for the mistake (Marlatt, 1985). Gave them compassion and understanding, along with encouragement to learn everything possible about how to deal with similar situations in the future and motivated them to think about negative outcome, past experience while admitted and remind their goal can took them decreased consumption. Confirm the significant of ACC Program that can effect on decrease alcohol consumption and can maintain long term self-care action (Figure 4). Related data recommended by Caetano and Cunradi (2002) about the risk of alcohol dependence begins at low levels of consumption and increases linearly with alcohol consumption. Suggestion agreeable with the previous studied long term follow-up and motivate for self-care between follow-up phases with repeated skill training will be improved positive self-care (Cebeci and Celik, 2007).

Numerous studies corroborated that teaching and supporting self-care action improves self-care scores and behavior (Hanucharurnkul et al., 1997; Cutler, 2001). A study by Stromerg and others (2003) determined that supportive training interventions increase patients' self-care behaviors while reducing their symptoms. In this study, the researcher also determined that the patients in the control group who had higher alcohol consumption means suffered more problems after they were discharged compared with the patients in the intervention group.

Implications and recommendations

The findings of this study have provided significant information for nursing practice and nursing research.

The results of this study show the effectiveness of the Alcohol Craving Control Program on alcohol consumption in alcohol dependents. Add this program into the usual care should improve the quality of care. This program may be adopted in another health center to decrease alcohol consumption among alcohol dependents.

Future studies

1. It would be useful if future research examine the long term effects of the Alcohol Craving Control Program.

2. The Obsessive Compulsive Drinking Scales should test psychometric properties of this instrument before implement in further study.

3. The further study should have a monitoring instrument for validity check to test the effectiveness of the program.

Conclusion

The hypothesis of the study was support. Alcohol Craving Control Program had significant decreased alcohol consumption in alcohol dependents. The results of the study extended and clarified the Orem's Self-Care Deficit Nursing Theory in used to develop the intervention. This nursing intervention should be available for patients with alcohol dependence after detoxification phase.

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APPENDICES

Appendix A

Standard Drink

Standard Drink

A standard drink contains about 14% g of pure alcohol. Standard drink equivalents include:

- One bottle of beer (5% alcohol) as 2.5 drinks, one can of beer as 1 drink.
- One bottle of white spirit or red spirit (35 % alcohol: 700 ml.) as 24 drinks.
- One bottle of white spirit or red spirit (40% alcohol: 700 ml.) as 22 drinks.
- One bottle of boil spirit (10% alcohol: 50 ml.) as 1 drink.
- One glass of wine (12% alcohol: 100 ml.) as 1 drink.

Percent above is ethanol content by volume (Kanitha Thaikla, Apinan Aramrat, and Savitree Assansngkornchai, 2008).

Appendix B

Additional Analysis

The OCDS score by individual in the intervention group were presented in table 7.

Table 7 OCDS score at pretest and posttest in the intervention group

No. of case	Pre OCDS scores	Post OCDS scores
1	30	9
2	34	6
3	25	7
4	22	7
5	41	8
6	16	30
7	32	5
8	31	27
9	48	5
10	15	7
11	19	6
12	34	3
13	18	7
14	30	6
15	29	9
16	30	8
17	34	7
18	25	7
19	22	9
20	41	6
21	16	7
22	32	7
23	31	8
24	48	30
25	19	5
26	34	27
27	18	5
28	30	7
29	29	6
30	34	3
31	18	7
32	30	6

From the Table 7 shown 31 cases had decreased their OCDS scores that mean the craving control agency had improved after completed the program. While 1 case had increased the OCDS scores after completed the program. In case No. 6 when looked at the detail between working on the performance of productive craving control agency in the real situation. He had the crisis event after discharge that

effected on his plan because he lost his job. The company had the plan to lay off some of the employee. When contracted by the telephone to encourage and support, he could not worked on his plan and got some sip. The researcher continued to motive self-care followed his plan. The data showed crisis event could effect on craving control in this participant.

The Qualitative results of alcohol craving control action

Preparation session

Investigate internal & external factors influence alcohol craving and consumption by factors related alcohol craving questionnaire in 32 samples.

1. Reason of consumption presented 58.6% (17 cases) consumed for relax and enjoyable, 31.03% (9 cases) for relieve stress, and 10.34% (3 cases) because of friends.

2. Mean age that they started consumption was 15 years old.

3. Other drug used were tobacco 82.76% (24 cases), amphetamine 37.9% (11 cases), in these, 7 cases were currently not used, and heroin 10.3% (3 cases) all of them currently not used.

4. Past intended to stop consumption; all cases had experience intended to stop consumption by themselves, and 27.58% (8 cases) had experienced with readmitted in health care center no more than 2 times.

5. Maximum time had stopped consumption was 1 year and 4 months and minimum was no more than 1 week.

6. Confidence of success on control consumption after discharge; total score was 10 as most confidence, 68.96% (20 cases) rated between 7-10, 31.03% (9 cases) rated between 4-6.

7. All cases had experienced with withdrawal symptoms such as headache, insomnia, nausea and vomiting, weakness, excessive sweating (i.e., diaphoresis), memory decline, depress, irritable, shaking (i.e. tremor), sticky saliva, and rapid heartbeat (i.e., tachycardia).

8. Problems related consumption; 24.13% (7cases) had experienced with accident, all cases had problems with work, family relationship and reduce income.

Session 1 Cue management

1. Investigate alcohol cues that influence them to crave and consume alcohol by cue assessment questionnaire. Internal cue included negative felling such as anger, fear, anxiety, despond, grief and loss, sadness, stress, or shame and positive felling such as satisfied, happiness, glad, hope fulfilled, joyful, or love. Results presented negative felling had rated to craving for alcohol more than positive felling.

External cue included things, time, place and person. Data presented times and person had rated to craving for alcohol more than others.

2. Cue management planning

All cases had planed to remove accessories that related to alcohol consumption such as glass, bottle, ice bottle or clamp that can provoked them to crave alcohol when they go back home. Some patients had problem with alcohol store that they always pass along the way. Planning to find a new way or make a detour. With family member consumption, assertive to tell those to stop consumption in the house or searched for separate out when they consumed were made. Special occasions, the

participants had planed to decide which one need to go and which one could refuse. Planning to deal with persuasion of their friends and practiced to refuse were made. About money, some of the participants presented if they had much money that could evoke them to buy alcohol. Managed daily money and carried to fit were made to manage this cue.

Session 2 Alcohol withdrawal management plan

From that mentioned, all cases had experienced with withdrawal symptoms. Talking from experience that early self-care when had some symptom that can reduce their craving such as when they felt excessive sweating (i.e., diaphoresis), sticky saliva and rapid heartbeat (i.e., tachycardia) find other open spaces, drinking cool water, and took relaxation were the best. Problem with insomnia they took relaxation, don't exercise nearly bedtime, or drank some warm beverages can made them sleep. When they got headache took medicine and rest.

Session 3 Refusal skill and Stress management plan

Between the interventions participants had evaluated their stress and score between 18-35 that mean the stress were a little bit more than the normal to high stress. When talked about cause of stress, problem with relationships and finance were presented. Example problems included the individual starts to distance himself from the people he loves and becomes more and more detached. He may lose his job or start experiencing serious health problems. Ordinarily, the alcohol dependence loses everything they care about: their homes, their families, cars, possessions, jobs and friends. Alcohol dependence is destroying their life. No one would be happy about this happening.

When provided relaxation technique; imagination with audio, muscle relaxation, deep breathing, 70% of the participants chosen to use deep breathing and no one chosen imagination because of the convenience. Positive self-talk was provided for negative thinking habits that may occur when they got the problems. Researcher provided the words to use as ‘anything happened it must be good’ for reminded the participants stop thinking and relieved stress.

Refusal skill, participants presented about problems with their friends who usually drunk together. Decision to away from them was the first choice that they planed and also prepared the reason to refuse such as told them about health problem or illness and doctor’s order to stop consumption were used.

Session 4 Emotional control & trips to stay sober

All cases accepted consumption made them relax and felt good. Finding other activity that made them felt the same was the choice. Some participants selected tree planting, house work, or artificial. Motivated them to confidence that they can felt happy by themselves though non alcohol. Emotion controlled with consciousness and used number count technique was done.

Trips to stay sober, participants presented thinking about make this day successful and stop drinking this day were very useful to remind. In addition, technique to control consumption was very useful when they got to sip for instance ate more food before consumption, mixed alcohol with other beverage for thin, or change to consume other beverage alcohol free were effective. Gave them the reminder cards that were used to automate the patients’ emergency response to a lapse.

Performance of productive craving control agency by 6 telephone calls

At first call talked about cue management planning, remind every planning and confirmed it's worked or not. The second till the sixth motivated adjust action which action should be continued and should be develop or discontinue. For instance, planning to eat dinner too early at the time they used to consume alcohol can decreased their craving. This action must be continuing in all cases. Other participant had planed with cue management when discharged his mother took him to live with grandmother. He had relocation and some planning must be changed. The other participant had lay off the job after discharged. He had high stress. Supportive to use relaxation technique and sheer up to be strong were done. Remind to use the positive self-talk 'anything happened it must be good' had the effective when used.

Another negative emotion that presented in many cases was guilt. The samples expressed feel guilty because he has committed dishonest deeds against the people he cares about. This is an integral part of the life cycle of alcohol dependence. A person who becomes dependence to alcohol doesn't just wake up one day and say, "Gee, I think I'll start using drugs until I destroy my family, my relationships and my life in general." Alcohol dependence starts with a problem. Alcohol is chosen as a solution to relieve the discomfort one is experiencing by not being able to solve the problem. Physical and mental complications then follow. It all adds up to a serious decline in the person's health and well-being.

To be successful, a rehabilitation program must help an alcohol dependence face his transgressions (violations of rules, laws or agreements) and enable him to clean up the wreckage of his current life that has resulted from the dependence and dishonesty.

Before dependence, most people are basically good people with a sense of right and wrong and with no intention or desire to hurt others. As the cycle of alcohol dependence progresses and the cravings and other mechanics of dependence begin to dissolve the individual's self-control, they get into situations where they are doing and saying things they know deep down aren't true or right. All these dishonest or damaging things are done to cover up and continue their alcohol consumption.

