BARRIERS TO ALCOHOL ADDICTION TREATMENT IN WOMEN AND MEN EXPERIENCING ALCOHOL ADDICTION IN A THAI CONTEXT

EXPLORING LIVED EXPERIENCES AND HEALTHCARE PROVIDERS’ PERSPECTIVES

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School of Health, Care and Social Welfare
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Abstract

Risky drinking behaviour can strongly influence the lives of individuals and families, including having negative effects on social welfare and health. The low rate of healthcare service use among people experiencing alcohol addiction is an important problem in Thai society.

The overall aim of the study was to explore the barriers to alcohol treatments for people experiencing alcohol addiction. This thesis includes four qualitative studies that employed three different data collection methods. Individual interviews were used in studies I and II and were analysed with descriptive phenomenology. Focus group interviews were conducted in study III, and the Delphi method was applied in study IV. Both of the latter studies employed content analysis. Purposive sampling was applied to identify participants for the four studies, which included 13 men (study I) and 12 women (study II) experiencing alcohol addiction, 32 healthcare providers (study III) and 32 experts in the alcohol treatment field (study IV); the providers and experts were primarily nurses (study III and IV).

The identified barriers at the individual level included the unawareness of alcohol addiction, gender differences in treatment and in society, the experienced stigma related to alcohol addiction and the lack of engagement in alcohol treatment. Barriers at the organizational level were related to healthcare providers’ agencies and engagement, vertical and horizontal collaborative practices within the hospital wards, and the collaboration with patients and their next of kin. Additionally, the struggle of handling the different sexes during treatment and the difficulties of using the required standard methods were described by the healthcare providers. At the structural level, the barriers were related to the patriarchal society, gender equity and the resources and funding from the Ministry of Public Health for improving the well-being and equal healthcare rights of people experiencing alcohol addiction in Thailand.

In order to improve equal rights to health for people experiencing alcohol addiction in Thailand, knowledge of alcohol addiction, stigma and domestic violence related issues needs to be improved in the healthcare service system. Formal training and nurse educational programmes are needed to reach the theoretical and practical potential of nurses and of other healthcare providers working in alcohol addiction.

Key words: alcohol addiction, gender perspective, lived experiences, alcohol dependency, focus-group interviews, Delphi study
Education is the most powerful weapon which you can use to change the world

Nelson Mandela
Abstract

**Background:** Risky drinking behavior can strongly influence the lives of individuals and families, including having negative effects on social welfare and health. The low rate of healthcare service use among people experiencing alcohol addiction is an important problem in Thai society.

**Aim:** The overall aim of the study was to explore the barriers to alcohol addiction treatments for people experiencing alcohol addiction.

**Methods:** This thesis includes four qualitative studies that employed three different data collection methods. Individual interviews were used in studies I and II and were analyzed with descriptive phenomenology. Focus group interviews were conducted in study III, and the Delphi method was applied in study IV. Both of the latter studies employed content analysis. Purposive sampling was applied to identify participants for the four studies, which included 13 men (study I) and 12 women (study II) experiencing alcohol addiction, 32 healthcare providers (study III) and 32 experts in the alcohol addiction treatment field (study IV); the healthcare providers and experts were primarily nurses (studies III and IV).

**Results:** The identified barriers at the individual level included the unawareness of alcohol addiction, gender differences in treatment and in society, the experienced stigma related to alcohol addiction and the lack of engagement in treatment. Barriers at the organizational level were related to healthcare providers’ agencies and engagement, vertical and horizontal collaborative practices within the hospital wards, and the collaboration with patients and their next of kin. Additionally, the struggle of handling the different sexes during treatment and the difficulties of using the required standard methods were described by the healthcare providers. At the structural level, the barriers were related to the patriarchal society, gender equity and the resources and funding from the Ministry of Public Health for improving the well-being and equal healthcare rights of people experiencing alcohol addiction in Thailand.
Conclusion: The findings of this thesis suggest that changes have to be made on at least three levels of Thai society to cope with the increasing problem of alcohol addiction. In order to improve equal rights to health for people experiencing alcohol addiction in Thailand, knowledge of alcohol addiction, stigma and domestic violence related issues needs to be improved in the healthcare service system. Formal training and nurse educational programs are needed to reach the theoretical and practical potential of nurses and of other healthcare providers working in alcohol addiction.

Key words: alcohol addiction, gender perspective, lived experiences, alcohol dependency, Delphi study, focus group interview
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


II Hanpatchaiyakul, K., Eriksson, H., Kijsomporn, J., Östlund, G. Lived experience of Thai women with alcohol addiction. *Submitted to Health Care for Woman International*


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Definitions

**Harmful use** is defined as a pattern of drinking that causes damage to health. This damage may be physical (e.g., liver damage from chronic drinking) or mental (e.g., depression) (Babor & Higgins-Biddle, 2001).

**Alcohol addiction** is a complicated condition that involves biological, psychological, behavioural, and spiritual factors. Addiction is a chronic, life-threatening and progressive disease that can result in disability or premature death (American Society of Addiction Medicine [ASAM], 2011; West & Hardy, 2007).

**Risky drinking behaviour** means drinking at levels that place a person at risk of medical or social problems according to Babor et al. (2001). The term ‘risky drinking behaviour’ is used to avoid describing a person as an alcoholic, excessive drinker, alcohol dependent person, or hazardous drinker. It is more appropriate to use ‘risky drinking behaviour’ to describe people who have a drinking problem than to directly label the person (Babor et al., 2001).

**Alcohol dependence** is a medical diagnosis that consists of experiencing or exhibiting three or more of the following criteria at any time in the previous twelve months, as stated in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). The criteria include drinking alcohol in larger amounts or for longer than intended; wanting but being unable to stop using alcohol; spending a large amount of time obtaining and using alcohol; having problems participating in important social, occupational or recreational activities because of alcohol use; and continuing to drink or use alcohol despite knowing that it is causing psychological and physical problems. Finally, the criteria include needing to use a larger amount of alcohol to obtain the desired effect or experiencing a decreased effect and experiencing uncomfortable psychological and/or physical signs and symptoms when no longer using alcohol that can only be relieved by more alcohol use (ASAM, 2011).

In the DSM-IV, the difference between alcohol abuse and dependence is based on the concept of abuse as experiencing mild symptoms or representing an early phase and dependence as experiencing more severe signs (American Psychiatric Association [APA], 2014).
Introduction

This thesis concerns the barriers to alcohol addiction treatment for people experiencing alcohol addiction. The inspiration to conduct this thesis came from the desire to explore the expertise of people experiencing alcohol addiction and of healthcare providers working in alcohol addiction treatment clinics in the hospital.

Risky drinking alcohol consumption is a problem that currently threatens health and welfare in Thailand; people experiencing alcohol abuse and addiction delay treatment and suffer from physical and mental illness (Center for alcohol studies [CAS], 2013). Alcohol consumption in Thailand generates substantial costs due to the losses in productivity caused by premature mortality and the costs of healthcare services (Thavorncharoensap et al., 2010). Reducing alcohol consumption is necessary to decrease harm, mortality and morbidity among Thai people.

Alcohol addiction treatment is one strategy used to help people experiencing alcohol addiction abstain from alcohol use and prevent premature death. One barrier to treating alcohol addiction is that people do not disclose their addiction to healthcare providers and that they instead seek treatment for other conditions such as physical illnesses (Proudfoot & Teesson, 2002). People receiving alcohol addiction treatment are not encouraged to obtain treatment through the Thai universal healthcare coverage (UHC). According to the WHO, the inequalities in health among people experiencing alcohol addiction are related to social determinants, the availability of alcohol (production, distribution, regulation, and alcohol quality), the drinking environment and culture, and the type of welfare system (Schmidt, Mäkelä, Rehm, & Room, 2010).