If the pattern of alcohol consumption continues, the alcohol dependence eventually becomes trapped in a vicious cycle of alcohol consumption, hiding the fact, lying about consumption and even stealing to support more alcohol consumption. At each turn, the alcohol dependence is committing more dishonest acts and, with each act, is creating more damage in his life and relationships. None of these acts are truly overlooked by the alcohol dependence; every misdeed is committed to memory.

The memory of each misdeed includes all the surrounding circumstances in place the moment the deed was done: who was involved, the time, the place and what the end result of the dishonest deed was. The alcohol dependence knows these misdeeds are wrong and because the basic person himself is good, he will feel bad or guilty after the dishonest act is committed. Over time, these memories of guilt accumulate. When the alcohol dependence sees people or places involved in his transgressions, these sights can trigger the guilt surrounding the misdeeds.

More and more transgressions are committed. And more and more, people and things related to the transgressions become triggers that remind the alcohol dependence of the dishonest acts. For example, perhaps a man steals cash from his mother's wallet and uses the money for alcohol consumption. Thereafter, whenever he sees his mother, it triggers the memory of that stolen money. It can be enough just

to see a person or an object to trigger the guilt! Sometimes no words even need to be said.

Guilt is an uncomfortable feeling and so can prompt the alcohol dependence to consume more alcohol to temporarily relieve this unwanted sensation. In this way, guilt helps maintain the trap of alcohol dependence.

The alcohol dependence will also begin to withdraw more and more from friends and family as the transgressions committed. He will eventually pull away from the family, seclude himself, and even become antagonistic towards those he loves. Remember, the basic personality of an addict is good and the reason they end up withdrawing from those they love is because they know they are doing the wrong things.

By the phone call some participants responded used the reminder cards was worked. In this study, the sticker reminder cards were given and motivated the participants to apply it into the place that they can read it every day. Many cased responded when they read it, it can remind them to stop consumption.

Some participants had some sip motivated them to think about negative outcome, past experience while admitted and remind their goal can took them decreased consumption. Discussions about causes of the slip were from interpersonal temptation situations, the patients' experiences explicit or implicit pressure by other people to consume. For example: the patients were eaten at a good restaurant on a special occasion with some friends. The waitress comes over and said "Drink before dinner?" Everyone else orders one. All eyes seem to the patient so the slip occurred. Other cause of slip was intrapersonal temptation situation such as three patients presented when they have been out of the hospital for a month and haven't taken a

single drink. However, they have wondering how well the treatment really worked, and they got a feeling like taking consumption to test it out.

One case that got a sip, after that in the morning he got some withdrawal symptoms such as sweating (i.e., diaphoresis), sticky saliva and rapid heartbeat (i.e., tachycardia). He took action with find other open spaces, drinking cool water, and took a deep breathing for 10 minutes and he got better. He responded all that can help him. In the next phone call he told that he can stop consumption.

The nursing intervention was planned following guidelines from Orem's Self-Care Deficit Nursing Theory for design a supportive-educative nursing system, Alcohol Craving Control Program. The guideline indicating a need for individuals to understand the level of their self-care requisites seemed particularly appropriate in this study. The nursing approach appeared to be highly acceptable to patients and to contribute to their motivation regarding alcohol consumption self-care. This study supports the utility of Orem's theory of self-care in nursing practice and clinical nursing research.

The use of Orem's conceptual framework for the study was appropriate in meeting the aim of the study. Self-care agency was found to be influenced by the nursing intervention and to be positively related to alcohol craving control and alcohol consumption in persons with alcohol dependence. The results of this study agreed with many previous researches (Cebeci and Celik, 2006; Culter, 2001; Hanucharurnkul et al., 1997; Kumlarn, 2004).

In evaluating the utility of guidelines for supportive-educative nursing care, consideration may be give to patient satisfaction with the approach, to patient motivation regarding self-care, and to self-care outcomes. In this study, there were no

measures of satisfaction or motivation. However, patients expressed positive reactions to the nursing intervention based on Orem's guidelines. Patients were very cooperative in arranging self-care planning in the manual of Alcohol Craving Control and high cooperative at follow-up phase.

Appendix C

The example of the Alcohol Craving Control Program

The example of the Alcohol Craving Control Program

โปรแกรมการพยาบาลเพื่อควบคุมความอยากดื่มแอลกอฮอล์ของผู้ติดแอลกอฮอล์

แนวคิดและหลักการ

โปรแกรมการพยาบาลนี้สร้างขึ้นตามกรอบแนวคิดทฤษฎีการดูแลตนเองของโอเร็ม (Orem, 2001) ที่อธิบายถึงการดูแลตนเอง ว่าเป็นการปฏิบัติกิจกรรมที่บุคคลเป็นผู้กระทำเพื่อประโยชน์ของตนในการคงไว้ซึ่งสุขภาพ ชีวิตและความผาสุก โดยผู้ที่กระทำกิจกรรมการดูแลตนเองนี้เป็นผู้ที่เติบโตเต็มที่แล้ว และเป็นผู้ที่มีความสามารถในการเรียนรู้วิธีการที่เหมาะสมเพื่อการควบคุมและพัฒนาการทำหน้าที่ของตนเอง ในการศึกษาครั้งนี้ ผู้ติดแอลกอฮอล์เป็นผู้ที่มีวัตถุประสงค์ของการดูแลตนเองมาจาก ความต้องการการดูแลตนเองที่จำเป็นเมื่อมีภาวะเบี่ยงเบนทางสุขภาพ ซึ่งได้แก่ สภาวะที่บุคคลเกิดการเจ็บป่วยอยู่ระหว่างการบำบัดรักษาและฟื้นฟูสภาพก่อให้เกิดความต้องการการดูแลตนเองให้ฟื้นคืนสู่สภาวะปกติและมีความผาสุกในชีวิต กระบวนการดูแลตนเองในสภาวะเจ็บป่วยนี้ เกี่ยวข้องกับสภาวะเปลี่ยนแปลงของสุขภาพที่เกิดขึ้นและปัจจัยที่เกี่ยวข้องกับสภาวะสุขภาพที่เปลี่ยนแปลงไปทำให้เกิดความต้องการการเพิ่มความสามารถในการดูแลตนเอง ที่แตกต่างไปจากภาวะปกติ ความสามารถเหล่านี้เกิดขึ้นได้จากการเรียนรู้การกระทำที่ตั้งใจควบคุมการทำหน้าที่และฟื้นฟูสภาพตนเองให้กลับสู่ภาวะปกติให้ได้มากที่สุด

จากการทบทวนเอกสารและงานวิจัยที่เกี่ยวข้องพบว่า ผู้ติดแอลกอฮอล์เป็นบุคคลที่มีความต้องการความสามารถในการลดปริมาณการดื่มแอลกอฮอล์ของตนเอง โดยพบสาเหตุหลักที่เกี่ยวข้องกับปัญหาที่ทำให้ไม่สามารถลดปริมาณการดื่มได้คือ ขาดความสามารถในการควบคุมความอยากดื่มแอลกอฮอล์ (Anton, 1999; Baker, Morse, & Sherman, 1986; Drummond, Litten, Lowman, & Hunt, 2000; Marlatt, 1985; Monti, Rohsennow, & Hutchison, 2000; Niaura, 2000) ปัจจัยที่เข้ามาเกี่ยวข้องทำให้เกิดความอยากแอลกอฮอล์ของผู้ป่วยนั้นได้แก่ สิ่งกระตุ้นที่เกี่ยวโยงกับพฤติกรรมการดื่ม โดยมีทั้งสิ่งกระตุ้นจากภายในและภายนอกตัวผู้ติดแอลกอฮอล์ สิ่งกระตุ้นภายในได้แก่ สภาวะอารมณ์หรือความรู้สึก เช่น ดีใจ เสียใจ กังวลใจ ความโกรธ เครียด เหงา เป็นต้น สิ่งกระตุ้นภายนอก ได้แก่ บุคคล สถานที่ สิ่งของ หรือช่วงเวลาที่เกี่ยวข้องกับพฤติกรรมการดื่ม (Lapham et al., 1998; Poikolainen, 2000; Walton et al., 2003) นอกจากนี้ประสบการณ์ในอดีตที่เกิดจากผลกระทบทางลบของการลดปริมาณการดื่มหรือหยุดดื่ม

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วัตถุประสงค์ของโปรแกรมการพยาบาลเพื่อควบคุมความอยากดื่มแอลกอฮอล์

ขั้นเตรียมการ

มีวัตถุประสงค์เพื่อสร้างความคุ้นเคยความเป็นกันเองและความไว้วางใจ รวบรวมข้อมูลและวิเคราะห์ปัญหาความอยากและการดื่มแอลกอฮอล์ สร้างแรงจูงใจ ความร่วมมือและสนับสนุนให้กำลังใจในการเพิ่มความสามารถในการดูแลตนเองที่เหมาะสม

★ วัตถุประสงค์การปฏิบัติการพยาบาล 3 ระยะ ดังนี้

ระยะที่ 1 การตรวจสอบและการสะท้อนกลับเพื่อการตัดสินใจ ประกอบด้วยขั้นเตรียมการและการปฏิบัติการพยาบาลตามโปรแกรม 5 ครั้ง ครั้งละ 60-90 นาที

ครั้งที่ 1 การเพิ่มความสามารถในการจัดการกับสิ่งกระตุ้นความอยากดื่มแอลกอฮอล์

มีวัตถุประสงค์เพื่อรวบรวมข้อมูลและวิเคราะห์สิ่งกระตุ้นที่เฉพาะเจาะจงที่เป็นสาเหตุของความอยากดื่มแอลกอฮอล์และพฤติกรรมการดื่มของตนเอง ให้ความรู้ที่เหมาะสมกับการเพิ่มความสามารถในการดูแลตนเองเพื่อควบคุมความอยากดื่มแอลกอฮอล์ และเพื่อให้ผู้ติดแอลกอฮอล์ได้ตัดสินใจเลือกและวางแผนการจัดการกับสิ่งกระตุ้นความอยากดื่มแอลกอฮอล์ของตนเอง นอกจากนี้ยังให้ความรู้ที่สำคัญเกี่ยวกับสิ่งแวดล้อมในชีวิตประจำวันชี้แนะและให้การสนับสนุนการวางแผนการจัดการกับสิ่งแวดล้อมเพื่อลดสิ่งกระตุ้นเมื่อกลับไปอยู่บ้านที่เหมาะสมกับตัว ผู้ติดแอลกอฮอล์