My pre-understandings based on fourteen years of experience as a nurse in a drug and alcohol addiction treatment hospital provided a relevant background for doing research on alcohol addiction. The idea that barriers to alcohol addiction treatment exist was an interest that was developed from these years used to formulate the aims and questions of the four studies presented in the current thesis. My thesis includes the experiences of people with alcohol addiction and the perspective of healthcare providers on the same topic. This thesis may gain new knowledge related to the barriers to alcohol addiction treatment in Thailand.
Background

Alcohol addiction is a major health problem worldwide and causes suffering among the victims of addiction and their families. This harmful form of alcohol consumption leads to mortality and morbidity among men and women worldwide (World Health Organization [WHO], 2014). Most countries emphasize providing welfare resources to ease the burden of addiction. However, despite these welfare efforts, many obstacles to treating alcohol addiction remain. In Thailand, people suffering from alcohol addiction have become the leading cause of welfare concerns as a result of the negative consequences of the condition, such as the higher rates of road traffic accidents, injuries (CAS, 2013; Sivak & Schoettle, 2015) and domestic violence against women in the families (Waleewong, Thamarangsi, Chaiyasong, & Jankhotkaew, 2015). Health policies regarding the health risks attributable to alcohol consumption substantially impact both society and the economy in Thailand (Rehm et al., 2009). Thai people who experience alcohol addiction have low rates of treatment admission, and alcohol addiction is also associated with mental health problems (Suttajit, Kittirattanapaiboon, Junsirimongkol, Likhitsathian, & Sirisurapanont, 2012).

Thai UHC and the barriers to alcohol treatment

In 2002, Thailand launched its universal healthcare coverage policy (UHC). This programme aimed to improve access to healthcare services and reduce health inequality. The primary resources are mostly supported by tax revenues (Panpiemras, Puttitanun, Samphantharak, & Thampanishvong, 2011; Suraratdecha, Saithanu, & Tangcharoensathien, 2005). The establishment of the UHC in Thailand highlighted the geographic healthcare service distribution and sought to strengthen coverage for people in rural areas (Tangcharoensathien, Mills, & Palu, 2015). However, the registered service package did not include alcohol and drug addiction treatment in the initial phase of the policy implementation (Suraratdecha et al., 2005).

The right to treatment for substance addiction has been granted by healthcare services through compulsory drug treatment policy since 2008 (Kerr et al., 2014; Kamarulzaman & McBrayer, 2015). Thousands of individuals experiencing drug addiction in Thailand have entered treatment involving long-term
rehabilitation by law since 2011 (Kerr et al., 2014). The healthcare services in primary, secondary and tertiary care centres are responsible for voluntary and compulsory drug addiction treatment. However, alcohol addiction has not been clarified in the UHC or mandatory drug policy.

The relationship between alcohol consumption and mental health problems is reciprocal; namely, alcohol consumption can lead to mental health problems, and an individual experiencing mental health problems can attempt to alleviate them by drinking. The Thai National Mental Health survey estimated that the prevalence of alcohol consumption in the adult Thai population (43 million) is high, with approximately 5 million people who exhibit risky drinking behaviours, 3 million who are diagnosed with alcohol dependence and 350,000 who are diagnosed with alcohol-induced psychosis. However, only 1.5% (75,000) of risky alcohol users have access to healthcare services (CAS, 2013).

Few people experiencing alcohol addiction, most of whom are men (on average 1,500 per year), undergo alcohol addiction treatment in Thailand (Than- yarak Hospital, 2013). The low rate of access to healthcare services among risky drinkers is the major barrier to alcohol addiction treatment. Delays in alcohol treatment might lead to increased suffering due to addiction and to premature death (Thavorncharoensap, 2010).

Several studies have addressed the obstacles to alcohol addiction treatment access that are related to the availability of treatment, such as the lack of special treatment and convenient transportation (Bobrova et al., 2006; Neale, Tompkins, & Sheard, 2008; Priester et al., 2016; Tucker et al., 2004). Additionally, there are obstacles related to the different needs of patients in terms of treatment content, such as quality and a safe environment (Nordfjaern, Rundmo, & Hole, 2010).

**Health and welfare perspectives**

The human rights approach seeks to provide people with basic access to essential healthcare services when needed, and this access can prevent people from developing disease and help them improve their health through healthcare services (Dahlgren & Whitehead, 2007). The right to health concerns how patients are able to access appropriate healthcare facilities and are encouraged to improve their health. Attaining the right to health is based on upholding people’s basic right to have access to essential healthcare when they are suffering from mental and physical illness. These human rights protect people from the severity of disease and help them improve their health.
The concept of right to health encourages healthcare services to be concerned about the equality of disadvantaged and marginalized groups (Forman & Bomze, 2012).

‘The right to standard of health’ can be achieved by designing appropriate social legislation and facilitating health welfare for all people (WHO, 2015). An essential element of the right to health is instructing state and non-state entities regarding the critical and systematic components needed to ensure access to the health system (Forman & Bomze, 2012). The availability, accessibility, acceptability and quality (AAAQ) framework defines these aspects as key components of human rights-based healthcare systems and services (Committee on Economic, Social and Cultural Rights, General comment No. 14 as cite in Forman & Bomze, 2012). People’s right to health includes the following characteristics, as described in the AAAQ framework:

- Availability of treatment includes the consideration of well-functioning public health and healthcare facilities and health services, as well as treatment programs of sufficient quantity.
- Accessibility of treatment implies that health facilities and services are accessible to everyone. Patient accessibility has four dimensions: 1) non-discrimination, 2) physical accessibility, 3) economical accessibility and 4) information accessibility.
- Patient acceptability indicates that health services must be respectfully managed with regard to medical ethics and provide culturally appropriate care as well as be sensitive to gender.
- Treatment quality means that healthcare services must be scientifically and medically of good quality. A strong health system is an essential component of promoting a healthy and equitable society. According to the WHO, strengthening the health system is one strategy used to improve health outcomes and accessibility of healthcare in the community (2007) (as cited in Backman, 2012), with the health and welfare system described as consisting of all organizations, people and actions whose primary purpose is to promote, restore or maintain health. This approach includes efforts to influence health determinants as well as to direct health-promoting activities.
Thai healthcare services for alcohol addiction

The healthcare system that is responsible for people experiencing alcohol addiction spans two departments within the Ministry of Public Health: the Mental Health Department and the Medical Service Department. The adoption of the Integrated Management for Alcohol Intervention Program (I-MAP) is under the Mental Health Department, and this programme focuses more on risky drinking behaviours. The Princess Mother National Institute on Drug Abuse Treatment places more emphasis on patients with combined alcohol and substance addictions.