ครั้งที่ 2 การเพิ่มความสามารถในการจัดการกับผลกระทบทางลบของการลดปริมาณการดื่มที่ก่อให้เกิดความอยากดื่มแอลกอฮอล์;

- **ภาวะขาดแอลกอฮอล์**

มีวัตถุประสงค์เพื่อทบทวนความรู้เรื่องแอลกอฮอล์และผลกระทบจากการดื่มแอลกอฮอล์และให้มีความรู้เกี่ยวกับการจัดการกับผลกระทบทางลบที่อาจเกิดจากการลดปริมาณการดื่มแอลกอฮอล์ โดยเกิดความตระหนักว่าปัจจัยที่เกี่ยวข้องที่ทำให้เกิดความอยากแอลกอฮอล์จากการกลัวผลกระทบทางลบจาการลดปริมาณการดื่มคือ การเกิดภาวะขาดแอลกอฮอล์ พร้อมทั้งให้ความรู้ ชี้แนะแนวทางการเพิ่มความสามารถในการป้องกันการเกิดภาวะขาดแอลกอฮอล์ และเพิ่มความสามารถในการดูแลตนเองเบื้องต้นเมื่อเกิดอาการ รวมถึงให้การสนับสนุนการตัดสินใจ การวางแผนการจัดการกับภาวะขาดแอลกอฮอล์อีกด้วย

ครั้งที่ 3 การเพิ่มความสามารถในการจัดการกับผลกระทบทางลบของการลดปริมาณการดื่มที่ก่อให้เกิดความอยากดื่มแอลกอฮอล์;

- ทักษะการปฏิเสธ และการจัดการกับความเครียด

มีวัตถุประสงค์เพื่อให้ผู้ติดแอลกอฮอล์มีความสามารถในการปฏิเสธการดื่มแอลกอฮอล์อย่างเหมาะสม โดยไม่ต้องกังวลหรือกลัวกับการต้องสูญเสียสัมพันธภาพกับบุคคลที่ชักชวนหรือบุคคลที่เคยดื่มด้วย ซึ่งเป็นผลกระทบทางลบจากการลดปริมาณการดื่มหรือหยุดดื่มที่ผ่านมา นอกจากนี้ยังมีวัตถุประสงค์เพื่อเพิ่มความสามารถในการจัดการกับความเครียดที่อาจเป็นผลทางลบจากการลดปริมาณการดื่มหรือหยุดดื่ม เนื่องจากการดื่มสามารถช่วยผ่อนคลายความเครียดได้ในระยะเวลาหนึ่ง การเลือกวิธีการจัดการกับความเครียดได้อย่างเหมาะสมจึงเป็นการลดสิ่งกระตุ้นความอยากดื่มแอลกอฮอล์ได้

ครั้งที่ 4 การเพิ่มความสามารถในการจัดการกับผลทางบวกที่เคยได้รับจากการดื่มที่ก่อให้เกิดความอยากดื่มแอลกอฮอล์;

- การควบคุมอารมณ์ และเทคนิคการหยุดดื่มให้สำเร็จ

มีวัตถุประสงค์เพื่อให้ผู้ติดแอลกอฮอล์มีความสามารถในการเลือกปฏิบัติกิจกรรมเพื่อทดแทนผลทางบวก ที่เคยได้รับจากการดื่มแอลกอฮอล์ ซึ่งได้แก่ ความผ่อนคลาย ความสนุกสนาน และความกล้าแสดงออก ซึ่งการฝึกทักษะการควบคุมอารมณ์และเพิ่มเทคนิคการหยุดดื่มให้สำเร็จ เป็นการเพิ่มความสามารถในการควบคุมปัจจัยที่ทำให้เกิดความอยากดื่มแอลกอฮอล์ได้

ครั้งที่ 5 การทบทวนแผนการเพิ่มความสามารถในการควบคุมความอยากดื่มแอลกอฮอล์;

กิจกรรมครั้งนี้เป็นการเตรียมผู้ป่วยเข้าสู่โปรแกรมการพยาบาลระยะสนับสนุนการปฏิบัติการดูแลตนเอง โดยมีวัตถุประสงค์เพื่อทบทวนทักษะการดูแลตนเองและแนวทางการนำไปปฏิบัติจริงในชีวิตประจำวัน สร้างแรงจูงใจ ให้กำลังใจและสนับสนุนการปฏิบัติกิจกรรมการดูแลตนเองเพื่อควบคุมความอยากดื่มแอลกอฮอล์อย่างต่อเนื่อง โดยร่วมกิจกรรมในวันจำหน่ายผู้ป่วยกลับบ้าน นอกจากนี้ยังมีการวางแผนการจัดตารางการติดต่อทางโทรศัพท์เพื่อสนับสนุนการดูแลตนเองของผู้ติดแอลกอฮอล์ในสถานการณ์จริง

ระยะที่ 2 การปฏิบัติเพื่อควบคุมความอยากดื่มแอลกอฮอล์

การปฏิบัติการพยาบาลเพื่อสนับสนุนการปฏิบัติการดูแลตนเองในชีวิตประจำวันของผู้ป่วย โดยใช้การติดต่อทางโทรศัพท์ ครั้งละประมาณ 10 นาที รวมทั้งสิ้น 6 ครั้ง

การสนับสนุนการปฏิบัติการดูแลตนเอง (ทางโทรศัพท์) มีวัตถุประสงค์เพื่อสนับสนุนการนำความรู้ คำชี้แนะ และให้การสนับสนุนการลงมือปฏิบัติกิจกรรมเพื่อควบคุมความอยากดื่ม

แอลกอฮอล์ในสถานการณ์จริง รวมถึงการติดตามผลการปฏิบัติที่เกิดขึ้น และให้การสนับสนุนการปรับเปลี่ยนแนวทางการควบคุมความอยากดื่มแอลกอฮอล์ให้เหมาะสม เพื่อการลดปริมาณการดื่มแอลกอฮอล์ได้จริง โดยติดต่อทางโทรศัพท์กับผู้ติดแอลกอฮอล์ ในสัปดาห์ที่ 1, 2, 3, 4, 6 และ 8 หลังจำหน่ายจากสถานบำบัด

……..

ขั้นเตรียมการ

วัตถุประสงค์

1. เพื่อสร้างความคุ้นเคย ความเป็นกันเองและความไว้วางใจ
2. เพื่อรวบรวมข้อมูลและวิเคราะห์ปัญหาความอยากและการดื่มแอลกอฮอล์
3. เพื่อสร้างแรงจูงใจในการดูแลตนเอง
4. เพื่อให้การสนับสนุนและให้กำลังใจในการเพิ่มความสามารถในการดูแลตนเอง

การปฏิบัติการพยาบาล

1. ศึกษาข้อมูลผู้ติดแอลกอฮอล์แต่ละรายเพื่อคัดเลือกให้ตรงตามข้อกำหนดของกลุ่มเป้าหมาย ได้แก่ ได้รับการวินิจฉัยตามเกณฑ์ DSM IV ว่าเป็นผู้ติดแอลกอฮอล์ โดยไม่มีอาการทางจิตเวชอื่นๆ ร่วม
2. พบผู้ติดแอลกอฮอล์แต่ละรายเพื่อขอความร่วมมือในการเข้าร่วมโปรแกรมการพยาบาล
5. ประเมินความบกพร่องทางความรู้ความเข้าใจ (cognitive impairment) ด้วยแบบทดสอบ Thai MMSE (Thai Mini-Mental State Examination; Taemeeyaprachit, et al., 1990; คู่มือพยาบาล หน้า 10) โดยผู้ป่วยต้องมีคะแนนการประเมินมากกว่า 23 คะแนนขึ้นไป ซึ่งหมายถึง ไม่มีความบกพร่องทางความรู้ความเข้าใจ
6. บอกให้ทราบสิทธิในการปฏิเสธการเข้าร่วมโปรแกรมที่จะไม่มีผลกระทบต่อการรักษาพยาบาลตามปกติที่จะได้รับ หากผู้ติดแอลกอฮอล์ยินยอมเข้าร่วมโปรแกรม ดำเนินการดังนี้

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การให้ข้อมูล ……	1. ชี้แจงระยะเวลา และรูปแบบของโปรแกรมการพยาบาล 2. เปิดโอกาสให้ผู้ติดแอลกอฮอล์ซักถามข้อสงสัย 3. ให้ผู้ติดแอลกอฮอล์เซ็นต์ใบยินยอมเข้าร่วมโปรแกรม……..	 ……	ใบยินยอมเข้าร่วมโปรแกรมการพยาบาล ……

การประเมินผล

1. ผู้ติดแอลกอฮอล์พูดคุยแลกเปลี่ยนประสบการณ์และแลกเปลี่ยนความคิดเห็น

2. ผู้ติดแอลกอฮอล์ร่วมมือในการร่วมกิจกรรมและตอบแบบประเมิน

3. ผู้ติดแอลกอฮอล์แสดงความสนใจในการร่วมกิจกรรมเพื่อเพิ่มความสามารถในการดูแลตนเอง

เครื่องมือที่ใช้

- ใบยินยอมเข้าร่วมโปรแกรมการพยาบาล

- แบบประเมินการบริโภคแอลกอฮอล์, แบบประเมินปัจจัยที่เกี่ยวข้องกับดื่มแอลกอฮอล์, แบบประเมินการควบคุมความอยากแอลกอฮอล์

สื่อการสอน

- ภาพพลิกเรื่อง ดื่มมาตรฐาน - คู่มือผู้ป่วย

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ครั้งที่ 1 การเพิ่มความสามารถในการจัดการกับสิ่งกระตุ้นความอยากแอลกอฮอล์

ระยะเวลา 60 นาที

วัตถุประสงค์

1. เพื่อสร้างความคุ้นเคย ความเป็นกันเอง และความไว้วางใจ

2. เพื่อรวบรวมข้อมูลและวิเคราะห์สิ่งกระตุ้นที่เป็นสาเหตุของความอยากแอลกอฮอล์และพฤติกรรมการดื่ม

3. เพื่อเพิ่มความสามารถในการดูแลตนเอง โดยให้ความรู้ที่เหมาะสมกับการเพิ่มความสามารถในการดูแลตนเองเพื่อควบคุมความอยากแอลกอฮอล์

4. เพื่อให้ได้ตัดสินใจเลือกและวางแผนการจัดการกับสิ่งกระตุ้นความอยากแอลกอฮอล์ของตนเอง

การปฏิบัติการพยาบาล

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การสร้างสัมพันธภาพ (5 นาที)		คู่มือพยาบาล หน้า 16	
2. การวิเคราะห์ปัจจัยที่เกี่ยวข้อง (15 นาที)	1. ทบทวนข้อมูลจากการตอบแบบสอบถามของผู้ติดแอลกอฮอล์เพื่อช่วยเหลือในการวิเคราะห์ปัญหาปัจจัยที่เป็นสาเหตุ, ระดับความสามารถในการควบคุมความ	- “จากการตอบแบบสอบถามของคุณครั้งที่ผ่านมายังจำได้บ้างไหม เราดูจากคู่มือประกอบไปด้วยเลยนะคะ คุณจะเห็นว่าสิ่งที่เกี่ยวข้องกับการดื่มของคุณมีอยู่หลายอย่าง	คู่มือผู้ป่วย หน้า 3, 4

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
	อยากที่ผ่านมา และสรุปปัญหาการดื่มแอลกอฮอล์ให้ผู้ป่วยได้ทราบ	ทีเดียว ที่สำคัญๆ คือ....."	
3. การชี้แนะ (10 นาที)	1. พูดคุยสะท้อนปัญหาให้เกิดความ	- "คุณคงเห็นแล้วว่า ปัญหาที่	
	ตระหนักโดยเน้นผลด้านลบของการขาดความสามารถที่จำเป็นในการดูแลตนเองเพื่อควบคุมความอยากดื่มที่นำมาสู่พฤติกรรมการดื่มที่ผู้ติดแอลกอฮอล์อาจมองข้าม 2. สร้างแรงจูงใจโดยให้ผู้ติดแอลกอฮอล์คิดถึงผลที่จะเกิดขึ้นหากสามารถหยุดหรือลดปริมาณการดื่มแอลกอฮอล์ได้ และสอบถามให้เกิดความตระหนักถึงผลด้านลบหากยังคงดื่มต่อไป 3. เชื่อมโยงปัญหาการดื่ม มาสู่ความต้องการความสามารถที่จำเป็นในการดูแลตนเอง คือ การควบคุมความอยากแอลกอฮอล์	เกิดขึ้นจากการดื่มของคุณมีหลายอย่างอยู่เหมือนกัน เช่น... นอกจากนี้ยังมีเรื่องของ.... ซึ่งจริงๆ แล้วก็เป็นเรื่องสำคัญเหมือนกัน" - "หรือคุณคิดว่าอย่างไร" - "คุณคิดว่าจะเกิดอะไรขึ้นกับคุณบ้าง หากคุณสามารถหยุดหรือลดปริมาณการดื่มของคุณได้" - "แล้วคุณคิดว่าจะเกิดอะไรขึ้นกับคุณได้บ้าง หากคุณยังคงดื่มต่อไป" - "จากที่พูดคุยกันมาทั้งหมด คุณเห็นด้วยหรือไม่ว่าปัญหาจากการดื่มของคุณนั้นมีมากมายหลายอย่าง ซึ่งมากกว่าที่คุณเคยคิดด้วยซ้ำ สิ่งสำคัญอันหนึ่งคือคุณยังดูแลตัวเองได้ไม่ดีเท่าที่ควร จะเห็นได้จากคะแนนการตอบแบบสอบถามต่างๆ โดยเฉพาะอย่างยิ่งการควบคุมความอยากที่นำไปสู่การดื่มแอลกอฮอล์"	คู่มือผู้ป่วย หน้า 7
4. สนับสนุนการตัดสินใจการดูแลตนเอง (20 นาที)	1. ซักถามถึงประสบการณ์ที่มีสิ่งกระตุ้นเข้ามาทำให้เกิดความอยากดื่มและพฤติกรรมการดื่มแอลกอฮอล์ 2. ให้ความรู้เพิ่มเติมเกี่ยวกับสิ่งกระตุ้น.....	- "เคยสังเกตบ้างไหมว่า โดยส่วนใหญ่แล้วความอยากดื่มของคุณแต่ละครั้งมีสาเหตุหรือมีอะไรเป็นสิ่งกระตุ้นบ้าง เช่น บางคนชอบบอกว่าอยากดื่มเพราะไม่มีอะไรทำ อยากดื่มเพราะเจอเพื่อน อยากดื่มเพราะเครียดแล้วคุณล่ะส่วนใหญ่เป็นอย่างไร"	.....

การประเมินผล

1. ผู้ติดแอลกอฮอล์พูดคุยแลกเปลี่ยนประสบการณ์และแลกเปลี่ยนความคิดเห็นกับผู้วิจัย

2. ผู้ติดแอลกอฮอล์ร่วมมือในการตอบแบบสำรวจสิ่งกระตุ้น

3. ผู้ติดแอลกอฮอล์สามารถสรุปปัญหาในการควบคุมความอยากดื่มของตนเองว่ามาจากสิ่งกระตุ้นอะไรบ้าง

4. ผู้ติดแอลกอฮอล์บอกแนวทางการดูแลตนเองเพื่อจัดการกับสิ่งกระตุ้นที่ทำให้เกิดความอยากดื่มของตนเองที่เหมาะสมได้

เครื่องมือที่ใช้

- แบบสำรวจสิ่งกระตุ้น
- แบบบันทึกการจัดการกับสิ่งกระตุ้น

สื่อการสอน

- ภาพพลิกเรื่อง สิ่งกระตุ้น, จัดการสิ่งแวดล้อมที่เป็นสิ่งกระตุ้นให้เกิดความอยากดื่มแอลกอฮอล์
- คู่มือผู้ป่วย

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ครั้งที่ 2การจัดการกับผลกระทบทางลบของการลดปริมาณการดื่มที่ก่อให้เกิดความอยากแอลกอฮอล์; ภาวะขาดแอลกอฮอล์

ระยะเวลา 60 นาที

วัตถุประสงค์

1. เพื่อทบทวนความรู้เรื่องแอลกอฮอล์และผลกระทบจากการดื่มแอลกอฮอล์
2. เพื่อให้ความรู้เกี่ยวกับการจัดการกับผลกระทบทางลบที่อาจเกิดจากการลดปริมาณการดื่มแอลกอฮอล์ ได้แก่ การเกิดภาวะขาดแอลกอฮอล์
3. เพื่อให้ความรู้ ชี้แนะแนวทางการเพิ่มความสามารถในการป้องกันการเกิดและการดูแลตัวเองเบื้องต้นเมื่อเกิดภาวะขาดแอลกอฮอล์
4. เพื่อให้การสนับสนุนการตัดสินใจและการวางแผนจัดการกับภาวะขาดแอลกอฮอล์

การปฏิบัติการพยาบาล

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การสร้างสัมพันธภาพ (5 นาที)		คู่มือพยาบาล หน้า 16	
2. การทบทวนการปฏิบัติ การพยาบาลครั้งที่ผ่านมา (5 นาที)		คู่มือพยาบาล หน้า 22	
3. การให้ความรู้ (10 นาที)	1. เปิดประเด็นการสนทนาเรื่องความรู้เกี่ยวกับแอลกอฮอล์และผลกระทบจากการดื่มแอลกอฮอล์เพื่อทบทวนความรู้ 2. ตรวจสอบการตอบแบบสอบถามโดยใช้ข้อมูลที่ผู้ติดแอลกอฮอล์ตอบผิดมาเป็นประเด็นการสนทนาโดยให้ข้อมูลที่ถูกต้องเพิ่มเติม	- “ดิฉันคิดว่า คุณคงได้รับข้อมูลเกี่ยวกับผลดีและผลเสียของการดื่มแอลกอฮอล์มาบ้างแล้ว ซึ่งข้อมูลเหล่านี้มีความสำคัญกับความตระหนักในการ ที่จะลดปริมาณการดื่มของคุณเป็นอย่างยิ่ง เพราะหากคุณรับรู้และยอมรับผลเสียของการดื่มที่มีต่อตัวคุณและคนรอบข้างมากเท่าไร ก็จะยิ่งช่วยให้คุณมีความพยายามที่จะควบคุมความอยากดื่มเพื่อลดปริมาณการดื่มได้ดียิ่งขึ้น” - “ขอให้คุณทบทวนความรู้โดยตอบแบบสอบถามต่อไปนี้ แล้วเรามาคุยรายละเอียดกัน”	คู่มือผู้ป่วย หน้า 20
4. การวิเคราะห์ปัจจัยที่เกี่ยวข้องกับความอยากและการดื่มแอลกอฮอล์ (10นาที)	1. เปิดประเด็นการสนทนาโดยกล่าวถึงปัญหาการหยุดดื่ม หรือลดปริมาณการดื่มที่มีต่อร่างกายของผู้ติดแอลกอฮอล์จากประสบการณ์ที่ผ่านมาว่ามีอะไรบ้าง 2. ซักถามประสบการณ์การดูแลตนเองของผู้ติดแอลกอฮอล์เมื่อเกิดภาวะขาดแอลกอฮอล์ว่ามีหรือไม่ โดยทบทวนจากการตอบแบบสอบถามที่ผ่านมา		คู่มือผู้ป่วย หน้า 4