The prototypes of alcohol addiction treatment were created by the Princess Mother National Institute on Drug Abuse Treatment. The purpose of outpatient treatment is to recruit patients who have no withdrawal symptoms using a modified matrix programme that emphasizes behavioural modification, family counselling and increasing knowledge of alcohol addiction. Inpatient treatment is for people who are experiencing alcohol addiction with withdrawal symptoms. After patients are discharged from the detoxification ward, they may or may not attend the rehabilitation ward with treatment based on the therapeutic community (TC), called the FAST model. The FAST model includes four activities related to treatment: family involvement; alternative activities, such as vocational or educational improvement; self-help groups; and milieu therapy in the therapeutic community (TC). The purposes of treatment are to explain the alterations in the brain caused by drugs and alcohol, practice behavioural modification and promote the participation of family members and significant others. The purpose of alcohol addiction treatment is to facilitate the patient’s control of alcohol use and abstention from drinking. There are seven substance dependence treatment hospitals located in four parts of Thailand. These hospitals are available to individuals who are experiencing alcohol addiction. These seven hospitals provide outpatient and inpatient alcohol addiction treatments that include four steps: preparation (1-7 days), detoxification (7-14 days), rehabilitation (4 months) and aftercare (1 year) (Chaipichitpan, 2012).
Thai local wisdom and Buddhists’ alcohol treatment

In Thailand, 94% of people declare themselves to be Buddhists, a religion that originated from Theravada Buddhism during the 3rd century B.C. (Kusalasaya, 2013). Thai Buddhists grasp religious beliefs as a way of life, and the ideas of karma relate to rebirth. The rules of karma are related to cause and effect, and the tenets of Buddhism involve the ideas of ‘what goes around, comes around’ or ‘you reap what you sow’. Buddhism teaches people that good deeds affect karma and that the Buddhists benefit from practicing Buddhist morality (Sila), mental discipline (Samadhi) and wisdom (Punya) (Klunklin & Greenwood, 2005). Abstaining from alcohol is a part of the practice of Buddhist morality (Sila). Buddhist tenets teach that drinking can cause carelessness and should be avoided (Assanangkornchai, Conigrave, & Sauders, 2002).

According to Thai local knowledge, the purposes of caring for people concern both individual well-being and kinship participation. The traditional scholars were known in society as people who focus on ‘Thad’ (physical) and ‘Kwan’ (spiritual), which are the local wisdom elements regarding herbs, nutrition and traditional ritual. The traditional scholars used herbs and food to elicit recovery from intoxication and bodily imbalances. The traditional ceremony was performed by practicing the five precepts, i.e., rules related to morality, self-commitment to Buddha, meditation and worship (Wanbun, Sethabouppha, Chanprasit, 2011). Sila involves 1) not destroying the lives of living beings; 2) refraining from taking that which is not given; 3) refraining from sexual misconduct; 4) refraining from telling falsehoods and 5) refraining from distilled and fermented intoxicants, which cause carelessness (His Royal Highness Supreme Patriarch Prince Vajirananavarorasa, 2016). The Buddhist method of caring for the whole minds and bodies of individuals experiencing alcohol addiction is influenced by Thai local wisdom.

Although Buddhism is the main religion and does not allow alcohol consumption, this life rule has lost its influence (Thamarangsi, 2008). Alcoholic drinks are the most familiar beverages for people in Thailand. The historic distribution of alcoholic beverages in Thai culture has been described in the Ayuthaya period (1350-1767). At that time, Chinese migrants built the alcohol market and introduced distillation techniques for the manufacture of spirits. Since that time, the alcohol market in Thailand has grown and has had a substantial influence on Thai and Chinese societies (Cochrane, Chen, & Conigren, 2003; Thamarangsi, 2008). Drinking alcohol is currently part of the cultural traditions of both China and Thailand. Chinese traditional medicines use alcohol as a major solvent in herbal medicine preparations (Cochrane et al., 2003).
Application of Western treatment programmes in the healthcare system

Western treatment programmes are applied in primary and secondary healthcare services in Thailand. Some studies that have been conducted in the primary healthcare system suggest that brief interventions (BIs) are useful and suitable tools for reducing drinking. BI is a method for healthcare providers to deliver consultations related to alcohol consumption to people experiencing alcohol addiction (Areesantichai, Iamsupasit, Marsden, Perngparn, & Taneep-anichskul, 2010; Noknoy, Rangsin, Saengcharnchai, Tantibhaedhyangkul, & McCambridge, 2010).

According to three studies in Thailand, the application of BI in primary healthcare services elicits positive outcomes for risky drinkers in the short-term (6 months). The effectiveness of these alcohol interventions in primary care relies on the knowledge and skill of the healthcare providers who deliver the treatment (Areesantichai, Perngparn, & Pilley, 2013; Noknoy, et al., 2010). Consistent with Finnish research that identified possible obstacles to primary healthcare services in terms of the application of BI in primary care, the possible obstacles include a lack of self-efficacy among primary healthcare professionals, a lack of simple guidelines for the BI and uncertainty regarding the justification for initiating discussions about alcohol issues with patients (Aalto, Pekuri, & Seppa, 2003). Another similar study implemented a BI in Swedish primary healthcare services and identified important barriers to the support of general practitioners (GPs) and nurses working with people experiencing alcohol addiction. These barriers included a lack of practical skills for counselling, a lack of training in suitable intervention techniques and unsupportive working environments (Geirsson, Bendtsen, & Spak, 2005).

The Mental Health Department of the Ministry of Public Health created and adopted the Integrated Management for Alcohol Intervention Program (I-MAP). Motivational Enhancement Therapy (MET) includes the application of Motivational Interviewing (MI), Brief Advice (BA) and Cognitive-Behavioural Therapy (CBT) in alcohol addiction treatment clinics in 7 psychiatric hospitals, 1 drug and alcohol addiction treatment hospital, 2 general hospitals, 18 community hospitals and 184 community healthcare centres. The evaluation claimed that the obstacles to implementation of I-MAP were a lack of clarity regarding the policy of the hospital and a lack of knowledge and skill to treat alcohol addiction among healthcare providers (Kittirattanaphiboon & Jumroonsawat, 2011).
In 1939, the ‘Big Book’, Alcoholics Anonymous (AA), by Bill Wilson, Bob Smith and other early members was published. AA was thus born, and a society for AA was created (Alcoholics Anonymous, 2001). AA aims to help people who are recovering from alcohol addiction through a mutual group process (Kelly, Stout, Magill, Tonigan, & Pagano, 2010).

In Thailand, a ‘Thai big book’ was published in 1993 by the Thailand Intergroup (AA members who established AA in Thailand) and introduced AA to the Thai population. However, AA is not widely spread in Thailand; the majority of members are particular groups of overseas individuals from other countries in Europe and the USA. Since 2004, the Thailand Intergroup and Thai Health Promotion Foundation have promoted the establishment of AA in alcohol clinics at healthcare services. These groups also support the Buddhist AA intervention and the training program for healthcare providers in Thailand. However, the AA is not well-known among Thai people, and there are many obstacles to the implementation process, including a lack of continuity in meeting attendance, a lack of members, a lack of understanding of the core concept of AA among healthcare providers and a lack of sponsors. Currently, there are 24 continuing groups supported by healthcare providers that are operating within healthcare services (Stop drink network, Thai Health Promotion Foundation, 2015). Additionally, a more Buddhist-influenced form of AA is now beginning to develop in Thailand.

Gender and alcohol consumption in a Thai context

In patriarchal societies such as Thailand, domestic violence is often perpetrated by men with addictive behaviours (e.g., gambling, alcohol use and drug use) (Waleewong et al., 2015). Women and children are the victims in most situations, and this problem is more frequently detected in low-income families (Ross, Stidham, Saenyakul, & Creswell, 2015; Waleewong et al., 2015). Women with experiences of domestic violence have voiced the need for available and specific support in Thai hospitals (Ross et al., 2015). Throughout Thailand, 25 women’s shelters are available for abused women and their children, although this is not sufficient for 33 million women in 79 provinces (Chaowilai, Pungcokesoong, Chaichetpipatkul & Reunthong, 2008).

It is accepted that men in Thailand exhibit a higher prevalence of and more serious problems with alcohol consumption than women; however, a pattern of increasing drinking among young women has been found (Assanangkornchai et al., 2010; ONCB, 2007). Although fewer women than men were found to exhibit risky drinking, the number of women with this problem has increased. Young Thai women drink alcohol to increase their self-confidence,
to demonstrate their ability to work as men, to be strong and to reduce stress (Jongudomkarn, Pultong, & Pongsiri, 2012). Thai researchers have argued that gender equity begins at work, where drinking alcohol seems to be accepted irrespective of gender (Rungreangkulkij, Kotnara, Chirawatkul, 2012).