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
5. การให้ความรู้ (5นาที)	1. ให้ความรู้เรื่องการจัดการกับภาวะขาดแอลกอฮอล์เพิ่มเติม		ภาพพลิกการจัดการกับภาวะขาดแอลกอฮอล์
6. การชี้แนะและสนับสนุนการตัดสินใจเลือกแนวทางการดูแลตนเอง (15นาที)	1. ร่วมวางแผนการนำความรู้และทักษะการดูแลตนเองเมื่อเกิดภาวะขาดแอลกอฮอล์ไปปฏิบัติจริง โดยบันทึกลงในแบบบันทึกแนวทางการจัดการกับภาวะขาดแอลกอฮอล์ 2. ให้กำลังใจและชมเชยเมื่อผู้ป่วยทบทวนการดูแลตนเองได้อย่างถูกต้อง และให้กำลังใจในการนำไปปฏิบัติต่อไป	- “จากที่ได้พูดคุยกันมา ขอให้คุณลองบอกวิธีการที่คุณจะนำไปใช้เพื่อดูแลตนเองให้ฟังหน่อย” - “ขอให้คุณบันทึกแนวทางทั้งหมดลงในแบบบันทึก เพื่อคุณจะได้ทบทวนได้ในสถานการณ์จริงของคุณภายหลังได้กลับไปอยู่บ้าน” - “วันนี้จะเห็นว่าเราเริ่มมีความก้าวหน้าในการวางแผนการดูแลตนเองของคุณมากขึ้นแล้ว ดิฉันเชื่อว่าหากคุณยังมีความตั้งใจและให้ความร่วมมืออย่างนี้ คุณต้องประสบความสำเร็จอย่างแน่นอน”	คู่มือผู้ป่วย หน้า 36
7. สรุปการปฏิบัติการพยาบาล (10นาที)		คู่มือพยาบาล หน้า 16	

การประเมินผล

1. ผู้ติดแอลกอฮอล์พูดคุยแลกเปลี่ยนประสบการณ์และความคิดเห็นกับผู้วิจัย
2. ผู้ติดแอลกอฮอล์บอกผลกระทบจากการดื่มแอลกอฮอล์ที่เกิดกับตนเองได้
3. ผู้ติดแอลกอฮอล์สามารถบอกแนวทางการดูแลตนเองเพื่อป้องกันภาวะขาดแอลกอฮอล์ เลือกวิธีการดูแลตนเองเบื้องต้นและวางแผนการปฏิบัติได้

เครื่องมือที่ใช้

- แบบประเมินความรู้เรื่อง แอลกอฮอล์และผลกระทบจากการดื่มแอลกอฮอล์
- แบบบันทึกแนวทางการจัดการกับภาวะขาดแอลกอฮอล์

สื่อการสอน

- ภาพพลิกเรื่อง แอลกอฮอล์และผลกระทบจากการดื่มแอลกอฮอล์, การจัดการกับภาวะขาดแอลกอฮอล์
- คู่มือผู้ป่วย

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ครั้งที่ 3การเพิ่มความสามารถในการจัดการกับผลกระทบทางลบจาการลดปริมาณการดื่มที่ก่อให้เกิดความอยากแอลกอฮอล์;

ทักษะการปฏิเสธ และการจัดการกับความเครียด

ระยะเวลา 90 นาที

วัตถุประสงค์

1. เพื่อให้สามารถตัดสินเลือกวิธีการปฏิเสธการดื่มแอลกอฮอล์ที่เหมาะสมได้
2. เพื่อให้สามารถตัสินใจเลือกวิธีจัดการกับความเครียดที่นำไปสู่ความอยากแอลกอฮอล์ของตนเองได้

การปฏิบัติการพยาบาล

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การสร้างสัมพันธภาพ (5 นาที)		คู่มือพยาบาล หน้า 16	
2. การทบทวนการปฏิบัติการพยาบาลครั้งที่ผ่านมา (5 นาที)		คู่มือพยาบาล หน้า 22	
3. การชี้แนะ (10 นาที)	1. เปิดประเด็นการสนทนาโดยกล่าวถึงสิ่งกระตุ้นสำคัญที่ทำให้เกิดความอยากแอลกอฮอล์คือ การตกอยู่ในสถานการณ์เสี่ยงและการถูกชักชวนให้ดื่มโดยผู้วิจัยกล่าวถึงความสำคัญของการปฏิเสธ เชื่อมโยงให้เห็นถึงการปฏิเสธสิ่งกระตุ้นเป็นหัวใจสำคัญของการป้องกันการกลับไปดื่มซ้ำ 2. ให้ผู้ติดแอลกอฮอล์เล่าประสบการณ์การปฏิเสธที่ผ่านมาโดยเล่าทั้งประสบการณ์ที่สามารถปฏิเสธได้สำเร็จและไม่สำเร็จ 3. ร่วมวิเคราะห์ประสบการณ์เพื่อหา	- “หากเราเป็นคนที่ปฏิเสธคนอื่นไม่เป็นจะมีผลดีและผลเสียอย่างไร” - “จากที่ผ่านมา ขอให้คุณลองยกตัวอย่างเหตุการณ์ที่คุณถูกเพื่อนชวนดื่ม คุณปฏิเสธการชวนหรือไม่อย่างไร ช่วยเล่ารายละเอียดให้ฟังหน่อย”	

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
	จุดอ่อนและจุดแข็งของการใช้ทักษะ	- “จากที่เล่ามาคุณคิดว่าเพราะอะไรครั้งนั้นถึงปฏิเสธได้สำเร็จ.....และเพราะอะไรครั้งนั้นจึงปฏิเสธไม่สำเร็จ”	
4. การให้ความรู้ (5 นาที)	1. เชื่อมโยงประสบการณ์มาสู่การให้ข้อมูลหลักการปฏิเสธเพิ่มเติม 2. ซักถามการนำไปใช้ในสถานการณ์จริงโดยให้ผู้ติดแอลกอฮอล์เสนอว่าจะนำไปใช้ได้อย่างไร จะมีปัญหาในการใช้หรือไม่ อย่างไร แล้วร่วมกันหาแนวทางการแก้ไขเพื่อนำไปใช้ได้จริง		ภาพพลิกหลักการปฏิเสธ
5. การชี้แนะสนับสนุนการดูแลตนเอง (15 นาที)	1. ให้ผู้ติดแอลกอฮอล์ฝึกการปฏิเสธโดยใช้สถานการณ์สมมติ 2 สถานการณ์ คือ ถูกเพื่อชวนไปงานเลี้ยง และหากจำเป็นต้องไปในงานเลี้ยงแล้วอยู่ในสถานการณ์ที่ถูกคะยั้นคะยอให้ดื่ม	- “สมมุติว่าเพื่อนสนิทของคุณมาชวนคุณไปงานเลี้ยงวันเกิด ซึ่งคุณทราบว่าคุณต้องตกอยู่ท่ามกลางการดื่มของเพื่อนๆ คุณจะปฏิเสธการไปร่วมงานอย่างไร โดยสมมุติว่าดิฉันเป็นเพื่อนของคุณ เราลองมาซ้อมกันดูก่อนว่าจะทำอย่างไรดี” - “ครั้งนี้สมมุติว่า คุณมีความจำเป็นต้องไปงานเลี้ยงจริงๆ เมื่ออยู่ในงานแล้วคุณถูกเพื่อชวนคะยั้นคะยอมากๆ คุณจะทำอย่างไร เดี๋ยวดิฉันจะทดลองเป็นเพื่อนของคุณ ขอให้คุณลองพยายามปฏิเสธตามสถานการณ์จริงๆ ดูนะคะ”	
6. การให้ความรู้ (10 นาที)	1. เปิดประเด็นการสนทนาโดยทบทวนสิ่งกระตุ้นที่ทำให้เกิดความอยากแอลกอฮอล์ของผู้ติดแอลกอฮอล์ว่ามีปัจจัยเรื่อง ความเครียดเข้ามาเกี่ยวข้องหรือไม่โดยให้ผู้ติดแอลกอฮอล์ทบทวนประสบการณ์การดื่มที่ผ่านมาว่ามีความเครียดเข้ามา		

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
.....	เป็นสาเหตุทำให้เกิดการดื่มบ้างหรือไม่ และให้ผู้ติดแอลกอฮอล์เล่าประสบการณ์นั้นให้ฟัง 2. เชื่อมโยงประสบการณ์ของผู้ติดแอลกอฮอล์มาสู่.....	- "จากเหตุการณ์ที่เกิดขึ้นคุณคิดว่า	ภาพพลิกการจัดกับความเครียด .....

การประเมินผล

- ผู้ติดแอลกอฮอล์ให้ความร่วมมือในการแลกเปลี่ยนประสบการณ์และตอบข้อซักถาม
- ผู้ติดแอลกอฮอล์ให้ความร่วมมือในการตอบแบบประเมิน
- ผู้ติดแอลกอฮอล์สนใจและร่วมมือในการฝึกปฏิบัติ
- ผู้ติดแอลกอฮอล์สามารถสรุปประเด็นสำคัญของการจัดการกับความเครียด หลักการปฏิเสธ และเลือกแนวทางที่ตนเองจะนำไปใช้ได้

เครื่องมือที่ใช้

- แบบประเมินความเครียด
- สถานการณ์จำลองการฝึกทักษะปฏิเสธ
- แบบบันทึกแนวทางจัดการกับความเครียด

สื่อการสอน

- ภาพพลิกการจัดการกับความเครียด, เทคนิคการผ่อนคลายความเครียด
- VCD การผ่อนคลายความเครียดของกรมสุขภาพจิต
- คู่มือผู้ป่วย

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ครั้งที่ 4การเพิ่มความสามารถในการจัดการผลทางบวกที่เคยได้รับจากการดื่มที่ก่อให้เกิดความอยากแอลกอฮอล์;

1. การควบคุมอารมณ์ และเทคนิคการหยุดดื่มให้สำเร็จ

2. การเตรียมผู้ติดแอลกอฮอล์ก่อนเข้าสู่กิจกรรมสนับสนุนการปฏิบัติการดูแลตนเอง

ระยะเวลา 60 นาที

วัตถุประสงค์

1. เพื่อให้สามารถตัดสินใจเลือกวิธีการควบคุมอารณ์และหากิจกรรมทดแทนผลทางบวกเคยที่ได้รับจากการดื่มแอลกอฮอล์
2. เพื่อให้สามารถตัดสินใจเลือกเคล็ดลับการหยุดดื่มให้สำเร็จไปวางแผนการปฏิบัติได้
3. เพื่อทบทวนแนวทางการดูแลตนเองและแนวทางการนำทักษะไปใช้จริงในชีวิตประจำวัน
4. เพื่อสร้างแรงจูงใจและให้กำลังใจในการปฏิบัติการดูแลตนเองในสถานการณ์จริง
5. เพื่อนัดหมายการติดต่อทางโทรศัพท์เพื่อสนับสนุนการปฏิบัติการดูแลตนเองของผู้ป่วย

การปฏิบัติการพยาบาล

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การสร้างสัมพันธภาพ(5 นาที)		คู่มือพยาบาล หน้า 16	
2. การทบทวนการปฏิบัติการพยาบาลครั้งที่ผ่านมา (5 นาที)		คู่มือพยาบาล หน้า 22	
3. การชี้แนะ (5 นาที)	1. เปิดประเด็นเกี่ยวกับอารมณ์อื่นๆ ที่เกิดขึ้นแล้วนำไปสู่การเกิดความอยากแอลกอฮอล์ เช่น อารมณ์ด้านบวก ได้แก่ ต้องการความสนุกสนาน ต้องการความผ่อนคลาย หรือความกล้าแสดงออก โดยให้ ผู้ติดแอลกอฮอล์เล่าประสบการณ์ที่ผ่านมาของตนเองที่เกี่ยวเนื่องกับอารมณ์เหล่านี้แล้วนำไปสู่การดื่มแอลกอฮอล์	- “ที่ผ่านมาเคยมีบ้างไหมที่คุณดื่มเพราะต้องการฉลอง ต้องการความสนุกสนาน หรือการผ่อนคลาย” - “ขอให้คุณช่วยเล่าเหตุการณ์เหล่านั้นให้ฟังหน่อย”	
4. การให้ความรู้ (10 นาที)	2. เชื่อมโยงประสบการณ์ของผู้ติดแอลกอฮอล์มาสู่แนวทางการควบคุมอารมณ์ และให้ข้อมูลเรื่องการควบคุมอารมณ์เพิ่มเติม		ภาพพลิกการควบคุมอารมณ์
5. การชี้แนะและสนับสนุนการตัดสินใจเลือกการปฏิบัติการดูแลตนเอง (15 นาที)	1. ให้ผู้ติดแอลกอฮอล์ทดลองนำแนวทางการควบคุมอารมณ์ไปปรับแก้ปัญหาหรือสถานการณ์ในอดีตที่เล่ามา	- “จากที่บอกไปเกี่ยวกับการคิด และพฤติกรรมที่เหมาะสมที่เราจะควบคุมอารณ์ของเราได้ อยากให้คุณลองคิดย้อนกลับถึงเรื่องเมื่อกี้ที่คุณเล่ามา หากคุณจะควบคุมอารณ์ของคุณตอนนั้นคุณจะทำอย่างไร”	

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
	2. ชี้แนะ หรือให้ทางเลือกเพิ่มเติม 3. ให้ผู้ติดแอลกอฮอล์ฝึกวางแผน การควบคุมอารมณ์ในอนาคตหากต้องพบกับภาวะอารมณ์ที่เป็นปัญหาจนอาจนำไปสู่การดื่มแอลกอฮอล์ว่าจะทำอย่างไร โดยทำแบบฝึกการควบคุมอารมณ์ …… 5. ให้ข้อมูลเคล็ดลับการหยุดดื่มให้สำเร็จ และเน้นย้ำการตั้งเป้าหมายของผู้ติดแอลกอฮอล์ที่จะนำเคล็ดลับไปใช้	- “ขอให้คุณลองคิดถึงเหตุการณ์ในวันหน้าว่าจะมีอารมณ์แบบใดที่อาจเป็นปัญหากับคุณ และลองคิดวิธีการควบคุมอารณ์ที่คุณจะนำไปใช้ แล้วบันทึกไว้ในแบบบันทึก” …… - “จากประสบการณ์การดูแลผู้ติดแอลกอฮอล์ที่ผ่านมา มีผู้ที่ประสบความสำเร็จในการลดปริมาณการดื่มและหยุดดื่มได้แนะนำเทคนิคที่ใช้แล้วได้ผลไว้ ดิฉันอยากให้คุณลองพิจารณาดูเพราะคงเป็นประโยชน์กับคุณอย่างมาก”	คู่มือผู้ป่วย หน้า 64 …….. ภาพพลิกเทคนิคการหยุดดื่มให้สำเร็จ

การประเมินผล

1. ผู้ติดแอลกอฮอล์ให้ความร่วมมือในการแลกเปลี่ยนประสบการณ์และตอบข้อซักถาม

2. ผู้ติดแอลกอฮอล์เลือกแนวทางการควบคุมอารมณ์และเทคนิคการหยุดดื่มให้สำเร็จที่จะนำไปใช้ได้

เครื่องมือที่ใช้

- แบบบันทึกการควบคุมอารมณ์

สื่อการสอน

- ภาพพลิกการควบคุมอารมณ์, เทคนิคการหยุดดื่มให้สำเร็จ

……

ครั้งที่ 5 การทบทวนแผนการปฏิบัติการดูแลตนเองเพื่อควบคุมความอยากดื่มแอลกอฮอล์

ระยะเวลา 60 นาที

วัตถุประสงค์

1. เพื่อทบทวนแนวทางการดูแลตนเองและแนวทางการนำทักษะไปใช้จริงในชีวิตประจำวัน
2. เพื่อสร้างแรงจูงใจและให้กำลังใจในการปฏิบัติการดูแลตนเองในสถานการณ์จริง
3. เพื่อนัดหมายการติดต่อทางโทรศัพท์เพื่อสนับสนุนการปฏิบัติการดูแลตนเองของผู้ป่วย

การปฏิบัติการพยาบาล

กระบวนการพยาบาล	แนวทางการปฏิบัติ	ตัวอย่างการปฏิบัติ	เครื่องมือ/สื่อ
1. การสร้างสัมพันธภาพ(5 นาที)		คู่มือพยาบาล หน้า 16	
2. การสนับสนุนเข้าสู่การปฏิบัติการดูแลตนเองในสถานการณ์จริง	1. ทบทวนกิจกรรมทั้งหมดที่ผ่านมาโดยใช้คู่มือผู้ป่วยประกอบการทบทวน 2. ให้ผู้ติดแอลกอฮอล์บอกแนวทางการดูแลตนเองที่จะนำไปปฏิบัติในชีวิตประจำวัน โดยทบทวนจากแบบบันทึกต่างๆ ในคู่มือ 3. มอบคู่มือผู้ป่วยให้กับผู้ติดแอลกอฮอล์ โดยเน้นย้ำการทบทวนเนื้อหาและกิจกรรมต่างๆ ในคู่มือ เพราะนี่คือตัวช่วยสำคัญที่จะทำให้ผู้ติดแอลกอฮอล์สามารถดูแลตนเองได้ตามเป้าหมายในสถานการณ์จริง และเน้นย้ำการใช้คู่มือเป็นแนวทางในการปฏิบัติการพยาบาลทางโทรศัพท์ต่อไป 4. สร้างแรงจูงใจในการลงมือปฏิบัติและให้กำลังใจ 5. บันทึกเวลานัดหมายในตารางการนัดหมายมอบให้ผู้ติดแอลกอฮอล์	- “อยากให้คุณบอกอีกซักครั้งว่าหากคุณดูแลตนเองได้ตามเป้าหมาย ใครบ้างที่จะได้รับประโยชน์และมีความสุขกับการเปลี่ยนแปลงของคุณ” - “ขอให้คุณจดจำสิ่งที่เราพูดคุยกันไว้ให้ดี เมื่อเรามีการวางแผนที่ดี มีความตั้งใจและความมุ่งมั่นกำหนดเป้าหมายไว้อย่างชัดเจนอย่างนี้แล้ว คุณก็จะสามารถทำได้และประสบความสำเร็จ ดิฉันขอเป็นกำลังใจและจะคอยให้การสนับสนุนคุณต่อไป”	คู่มือผู้ป่วย คู่มือผู้ป่วย หน้า 68
……	……	……	……

การประเมินผล

1. ผู้ติดแอลกอฮอล์ทบทวนกิจกรรมที่ผ่านมาและบอกแนวทางการนำทักษะต่างๆ ไปใช้ได้

2. ผู้ติดแอลกอฮอล์มีแรงจูงใจและกำลังใจในการนำกิจกรรมต่างๆ ไปใช้ในชีวิตประจำวัน โดยแสดงความตั้งใจและร่วมมือในกิจกรรม

3. ผู้ติดแอลกอฮอล์ให้ความร่วมมือในการจัดตารางนัดหมาย

4. ผู้ติดแอลกอฮอล์รับคู่มือกิจกรรมและรับตารางนัดหมาย

เครื่องมือที่ใช้

- ตารางนัดหมายการสนับสนุนการปฏิบัติการดูแลตนเอง (ทางโทรศัพท์)

สื่อการสอน

- คู่มือผู้ป่วย

.....