In Thai society, alcohol consumption is currently an expected social activity. Thai people drink alcohol for recreation and to enhance relationships with friends (Jongudomkarn et al., 2012; Moolasart, 2011). The most common problems described by male and female drinkers are similar and include the effects of drinking on work, study and employment opportunities; poor finances; and feelings of guilt or remorse. However, the most frequent problem among male adolescents is fighting while drinking, whereas the most frequent problem for female adolescents is feelings of guilt or remorse for drinking (Assanangkornchai et al., 2010). The feeling of guilt or remorse among people experiencing alcohol addiction can be explained by Buddhist traditions, in which drinking is not accepted among men and is even less acceptable among women, who, according to the same traditional beliefs, cannot control themselves (Moolasart, 2011). In Thailand, there is a more tolerant attitude towards drinking in men, but alcohol use remains restricted for women (Assanangkornchai et al., 2010).

Individuals experiencing alcohol addiction

The effects of public stigma identified by individuals who are experiencing addiction include fear of being labelled an addicted person, embarrassment and not wanting to reveal related problems to healthcare providers. Research has demonstrated that public stigma towards addiction is more severe than the stigmas of other mental illnesses, and people with addiction might be viewed as being more dangerous, unpredictable and less valuable (Ahern, Stuber, & Galea, 2007; Fortney et al., 2004; Schomerus et al., 2011).

Individuals with addiction might not want to reveal their problems to healthcare providers due to fear of public stigma and may not want to seek help due to dissatisfaction with previous treatment. The influences of public stigma that have been identified include the fear of being labelled as an addicted person, embarrassment and worry about being looked down upon by others. The effects of being stigmatized due to alcohol addiction have been found in the behaviours and actions of some healthcare providers. The stigmatization of behaviours by healthcare providers has the potential to increase client frustration and the risk of the patient impulsively leaving treatment, act-
ing inappropriately or refusing to return to a particular alcohol addiction treatment setting (Saunders, Zygowicz, & D'Angelo, 2006; Sleeper & Bochain, 2013).

Self-stigma is a cognitive and emotional process, and self-stigma can be developed from public stigma via a basic idea that is linked to the cause and consequences of addiction. The internal attitude of self-stigma can be formulated by people experiencing alcohol addiction due to the public contributing negative stereotypes and the application of those public stereotypes by people with risky drinking behaviours to themselves (Schomerus et al. 2011). The consequences of self-stigma may hinder treatment due to shame and embarrassment (Saunders et al. 2006). Self-stigma influences an individual’s ability to achieve alcohol abstinence and hinders the seeking of treatment among people experiencing alcohol addiction. Self-stigma may result in treatment avoidance or neglect, decreased self-esteem and self-efficacy and worries about the future among people experiencing alcohol addiction (Ahern et al., 2007; Saunders et al., 2006).

Moreover, barriers to treatment for women experiencing addiction include the fear of losing custody of their children, the fear of losing a partner or a partner acting antagonistically in relation to the possibility of treatment, the experience of shame and stigma and the fear of having to reveal experiences of physical and sexual abuse in treatment (Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm, & Gmel, 2009).

Barriers to alcohol addiction treatment from the patients’ perspective comprise concerns about privacy and the belief that treatment is either unnecessary or not beneficial (Saunders et al., 2006). The most frequent claim made by individuals experiencing alcohol addiction is the desire to ‘handle the problem on my own’ (Barman et al., 2011; Cunningham et al., 1993; Rapp et al. 2006). Issues of privacy concerns, time difficulties and the fear of treatment have also been reported (Barman et al., 2011). Economic intrusions are less influential than privacy concerns and the notion that clients believe they can solve the problems on their own (Fortney et al., 2004).
Described challenges in working with people experiencing alcohol addiction

The stigma and negative attitudes of nurses and other healthcare providers have been shown to effect treatment entry and maintenance among people experiencing alcohol addiction (Cunningham et al., 1993; Skinner, Feather, Freeman, & Roche, 2005). For example, patients occasionally feel that they are not warmly welcomed into treatment (Neale et al., 2008). As another example, nurses occasionally believe that individuals experiencing alcohol addiction ‘are not really sick’ and should not receive any help from healthcare providers (Lovi & Barr, 2009). Healthcare providers are gatekeepers and play important roles in identifying patients with drug or alcohol abuse problems. The stigma and negative attitudes of professionals can be related to inadequate training, education and support structures among people working with patients who are experiencing drug and alcohol addiction (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013).

Nurses have described that working with the dual diagnosis of depression and alcohol abuse is particularly difficult in terms of cooperating and dealing with patients who deny their risky drinking behaviours. Furthermore, this research shows that nurses refuse to ask patients about risky drinking behaviours due to a belief that such problems are not their responsibility (Wadell & Skärsäter, 2007). However, no studies have focused on the barriers to alcohol addiction treatment from the perspective of people experiencing alcohol addiction or from the perspective of healthcare providers in Thailand.

Concepts and framework

Phenomenology

According to Dahlberg, Drew and Nyström (2001) described that phenomenology seeks to understand phenomena, such as caring, healing and the meaning of life, based on subjective experiences. Researchers who work with phenomenology have to develop their own scientific culture and competence of communication with the participants regarding the phenomena under study by both speaking and listening. Understanding the researcher’s role requires the creation of a respectful climate with the research participants.

Phenomenology is rooted in philosophical traditions and was developed as a method of inquiry by Husserl and Heidegger as described by Polit and Beck (2008). Phenomenological descriptive research does not seek to interpret but rather aims to describe the essence and meaning of the lived experience of a
particular phenomenon. They further explain that researchers using this approach explore the manifested and described dimensions of the phenomenon under study (Polit & Beck, 2008)

**Descriptive phenomenology**

Wojnar and Swanson (2007) described the nature of descriptive phenomenology as requiring the researcher to set aside preconceptions throughout the procedures involved in bracketing to more clearly understand the participants’ lived experiences. Phenomenologists use frames of reference including transcendental subjectivity in remaining neutral and open to the reality of others and the essence and interaction between the researcher and participants. Descriptive phenomenological studies involve four steps: bracketing, intuiting, analysing, and describing. Bracketing is the process involved in suspending pre-understandings of the phenomena to ensure that the researcher withholds any preconceived ideas during data collection and analysis. Husserl believed that it is possible to gain insight into the common features of any lived experience through bracketing (Wojnar & Swanson 2007). Intuiting in descriptive phenomenology occurs when the researcher is open to the meaning related to the phenomena and is followed by the analysis phase. Finally, the descriptive phase provides the meaning of the subjective experience of phenomena.

**Feministic phenomenology**

Young (1980) developed a study based on women’s subordination in the patriarchal society with a phenomenological approach in which the mind and the body are inseparable. According to Young, (1980) the theory of the lived body is central to a deeper understanding of women’s lived experiences. This feminist phenomenology theory defines women as physically limited, in confined positions and objectified both by men and by their own perceptions of reality. From a feminist phenomenological perspective, this situation is visible in women’s often restricted bodily movements and in their perceived self-agency (Young, 1980). According to this theory, women are not given the full opportunity to use their bodily space as much as men and might, without knowing, choose to live their life with restrictions, e.g., being ‘kept in her place’ (Raine, 2001; Young, 1980).
Gender perspective

In this thesis, the gender perspective is applied. Gender according to Connell (2009, pp 11) is defined as ‘... the structure of social relations that centres on the reproduction arena and the set of practices that brings the reproductive distinctions between bodies into social processes’. This definition means that ‘doing gender’ involves social practices that focus both on the body and social behaviours (Young 1980; Connell, 2009). Gender is not a set of two categories, but gender habits are socially constructed when acting according to the expected roles in the society. The difference between male and female performance is not biological differences, but they are acted out, e.g., in ‘doing gender’ differences in adapting or reacting to cultural norms (Courtenay, 2000; Connell, 2009; Young, 1980).

‘Doing gender’

According to West and Zimmerman (1987), ‘doing gender’ means that men and women are accountable for their actions and adapt to current cultural norms and behaviour (West & Zimmerman, 2009). ‘Doing gender’ also includes creating differences between ‘men’ and ‘women’ and acting out the notion that the division of gender is based on nature, essence or biology. In this thesis, the concept of ‘doing gender’ will be used at the individual level in terms of how men and women experiencing alcohol addiction display their gender roles through interaction with the others in their environments.

When ‘doing difference’ has been constructed at the structural level, it is used to reinforce and arrange differences between the sexes. ‘Doing gender’ analyses the relationship between men and women, particularly in organizations that focus on patriarchal forms and orders (West & Zimmerman, 1987). West and Zimmerman encourage politicians to change the gender inequity that exists in organizations and at the policy level. The consequences of ‘doing gender’ can also be seen as differences in power and accountability. At the organizational and political levels, ‘doing gender’ refers to how organizations and professionals handle the sexes in terms of attitudes, available resources and equal rights.
‘The gender double standard’

The gender double standard has been used as a concept to increase the visibility of differences in welfare conditions that women experience in relation to norms, demands and attitudes in moral action and in performing and producing to achieve similar respect, positions and salaries. Despite the increasing independence of women in both economic and social matters, the negative attitudes towards women experiencing alcohol addiction at both the individual and political levels still exist in certain parts of society (Raine, 2001). Because women are the key persons in the maintenance of social reproduction and the family, the public likely expects them to avoid deviant behaviours, such as drug use and heavy alcohol consumption. These social attitudes are not as strict for men. The gender double standard also affects women’s views of themselves and the manner in which they understand what they are able to do (Raine, 2001).

Drinking alcohol can be considered a component of masculine behaviour, and men who are insecure in their masculine identities may use alcohol consumption to gain self-confidence. The attempt to show toughness or conceal vulnerability may make men unwilling to seek help or reveal their problems (de Visser & Smith, 2007). Masculinity is partially constructed by sharing stories within homo-social groups, for example describing heavy alcohol consumption behaviours, and overestimating the body’s ability to tolerate alcohol (Courtenay, 2000; Connell & Messerschmidt, 2005). Alcohol consumption is often used in homo-social interactions to promote cohesion as well as in the construction of male identities through acting out and taking risks. Male adulthood often includes times of shared alcohol drinking as part of building and maintaining male friendships (de Visser & Smith, 2007; Emslie, Hunt, & Lyons, 2013; Moolasart, 2011).
Rationale

In the 21st century, Thailand has encountered increased alcohol consumption and risky drinking behaviour in the adult and young populations (Assanangkornchai et al., 2010). A large amount of Thai research on alcohol addiction has been performed in the area of prevention and epidemiological studies promoted by policy makers and performed by the Center for Alcohol Studies (Tanpanit, 2014). However, the field of alcohol addiction treatment has been developed recently, and the majority of research has focused on interventions involving modified standard methods in the psychiatric hospital, drug and alcohol addiction treatment hospital, general hospital, community hospital and community healthcare service centres.

Overseas studies on the barriers to treatment utilization have identified hindrances that include public stigma, poor treatment availability and admission difficulties (Barman et al. 2011; Rapp et. al, 2006). Two articles that explored the barriers to utilizing alcohol addiction treatment were identified by searching the literature on alcohol addiction treatment. One could argue that there is little knowledge of evidence related to alcohol addiction treatment research from a Thai perspective. Alcohol-related harm and addiction problems are increasing in Thailand (CAS, 2013). Research focusing on barriers before, during and after alcohol addiction treatment is particularly important in Thailand because the changes made to both policies and healthcare interventions have not been sufficiently effective, and research into alcohol addiction treatment has been insufficiently explored both in relation to people experiencing alcohol addiction and in relation to healthcare providers working in this field. Based on the lack of Thai policies related to alcohol addiction treatment and the few research articles found in the field of alcohol addiction treatments in Thailand, there is a need to explore the barriers to alcohol addiction treatment from the perspectives of people experiencing alcohol addiction, healthcare providers and experts in the field of alcohol addiction.

This thesis sought to identify the barriers related to alcohol addiction treatment based on the subjective experiences of the people experiencing alcohol addiction and the views and expertise of healthcare providers.
Aims

The overall aim of the study was to explore the barriers to alcohol addiction treatments for people experiencing alcohol addiction. The current research aim was to gain more knowledge regarding alcohol addiction treatment from the individual, organizational and structural levels.

The specific aims were as follows:

I To explore men’s experiences in terms of the ‘pros and cons of drinking’ in order to identify the relevant barriers that exist before, during and after alcohol addiction treatment.

II To explore the lived experiences of Thai women in relation to alcohol addiction treatment.

III To explore healthcare providers’ experiences of working with people experiencing alcohol addiction and the treatment program in a Thai hospital.

IV To identify the barriers to alcohol addiction treatment and to find out how experts would improve treatment for people experiencing alcohol addiction.
Methods

The four studies applied different qualitative methodologies. The combination of methods used portrays the area of research in greater depth to generate knowledge from different angles and perspectives. The first (I) and second (II) studies explored the lived experiences of both men and women experiencing alcohol addiction using phenomenological descriptive methodology. The third study (III) explored the healthcare providers’ experiences as does the fourth study (IV) but from the different perspective of expert opinions and Delphi methodology.

Table 1 Overview of designs, data collection, time of data collection, the number of participants and data analysis in study I, II, III, IV

<table>
<thead>
<tr>
<th></th>
<th>Study I</th>
<th>Study II</th>
<th>Study III</th>
<th>Study IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design</strong></td>
<td>Explorative study</td>
<td>Explorative study</td>
<td>Explorative study</td>
<td>Consensus study</td>
</tr>
<tr>
<td><strong>Data collection method</strong></td>
<td>Individual interviews</td>
<td>Individual interviews</td>
<td>Focus group interviews</td>
<td>Delphi method</td>
</tr>
<tr>
<td><strong>Time of data collection</strong></td>
<td>December 2012 to January 2013</td>
<td>August to December, 2015</td>
<td>July to August, 2013</td>
<td>January to September, 2015</td>
</tr>
<tr>
<td><strong>The number of participants</strong></td>
<td>13</td>
<td>12</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td><strong>Data analysis</strong></td>
<td>Phenomenological descriptive method</td>
<td>Phenomenological descriptive method</td>
<td>Content analysis</td>
<td>Content analysis</td>
</tr>
</tbody>
</table>

Table 1 summarizes the four studies in the thesis in relation to design, data collection, time of data collection, the number of participants and data analysis.
Individual interviews

In studies I and II, individual interviews were conducted using phenomenological descriptive methodology in interviewing and analysing the results (Dahlberg et al., 2001; Polit & Beck, 2008). The individual interviews were focused on a specific phenomenon and had the potential to capture human experiences using open questions and probing questions, such as ‘Could you tell me more’? and ‘Could you give me an example’? The researcher can help informants explain their lived experiences without leading the conversation and sharing pre-conceived notions. The researcher explore and provides descriptions of the central aspects of the phenomena under study based on the participants’ utterances to capture the essence and meaning of their subjective experiences (Dahlberg et al., 2001).