ระยะที่ 2 การปฏิบัติการดูแลตนเองเพื่อควบคุมความอยากแอลกอฮอล์;

การสนับสนุนการปฏิบัติการดูแลตนเอง (ทางโทรศัพท์)

ระยะเวลา ครั้งละประมาณ 10 นาที (สัปดาห์ที่ 1, 2, 3, 4, 6, และ 8 หลังจำหน่าย) รวมทั้งสิ้น 6 ครั้ง

กรอบแนวคิดการปฏิบัติการพยาบาลระยะที่ 2

การนำความรู้และแนวทางต่างๆ ไปลงมือปฏิบัติเพื่อตอบสนองความจำเป็นในการดูแลตนเองโดยผู้ติดแอลกอฮอล์สามารถนำแนวทางการควบคุมความอยากแอลกอฮอล์ไปปฏิบัติในชีวิตจริง และสามารถปรับเปลี่ยนการปฏิบัติการดูแลตนเองเพื่อควบคุมความอยากแอลกอฮอล์ที่เหมาะสมโดยมีการติดตามประเมินผลการปฏิบัติอย่างต่อเนื่อง นำไปสู่การลดปริมาณการดื่มได้จริง

วัตถุประสงค์

1. เพื่อสนับสนุนการนำความรู้ และคำชี้แนะเกี่ยวกับการควบคุมความอยากแอลกอฮอล์ไปใช้ในสถานการณ์จริง

2. เพื่อติดตามผลการปฏิบัติกิจกรรมเพื่อควบคุมความอยาก แอลกอฮอล์ที่เกิดขึ้นกับผู้ป่วย

3. เพื่อให้การสนับสนุนการปรับเปลี่ยนแนวทางการควบคุมความอยากแอลกอฮอล์ให้เหมาะสมเพื่อการลดปริมาณการดื่มได้จริง

4. เพื่อให้กำลังใจและสร้างแรงจูงใจในการปฏิบัติการดูแลตนเองอย่างต่อเนื่อง

ตารางการนัดหมายการสนับสนุนการปฏิบัติการดูแลตนเองทางโทรศัพท์

ครั้งที่ 1 วันที่ เวลา	**ครั้งที่** 2 วันที่ เวลา	**ครั้งที่** 3 วันที่ เวลา	**ครั้งที่** 4 วันที่ เวลา
ครั้งที่ 5		**ครั้งที่** 6	
ครั้งที่ 7			

……..

แบบบันทึก การสนับสนุนการปฏิบัติการดูแลตนเอง ครั้งที่ ……

วันที่.....เวลาเริ่มโทร.....เวลาสิ้นสุดการโทร.....

ประเด็นการสนทนา	**ปัญหา**	**แนวทางการปรับปรุง**

จุดแข็งของผู้ป่วย	**จุดที่ต้องปรับปรุง**

ประเด็นการติดตามครั้งต่อไป

Appendix D

The Alcohol Consumption Assessment (ACA)

แบบประเมินการบริโภคแอลกอฮอล์

The Alcohol Consumption Assessment (ACA)

แบบประเมินการบริโภคแอลกอฮอล์

ขอความร่วมมือ โปรดตอบแบบสอบถามต่อไปนี้เพื่อเป็นประโยชน์ในการลด/เลิกดื่มแอลกอฮอล์ของคุณ

ชื่อ-สกุล..... อายุ .....ปี

ที่อยู่ปัจจุบัน.....

.....

โทรศัพท์.....สถานภาพ.....

อาชีพ.....รายได้เฉลี่ย/เดือน.....

ประวัติการดื่มแอลกอฮอล์ของสมาชิกในครอบครัว.....

1. ชนิดของแอลกอฮอล์ที่ดื่ม.....
2. ปริมาณแอลกอฮอล์ที่คุณดื่มโดยเฉลี่ย..... (จำนวนดื่มมาตรฐาน.....ดื่ม)
3. จำนวนวันที่คุณดื่มใน 1 สัปดาห์ที่ผ่านมา.....วัน

วันที่เข้ารับการบำบัด..... **วันที่จำหน่าย**.....

ข้อมูลเพิ่มเติม.....

.....

Appendix E

The Obsessive Compulsive Drinking Scale (OCDS)

The Obsessive Compulsive Drinking Scale (OCDS)

แบบประเมิน การควบคุมความอยากดื่มแอลกอฮอล์

คำชี้แจง; ข้อคำถามต่อไปนี้เป็นคำถามเกี่ยวกับการดื่มและความพยายามในการควบคุมความอยากดื่มแอลกอฮอล์ของคุณ กรุณาทำเครื่องหมาย **X** หน้าข้อความที่ตรงกับคำตอบของคุณมากที่สุด

1. ใน 1 วัน คุณใช้เวลาคิดถึงหรือนึกเห็นภาพเกี่ยวกับการดื่มแอลกอฮอล์มากน้อยเพียงใด

   (0) ไม่เลย
   (1) น้อยกว่า 1 ชั่วโมงต่อวัน
   (2) 1-3 ชั่วโมงต่อวัน
   (3) 4-8 ชั่วโมงต่อวัน
   (4) มากกว่า 8 ชั่วโมงต่อวัน

2. คุณคิดถึงการดื่มแอลกอฮอล์บ่อยแค่ไหน

   (0) ไม่เลย
   (1) ไม่เกิน 8 ครั้งต่อวัน
   (2) มากกว่า 8 ครั้งต่อวัน แต่ใช้เวลาคิดถึงแต่ละครั้งไม่นานมากนัก
   (3) มากกว่า 8 ครั้งต่อวัน และคิดถึงวนเวียนอยู่เกือบตลอดเวลา
   (4) คิดถึงบ่อยมากที่สุดจนไม่สามารถนับได้

3. การคิดถึงหรือนึกเห็นภาพเกี่ยวกับการดื่มแอลกอฮอล์รบกวนการดำเนินชีวิตหรือการทำงานของคุณมากน้อยเพียงใด

   (0) ไม่เลย (1) รบกวนเล็กน้อยแต่ไม่มีผลกระทบต่อชีวิตหรือทำงานได้ตามปกติ
   (2) รบกวนชีวิตและการทำงานอย่างแน่นอนแต่ยังสามารถจัดการได้
   (3) รบกวนและก่อให้เกิดปัญหากับการดำเนินชีวิตหรือการทำงานบ้าง
   (4) รบกวนและก่อปัญหากับการดำเนินชีวิตและการทำงานอย่างมาก

4. การคิดถึงการดื่มแอลกอฮอล์ทำให้คุณเกิดความเสียใจหรือรบกวนจิตใจของคุณมากน้อยเพียงใด

   (0) ไม่เลย (1) เล็กน้อย ไม่บ่อย และไม่ได้ทำให้เสียใจหรือรบกวนจิตใจมากนัก
   (2) พอสมควร เกิดขึ้นบ่อย และรบกวนจิตใจบ้าง
   (3) มาก เกิดขึ้นบ่อยมาก และรบกวนจิตใจมาก
   (4) รุนแรงมาก เกิดขึ้นเกือบตลอดเวลา และรบกวนจิตใจทำให้เสียใจจนทำอะไรไม่ได้

5. คุณใช้ความพยายามมากน้อยเพียงใดที่จะ**<u>ต่อต้านการคิดถึง</u>** **<u>หรือพยายามที่จะมองข้าม</u>**

……

Appendix F

Patient/participant information sheet

ข้อมูลสำหรับประชากรตัวอย่างหรือผู้มีส่วนร่วมในการวิจัย

ชื่อโครงการวิจัย ผลของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์

ชื่อผู้วิจัย นางสาวสุนิศา สุขตระกูล

ตำแหน่ง นิสิตคณะพยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย

สถานที่ติดต่อผู้วิจัย คณะพยาบาลศาสตร์จุฬาลงกรณ์มหาวิทยาลัย

ที่บ้าน 70/2 หมู่ 2 ตำบล ไผ่ลิง อำเภอ พระนครศรีอยุธยา จังหวัด พระนครศรีอยุธยา13000

หมายเลขโทรศัพท์-ที่บ้าน 035-242-965 **มือถือ** 08-1804-0459

ข้อมูลที่เกี่ยวข้องกับการให้คำยินยอมและเอกสารอื่นๆ ในการวิจัย ประกอบด้วย

1. วัตถุประสงค์ของการวิจัย: เพื่อศึกษาผลของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์

ประโยชน์ของงานวิจัย:

- ช่วยป้องกันปัญหาสุขภาพและปัญหาอื่นๆ ที่อาจเกิดจากการดื่มแอลกอฮอล์ของผู้ติดแอลกอฮอล์และผู้ที่เกี่ยวข้อง

- ประสิทธิภาพของโปรแกรมสามารถนำไปปรับใช้กับปัญหาสุขภาพอื่นๆ ที่เหมาะสมได้

- ผลการศึกษาประสิทธิภาพของโปรแกรมสามารถนำไปเป็นข้อมูลสำหรับการพัฒนาองค์ความรู้ของทฤษฎีการดูแลตนเองของโอเรม เพื่อประโยชน์ด้านงานบริการและการศึกษาวิจัย

2. ลักษณะของประชากรตัวอย่าง สถานที่ และวิธีการได้มาซึ่งกลุ่มตัวอย่าง: งานวิจัยนี้ผู้มีส่วนร่วมในการวิจัยเป็นผู้ติดแอลกอฮอล์ที่มีอายุ 20 ปี ขึ้นไปที่เข้ารับการรักษาในสถาบันยาเสพติดธัญญารักษ์ ผู้เข้าร่วมในการศึกษาในกลุ่มทดลองและกลุ่มควบคุมได้มาโดยวิธีการสุ่ม ผู้เข้าร่วมการวิจัยทั้งสองกลุ่มจะตอบแบบสอบถามการควบคุมความอยากดื่มและแบบสอบถามการบริโภคแอลกอฮอล์ สำหรับผู้วิจัยกลุ่มทดลองจะได้รับทราบข้อมูลภาพรวมเกี่ยวกับโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ การติดตามผลการปฏิบัติกิจกรรมอย่างต่อเนื่องโดยการติดต่อโทรศัพท์ระหว่างผู้วิจัยกับผู้มีส่วนร่วมในการวิจัย การนัดติดตามผลที่สถาบันธัญญารักษ์ภายหลังจำหน่ายออกจากสถายบำบัดในสัปดาห์ที่ 8

3. ผู้เข้าร่วมในการวิจัยมีสิทธิในการปฏิเสธการเข้าร่วมหรือสามารถถอนตัวจากการศึกษาได้ตลอดเวลา ทั้งนี้ การปฏิเสธจะไม่ก่อให้เกิดผลกระทบใดต่อผู้มีส่วนร่วมในการวิจัยและจะไม่มีผลรบกวนต่อการได้รับบริการต่างๆ ที่จะได้รับตามปกติ

4. หากผู้เข้าร่วมวิจัยมีข้อสงสัยสามารถสอบถามเพิ่มเติมได้จากผู้วิจัย โดยสามารถติดต่อผู้วิจัยได้ตลอดเวลาที่ สุนิศา สุขตระกูล คณะพยาบาลศาสตร์จุฬาลงกรณ์มหาวิทยาลัย หรือทางโทรศัพท์ที่คณะพยาบาลศาสตร์หมายเลข 02-218-9825 หรือมือถือ 08-1804-0459

5. ข้อมูลที่ได้จากการเข้าโปรแกรมและจากการตอบแบบสอบถามของผู้เข้าร่วมวิจัยจะถูกเก็บเป็นความลับและผู้วิจัยใช้รหัสแทนชื่อ-นามสกุลของผู้เข้าร่วมในแบบบันทึกต่างๆ หากผู้วิจัยเปิดเผยผลการศึกษา ผู้วิจัยจะไม่ระบุชื่อของผู้เข้าร่วมไม่ว่ากรณีใดๆ

6. จำนวนของผู้เข้าร่วมในการวิจัยรวมทั้งสิ้น 70 คน

Appendix G

Human Subjects Approval Document

คณะกรรมการพิจารณาจริยธรรมการวิจัย สถาบันธัญญารักษ์ กรมการแพทย์

60 ถ.พหลโยธิน ต.ประชาธิปัตย์ อ.ธัญบุรี จ.ปทุมธานี โทร 02-5310080-8 ต่อ 499, 503

.....

เอกสารรับรองจริยธรรมโครงการวิจัย

1. ชื่อวิทยานิพนธ์ / โครงการวิจัย

ชื่อเรื่อง (ภาษาไทย)..... ผลของโปรแกรมการควบคุมความอยากแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ ..... ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์ .....

ชื่อเรื่อง (ภาษาอังกฤษ).. The Effective of Alcohol Craving Control Program on Alcohol Consumption …… in Persons with Alcohol Dependence ……

2. ชื่อผู้วิจัย (นาย, นาง,นางสาว).. สุนิศา ..... สุขตระกูล .....

หลักสูตร .....

คณะ ..... พยาบาลศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย .....

3. หน่วยงานที่สังกัด.....

4. ผลการพิจารณาของคณะกรรมการจริยธรรมการวิจัย :

คณะกรรมการจริยธรรมการวิจัย ได้พิจารณารายละเอียดวิทยานิพนธ์ /โครงการวิจัยเรื่องดังกล่าวข้างต้นแล้ว ในประเด็นที่เกี่ยวกับ

1) การเคารพในศักดิ์ศรี และสิทธิของมนุษย์ที่ใช้เป็นตัวอย่างการวิจัย

2) วิธีการอย่างเหมาะสมในการได้รับความยินยอมจากกลุ่มตัวอย่างก่อนเข้าร่วมโครงการวิจัย (Informed consent) รวมทั้งการปกป้องสิทธิประโยชน์และรักษาความลับของกลุ่มตัวอย่างในการวิจัย

3) การดำเนินการวิจัยอย่างเหมาะสม เพื่อไม่ก่อความเสียหายต่อสิ่งที่ศึกษาวิจัย ไม่ว่าจะเป็นสิ่งที่มีชีวิต หรือไม่มีชีวิต

คณะกรรมการจริยธรรมการวิจัย มีมติเห็นชอบดังนี้

(✓) รับรองโครงการวิจัย

( ) ไม่รับรอง

5. วันที่ที่ให้การรับรอง..... 26 .....เดือน... ธันวาคม .....พ.ศ.. 2552 .....

วันที่ที่หมดอายุ …… 25..…… เดือน.... ธันวาคม .....พ.ศ.. 2553 .....

ลงนาม .....

(... นายแพทย์ล่ำซำ ... ลักขณาภิชนชัช ...)

ประธานคณะกรรมการพิจารณาจริยธรรมการวิจัย

ลงนาม .....

(..... นางสำเนา .... นิลบรรพ์ .....)

เลขาฯคณะกรรมการพิจารณาจริยธรรมการวิจัย

ทั้งนี้ การรับรองนี้มีเงื่อนไขดังที่ระบุไว้ด้านหลังทุกข้อ (ดูด้านหลังของเอกสารรับรองโครงการวิจัย)

Appendix H

Informed consent form

Informed consent form

1. Title: The effect of alcohol craving control program on alcohol consumption in alcohol dependents

Code number: Population or participant……

I was informed by the nurse researcher namely Sunisa Suktrakul, address 70/2 M. 2, T. Pailing, Ayutthaya, Thailand, 13000.

I am willing to take part in a research study, which help me to manage some factors that effect my alcohol consumption. This study should help to prevent my health problems and problems related to others. Results of this study should benefit on other health problems and on nursing knowledge.

I know that I will be one out of 60 persons who asks to answer some questionnaire and also participate in the 2 weeks program which one hour in each session. I have been told that I will continue contact with the researcher after discharge by telephone and follow-up in Thanyarak institute on drug abuse at week 2, 4, and 8 after discharge.

I know that I strictly voluntary in the study, or I can dropout of the study at any time without penalty. Whether I am in the study or not, there will be no affected on health, or usual care.

I have been told about the reason for study and about my part in it, and I have been able to ask question. I will be assigned number and name will not be connected with the study in any way when the results are reported. The nurse researcher will make every effort to keep my identity confidential. Only the nurse researcher will have assessed to any my information.

I understand that during the study I can contact the researcher by calling Sunisa Suktrakul, at the Faculty of Nursing, Chulalongkorn University by calling 02-2189825, at home by calling 035- 242-965, and via call phone by calling 08-1804-0459.

I have read the information above. I am willing to be in this study and participation is voluntary. After I sign on this from I understand I will receive a copy of this consent form.

……	……
Place/Date	Name of participant
……	……
Place/Date	(……..)
	Main researcher signature
……	……
Place/Date	(……..)
	Witness signature

ใบยินยอมของประชากรตัวอย่างหรือผู้มีส่วนร่วมในการทำวิจัย

ชื่อโครงการ ผลของโปรแกรมการควบคุมความอยากดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์

เลขที่ผู้มีส่วนร่วมในการวิจัย.....

ข้าพเจ้าได้รับทราบข้อมูลจากผู้วิจัย ชื่อ นางสาวสุนิศา สุขตระกูล ที่อยู่ 70/2 หมู่ 2 ต. ไผ่ลิง อ. พระนครศรีอยุธยา จ.พระนครศรีอยุธยา 13000

ข้าพเจ้ายินดีเข้าร่วมการศึกษาครั้งนี้**โดยความสมัครใจ**

งานวิจัยนี้ศึกษาเกี่ยวกับผลของโปรแกรมการควบคุมความอยากเครื่องดื่มแอลกอฮอล์ต่อการบริโภคแอลกอฮอล์ของผู้ติดแอลกอฮอล์ ซึ่งประโยชน์ของการวิจัยครั้งนี้มีต่อการพัฒนารูปแบบการบำบัดและความรู้ทางการพยาบาล อันจะส่งผลต่อข้าพเจ้า บุคคลผู้เกี่ยวข้องและผู้ติดแอลกอฮอล์ต่อไปในอนาคต

ข้าพเจ้าทราบว่า ข้าพเจ้าคือผู้เข้าร่วมวิจัยหนึ่งใน 70 คน ที่ต้องเข้าร่วมกิจกรรมตามโปรแกรม ครั้งละประมาณ 1 ชั่วโมง เป็นเวลา 2 สัปดาห์ ข้าพเจ้าต้องตอบแบบสอบถามในการศึกษา ได้รับการติดตามผลอย่างต่อเนื่องจากผู้วิจัยโดยติดต่อทางโทรศัพท์ และเข้ารับการติดตามผลที่สถาบันธัญญารักษ์ภายหลังจำหน่ายจากสถานบำบัดในสัปดาห์ที่ 2, 4, และ 8

ข้าพเจ้าจะได้รับการดูแลเก็บรักษาข้อมูลต่างๆ ที่เกี่ยวข้องกับข้าพเจ้าไว้เป็นความลับ โดยผู้วิจัยมีวิธีการป้องกันการเก็บรักษาข้อมูลที่น่าเชื่อถือ ข้าพเจ้าสามรถถอนตัวจากการเข้าร่วมวิจัยเมื่อใดก็ได้ โดยการถอนตัวนั้นจะไม่มีผลกระทบต่อตัวข้าพเจ้าและการบำบัดรักษาที่ได้รับ

ข้าพเจ้าได้รับทราบว่าขณะเข้าร่วมวิจัย ข้าพเจ้าสามารถติดต่อผู้วิจัยได้ตลอดเวลาที่ คุณสุนิศา สุขตระกูล คณะพยาบาลศาสตร์จุฬาลงกรณ์มหาวิทยาลัย หรือทางโทรศัพท์ที่คณะพยาบาลศาสตร์หมายเลข 02-218-9825 หรือมือถือ 08-1804-0459

ข้าพเจ้าได้อ่านข้อความข้างต้นทั้งหมดและยินดีที่จะเข้าร่วมการศึกษาวิจัยนี้โดยความสมัครใจและได้ลงนามในท้ายเอกสารนี้

.....	.....	.....
สถานที่/วันที่	(.....)	(.....)
	ลงนามผู้วิจัยหลัก	ลงนามพยาน

.....

ลงนามผู้เมีส่วนร่วมในการวิจัย

Appendix I

List of Experts

List of experts:

1. Associate Professor Sureeporn Thanasilp, D.N.S.

   Faculty of Nursing, Chulalongkorn University

2. Aungkul Pattrakorn, M.D.

   Thanyarak Institute on Drug Abuse

3. Dr. Nipa Kimsungnern, Ph.D.

   Thanyarak Institute on Drug Abuse

4. Mrs. Aranya Pairjui, M.N.S.

   Chiang-Mai Institute on Drug Abuse

BIOGRAPHY

Sunisa Suktrakul was born in 1969. She received a Bachelor of Nursing Science from Boromrajonani College of Nursing Chon Buri in 1991. She got a Master of Nursing Science (Mental Health and Psychiatric Nursing), Chiang Mai University in 2001. Sunisa had two years working experience in Intensive Care Unit, 5 years in Medical Unit, and 4 years in Mental Health and Psychiatric Unit at Sena Hospital, Ayutthaya. She has been an Advanced Practice Nurse in Mental Health and Psychiatric Nursing since 2004. She had received the scholarship from the Higher of Education Commission to study Philosophy Program in Nursing Science, Faculty of Nursing, Chulalongkorn University since 2005-2009.