Participants and settings in study I

Purposive sampling was performed in study I to include participants from the alcohol ward of a hospital in Thailand. Permission from the director of the hospital was received to conduct the study. The inclusion criteria for study I were that the patients had a diagnosis of alcohol dependence and were over 20 years of age. The exclusion criterion was patients diagnosed with severe psychiatric disorders. Thirteen men aged ranged 32-49 years were included. Seven men were single, four were divorced and two were married. The majority of the men had nine years of schooling and aged between 40 and 49 years (see Table 2). Ten men were admitted to the detoxification unit, and three men were admitted to the rehabilitation unit at the time the interviews occurred. Five participants were interviewed twice to obtain sufficient and rich data from each person; the other eight men were interviewed only once. The data were collected from December 2012 to January 2013 (see Table 1).

Data collection in Study I

The researcher made appointments with the participants in a quiet room in the alcohol ward. All men experiencing alcohol addiction consented to the interviews at the hospital and to tape recording of the interviews. The individual interview began with ‘small talk’ and a formal introduction. The author asked questions about the patient’s lived experiences with regard to alcohol addiction and alcohol treatment. The interviewer kept an open mind, listened carefully and encouraged the patients to reflect on their experiences. The follow-up questions facilitated the patients’ discussion of their lived experiences. Each interview lasted at least 1.5 hours, and the second interviews were at
least 30 min. Data were saturated when no additional data emerged and the richness of the data was ensured, leading to 203 pages of transcripts to analyse.

Participants and settings in study II

Purposive sampling and the snowball technique were used to recruit participants from two special hospitals and one outpatient clinic of a general hospital. Women experiencing alcohol addiction were recruited according to the inclusion criteria of having a diagnosis of alcohol dependence and being over 20 years of age. Women with diagnosed severe psychiatric disorders were excluded. Twelve women aged ranged 20-65 years were included. Eight women were recruited from two special hospitals and one outpatient clinic of a general hospital. The other four women were recruited from an AA organization that had been recommended by a colleague from a special hospital. Twelve of these women had experienced alcohol addiction for at least three years. Six women were divorced; two were single and four were married. The majority of women were aged between 50 and 59 years and had primary school (see Table 2).

Data collection in Study II

After receiving permission from the director of the hospital, the head nurse assisted me in the selection of participants who could provide information related to the aim of the study. The participants supplied both verbal and written information and provided written consent before the interview process began. Twelve women experiencing alcohol addiction provided tape-recorded interviews. Eight women were interviewed in a room at the alcohol clinic where these women were recruited, and four women were interviewed in their homes. The individual interviews began with a formal introduction and a warm welcome. The first question was directed towards the experiences of alcohol addiction. Specifically, the first question was ‘Could you explain your experience with alcohol addiction’? The author listened carefully and supported the participants’ reflections. Further questions were related to the described life situations and involved simple and clear words exploring the lived experiences of the individuals in relation to the aim of this study. Each woman was interviewed for at least 50 minutes, and the maximum time was 1 hour and 45 minutes. The data were collected from August to December of 2015 (see Table 1). Data were saturated when no additional data emerged and the available data provided transcripts of at least 125 pages to analyse.
Table 2 below demonstrates the number, sex, age range in years, marital status and education level of the participants who were experiencing alcohol addiction in studies I and II.

Table 2. Numbers of participants experiencing alcohol addiction in studies I and II

<table>
<thead>
<tr>
<th>Participants</th>
<th>Study I</th>
<th>Study II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>Age range in year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>30-39</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>50-59</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>60+</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Divorced</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Nine years in school</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Twelve years in school</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Vocational school</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Bachelors</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

Data analysis for studies I and II

The data were analysed using the phenomenological descriptive method to understand the meaning of the lived experiences. The analysis aimed to explore the lived experience of men and women with alcohol addiction and with alcohol addiction treatment. The descriptive analysis in the phenomenological approach included the separation of data into meaning units, transformation of the content of the lived experiences and simplification and clarification of
the phenomena (Dahlberg et al., 2001). I read the transcriptions carefully and made myself familiar with the data. The reading process involved close reading of the text while attempting not to put my own attitudes and pre-conceptions into the process. The purpose of the reading was to obtain the sense of the whole phenomenon. Then, the reading focused on the meaning units from the holistic perspective of both the women’s and men’s experiences of the phenomenon of alcohol addiction. The meaning units were highlighted during the reading process. The similarities and differences related to meaning in the transcripts were placed into specific categories in which all meaning units were clustered. The meaning units were preliminarily related to the aim of the study and were then translated into English and discussed with my supervisors. The reflections on all relevant meaning units were accomplished by asking specific questions, such as ‘What is the woman/man really saying’? and ‘What are the women’s/men’s combined experiences’? During these repeated reflections, essential aspects began to emerge, and an understanding of the women’s lived experiences of alcohol addiction could be explored (Dahlberg et al., 2008). The meaning units were described, and a new phenomenon of the men and women experiencing alcohol addiction emerged.

Focus group interviews

Focus group interviews were conducted to explore the healthcare providers’ experiences of working with alcohol addiction in a hospital treatment programme. The questions were formed to encourage the participants to freely discuss their experiences of practice together both in broad terms and in detail and to enable the participants to raise any issues related to the aim of the study that were created by their own views and experiences.

Participants and settings in study III

In study III, purposive sampling was applied to select participants who were recruited from different healthcare professions at one hospital. The sample consisted of nurses, a social worker, a psychologist, a nutritionist, a vocational therapist and nurse aids. The inclusion criteria were at least five years of experience working with alcohol addiction. The 32 participants included 26 females and six males who had worked with people experiencing alcohol addiction for five years or more and were still working in the hospital. The majority of the healthcare providers in study III were female nurses, aged between 30 and 40 years, with 5-15 years of work experience and a bachelor’s degree (see Table 3). Data collection was performed from July to August, 2013 (see Table 1).
Table 3 provides the numbers, sexes, ages, work experiences, education levels, professions and regions of the healthcare providers who participated in studies III and IV.

Table 3 Data for the healthcare providers in studies III and IV

<table>
<thead>
<tr>
<th>Healthcare provider participants</th>
<th>Study III</th>
<th>Study IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-40</td>
<td>21</td>
<td>5</td>
</tr>
<tr>
<td>41-50</td>
<td>11</td>
<td>14</td>
</tr>
<tr>
<td>51-60</td>
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<td>13</td>
</tr>
<tr>
<td><strong>Work experience (years)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-15</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>16-25</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>26-30</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Education level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Bachelors</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Masters</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Profession</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Physician</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social Worker</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A. A. member</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Health office</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Nurse-aid</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Vocational</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>South</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Central</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Northeast</td>
<td>32</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32</td>
<td>32</td>
</tr>
</tbody>
</table>
Data collection in study III

The focus group interviews were performed after receiving a permission letter from the hospital’s director, and the head nurse assisted in the recruitment of the participants. After receiving informed consent from the healthcare providers, five focus groups were scheduled. The focus group comprised three groups of nurses (22 nurses); one group of six nurse-aids and one multidisciplinary group that included a psychologist, a social worker, an occupational therapist and a nutritionist.

Before the group interview, consent for tape recording was obtained. The focus groups were conducted at the alcohol ward. The moderator’s role during the focus group was to facilitate the discussion and maintain a non-judgemental climate in the group. The co-moderator assisted in creating a comfortable atmosphere in which all participants could share their thoughts and feelings as well as taking note through the session. At the start of the discussion, the moderator explained the arrangement of the group and the aim and outline of the study, including the moderator’s and the co-moderator’s roles in the group.

Next, the participants, introduced themselves and their expectations of participating in the focus group. Then, the moderator opened the discussion by asking the question ‘What are your experiences of working with alcohol addiction’? Further questions included ‘How do you work as a professional with individuals experiencing alcohol addiction’? and a question to facilitate discussion of improvement, i.e., ‘How would you like to improve your work’? The final question was ‘What is the best way to help people experiencing alcohol addiction’? Based on these discussions, each focus group lasted between one to two hours.

Data analysis in study III

The data analyses for study III were performed using analysis of content to identify the experiences of healthcare providers. Analysis of content meant that the author dealt with the text and data, and the process was both deep and abstract in terms of condensing the meanings, which were then labelled with codes. The audio recording was transcribed verbatim, and the transcript were read several times. The initial process of analyses involved reading the transcriptions and highlighting the text related to the aim of the study. The meaning units were condensed into descriptions to maintain the discourse. The condensed meaning units were presented and labelled with preliminary codes. Similar codes were arranged into sub-categories and then developed into categories. The preliminary meaning units that were related to the sub-categories
and categories were translated from Thai to English and discussed with the three supervisors.

**Delphi methodology**

The Delphi methodology was used to collect knowledge from the experts working with alcohol addiction. The present study aimed to achieve a consensus of opinions and central ideas (Keeney, Hasson, & McKenna, 2011). According to Keeney et al. (2011), the strengths of the Delphi technique are that it is based on expert panel consensus agreements generated through several rounds of questionnaires. Expert evaluations are more accurate and credible for specific fields than general opinions. The Delphi technique is also well-suited when there is a lack of existing research evidence in a particular field.

**Participants and settings in study IV**

In study IV, the participants represented different types of healthcare experts with a minimum of five years’ experience in the alcohol addiction area who were currently involved in alcohol addiction treatment. There were 32 participants in the three rounds of the Delphi study. In the third round, the majority of expert were female nurses, aged between 41 and 50 years, had 5-15 years of work experiences in the field of alcohol addiction and had an education level of master’s degree (see Table 3). The data were collected from January to September, 2015 (see Table 1).

**Data collection in study IV**

Data collection in each of the rounds consisted of sending out questionnaires and obtaining consensus from all participants regarding the developed statements. Three rounds of questionnaires were sent out through the mail, and each round in study IV lasted four weeks.
Data analysis in study IV

The data analyses were performed through the three rounds of the Delphi study.

The first round

In the first round, the forty-nine experts received five open-ended questions. Thirty-four participants completed and returned the survey. These open-ended questions were developed by the research team based on earlier research and practical experiences from the treatment of alcohol addiction. The open questions included how to encourage the engagement of patients in the treatment, how to prevent patients from relapsing, how patients respond to alcohol treatment, how could healthcare services be organized and improved for people experiencing alcohol addiction and what strategy should the Thai Ministry of Public Health develop for treating people experiencing alcohol addiction.

In the first round, the participants’ answers to the questions were gathered and analysed via content analysis of the text (Keeney et al., 2011). In the analysis process, all similar opinions were grouped into themes. One hundred and sixty-seven statements made by the experts were translated into English. The author and supervisors discussed and categorized the statements and condensed the similar content into fewer statements. The resulting sixty statements were then organized into three overarching themes, all of which were rated with a scale of four possibilities later in the second round.

The second round

In the second round, the thirty-four experts received a questionnaire that included 60 items that were formulated from the categorized answers received in the first round. Thirty-three participants completed and returned the survey. Each statement was rated with the following scale: 1=strongly disagree, 2=disagree, 3=agree and 4=strongly agree. Additionally, two open-ended questions were included at the end of the questionnaire that were related to the participants’ experiences of strengths and obstacles while using the standard methods and any obstacles related to the care of the different sexes in relation to alcohol addiction treatment. More than 80% were marked as complete consensuses (Hsu & Sandford, 2007).
The third round

In the third round, thirty-three experts received a questionnaire with the same rating scale. Thirty-two participants completed and returned the survey. The questionnaire was divided into two parts: the first part contained the 13 items for which consensus had not been reached in the second round, and the second part included 17 statements that were formulated from the answers from the open-ended questions in the second round.

Figure 1 provides a flow chart of the steps for the included participants in the Delphi design.

Figure 1  Illustration of the Delphi process of study IV
Ethical considerations

The thesis was approved by the Ethical Research Consideration Committee of the Princess Mother National Institute on Drug Abuse Treatment (No. 58014) in Thailand and in Sweden by the Uppsala Ethical Vetting Board (number 2012/493).

In this thesis, extra concern was placed on the participants’ voluntary decision to take part in the research. A written information sheet was provided, which included a summary of the ethical aspects. This sheet was sent to all participants before they formally provided consent. The information sheet included information about the study’s aim, procedure, sponsorship, compensation, confidentiality, voluntary consent, right to withdraw and contact information. In studies I, II and III, the written information sheet and consent form were sent by hand, and in study IV, it was sent by post. The information was provided both orally and in writing for studies I, II and III and only in writing for study IV. The data collections were conducted after receiving permission from the director of the hospital in studies I, II and III.

No other ethical problems during data collections were identified. Participation in each study was voluntary, and no participant wanted to withdraw from studies I, II or III during the research process.

The confidentiality of the data transcriptions was ensured by keeping them in a university computer that was accessed using a specific username and password of Mälardalen University. The transcriptions were altered to provide anonymity, and no one could have identified the participants from the documents except me. The data collected for each study were kept on Mälardalen University hardware in separate folders for each study. All excerpts used in the publication of the results include pseudonyms to preserve the integrity of the participants.
Results

The results section presents a summary of the main results of each study beginning with studies I and II, which were based on individual interviews, and then continuing with studies III and IV.

Lived experiences of men

Study I identified three main aspects of the lived experiences of Thai men with alcohol addiction, i.e., alcohol as a ‘tool for mending the body’, alcohol as a method for ‘payoff and doping’ and alcohol as a best friend.

*Alcohol treatment as a ‘tool for mending the body’*

Men's experiences of treatment related to solving physical problems and injuries from accidents and fights. Their fragile and worn-out bodies led them to treatment to recover and mend the body. Treatment as a process had little influence on their motivation to quit drinking, and most of the men still believed that they could handle drinking on their own. This lack of understanding of addiction was based on another important aspect of the men’s lived experiences, i.e., they wanted to keep alcohol as a part of their lives. The men experiencing alcohol addiction believed that treatment could help them stop drinking temporarily and that they could then return to drinking after a short period. The men felt no confidence in treatment and did not see complete alcohol abstinence as a possibility, although they perceived that their family and significant others expected them to stop.

*Alcohol as a method for ‘payoff and doping’*

Alcohol was used as a method of payoff and doping in the interviewed men’s experiences, and they saw drinking alcohol as part of the working culture and their relationship with other men. The men thought that drinking together increased the sense of friendship and belonging in the group of men and believed that drinking was reasonable if they worked and earned money. The interviewed men also perceived that giving alcohol to employees was a tool to
stimulate and extend the time spent working and was necessary for being evaluated as a generous boss.

*Alcohol as a ‘best friend’*

Alcohol was explored as a ‘best friend’, meaning that these men experienced alcohol almost as a part of themselves. If alcohol was not there, they would feel lonely and that life was without meaning. Drinking was the only thing they could do when they did not have the possibility of socializing with others and when they found no one to support them. The men with long periods of drinking suffered from multiple failures in life, including failed marriages and loss of work. The interviewed men were ashamed of having to attend treatment, even though they had several previous treatment attempts. Drinking alone was a way to ease life when feeling different or marginalized. These men also reported that they needed alcohol to survive, to relieve pain and to lessen the sense of being worthless.

**Lived experiences of women**

Study II focused on the lived experiences of Thai women in relation to alcohol addiction. The essence of the lived experience of alcohol addiction among the studied Thai women was an ambivalence between feeling inferior when relinquishing female roles and feeling superior and powerful when acting as a man. In the short term, drinking alcohol lessened life’s difficulties and fears, for example, of violence, physical deterioration, premature death and marginalization from family and society.

*Feeling inferior when relinquishing female roles*

Women experiencing alcohol addiction perceived a sense of inferiority and felt that they did not belong to family or society due to alcohol addiction based on the need to let go of traditional female roles. The women struggled with experiencing hopelessness and perceived stigma in relation to family members, significant others and the Thai public. These women had access to the men’s world through work life, had been economically independent and often provided economic support for their extended family. Therefore, it became difficult to handle the dependency of others when the women became alcohol-dependent and began to also develop economic problems. However, these women tried to balance their sense of inferiority by adapting to Buddhist beliefs and making offers to receive better karma in this and the next life. Thai women experiencing alcohol addiction went to the temple to pay respect and
earn merit for supporting the hope for the possibility of a better situation in the future.

*Feeling physically and emotionally hurt*

The women experiencing alcohol addiction had been exposed to domestic violence; for them, drinking alcohol could also be a way of finding relief from an abusive husband, a way of letting go of their own restrained anger and a way to have the courage to start a fight. Moreover, the women often found themselves in accidents, which also resulted in additional physical and emotional injuries. The interviewed women used alcohol to try to handle the physically and emotionally hurtful situations they had experienced because alcohol releases one from the demanding control of norms and expected behaviours and from maintaining negative thoughts and memories.

*Fearing physical deterioration and premature death*

The experiences of physical disabilities due to chronic diseases and withdrawal symptoms were especially difficult to handle for women who were middle-aged and older. The older women experienced multiple health problems and depression, became fragile and feared premature death. The advantages of drinking according to the interviewed women were that it facilitated their social interactions and lessened their physical and emotional difficulties. The disadvantages of drinking bodily exhaustion and the need for relief from intoxication to stay alive and re-achieve a healthy state.

*Feeling superior and powerful*

The Thai women experiencing alcohol addiction found that working outside the home provided access to the men’s world and to socializing on more equal terms. However, this socializing at work included drinking alcohol, and in Thailand, it also included letting go of traditional female roles. The interviewed women who were experiencing alcohol addiction had let go of femininity due to drinking outside the home, particularly for mothers who left that role to other family members. These women instead chose masculine roles that maintained the economic authority of providing for the family. The interviewed women grieved about the lack of positive relationships with their children and family and the offers that their choice of gender equity included.
Healthcare providers’ perspectives on alcohol treatment

In study III, healthcare providers involved in alcohol addiction treatment at hospitals discussed their work experiences and indicated areas for further improvements. The majority of healthcare providers interviewed were nurses, and the others included nurse-aids, a psychologist, a social worker, an occupational therapist and a nutritionist. The main obstacles to the studied alcohol addiction treatment programme according to the healthcare providers were the following: the tailoring of the alcohol treatment programme and communication problems experienced within the different collaborative practices at the hospital.

The tailoring of the alcohol treatment program

The healthcare providers explored the difficulties of managing patients experiencing alcohol addiction throughout the different stages of the treatment programme. The nurses experienced stress and demands at work and felt that they were lacking sufficient knowledge and skills in relation to the methods used in the standard programmes. The nurses also experienced fears related to handling violent acts of patients and difficult situations in caring for patients with severe comorbidities, such as those due to long-term delirium tremens (DT).

Nurses argued that working with groups was less effective for people experiencing alcohol addiction due to the limited time allotted for these treatment activities at the hospital. Individual counselling was suggested by the nurses to be more suitable than group counselling for Thai people. The group discussions were also related to the reduced access to alcohol addiction treatment for women due to the small number of female patients present in the alcohol treatment programmes and an insufficient number of wards and human resources specialized for the treatment of women. For example, all the nurse aids in alcohol treatment programmes were men, which is a common situation in Thailand.

One hindrance to successful treatment discussed by all focus groups was that patients did not complete the treatment phase, i.e., the rehabilitation phase, of the programme. Instead, they returned to drinking after the short period in the detoxification unit. The most important aspect of alcohol addiction treatment was the continuation of care throughout the entire programme and the receipt of family support during and after treatment.
Collaborative practices

The focus groups discussed the lack of communication in relation to the organization and the difficulties in communicating and collaborating with other professionals within different hierarchal positions. The focus groups also reported that it was difficult to communicate and collaborate with the patients and their next of kin. The nurses in particular wanted to improve the collaborative practices by employing multidisciplinary team meetings to facilitate collaboration and encourage the staff to communicate and share ideas. Healthcare providers need to re-establish multidisciplinary teams within each section of the alcohol treatment programme according to their suggestions.

Related to patient and family collaboration, from the healthcare providers’ perspective, both the patients and their families lack awareness of the seriousness of alcohol addiction and the amount of time required for the treatment process. For example, families expected that the short sober period at the hospital that involved medication would result in the patient being cured and that he would remain sober.

Experts panel suggestions for improving alcohol addiction treatment

In the Delphi study, an expert panel from the practical field of alcohol addiction identified barriers in accessing alcohol addiction treatment and provided suggestions for improving policies and alcohol prevention for Thai people. The expert panel’s consensus agreements on suggestions for improvements and the experienced obstacles were separated into three themes: general obstacles within alcohol addiction treatment and care, improvements in equal rights related to alcohol addiction treatment and general policy improvements related to alcohol consumption.

Obstacles within alcohol treatment and care

The obstacles agreed upon by the experts comprised patient’s motivation to stop drinking, as most patients believed that they knew how to manage their alcohol consumption; the need for healthcare providers to have adequate skills and education to manage alcohol addiction; the number of staff needed for alcohol addiction treatment and the engagement of healthcare providers at work.
Equal rights to treatment for people experiencing alcohol addiction

A suggestion from the expert panel was to improve the Thai people’s access to alcohol treatment clinics by including treatment clinics in every general hospital so people can access alcohol treatment in every part of the country. To improve availability, specific wards and beds for people experiencing alcohol addiction need to be available, and separate wards should be available for women and men. There is also a need to develop a continuing care process and to train more health volunteers to identify risky drinking behaviours in the community.

The expert panel suggested improving acceptability, which included aspects such as promoting patient-centred care and working alliances between patients and personnel and promoting the active participation of family members in treatment. Another suggestion was to initiate alcohol harm reduction goals in treatment. Moreover, healthcare providers should encourage patient engagement in treatment. The panel also agreed that personnel may need to adjust their attitudes towards patients experiencing alcohol addiction, including paying attention to gender differences in the needs related to treatment.

The statements regarding prevention elicited high degrees of consensus. These statements included suggestion of a hotline telephone service related to alcohol and the provision of more information about alcohol addiction to the public. Specific clinical practice guidelines for the prevention and treatment of alcohol addiction should be developed to support healthcare services. The expert panel suggested that people in treatment for alcohol addiction should remain in a continuing care process for at least one year. The treatment process should include after-care and self-help groups, such as Buddhist AA. The panel also emphasized the need to provide adequate medication for patients who have relapsed several times.

The panel called for organizational improvements, such as more bottom-up strategies, in which the staff has the opportunity to decide how to develop treatments through multidisciplinary teamwork and developments that agree with evidence-based practice.
Policy suggestions for reducing the negative effects of alcohol consumption

The expert panel agreed on the types of policies that are needed to reduce the negative effects of alcohol consumption in Thailand. Most consensus statements included restricting the sale of alcohol and its consumption, e.g., no drinking and driving. Adequate funding for treatment would provide more beds for patients and sufficient numbers of healthcare providers. The Ministry of Public Health should promote alcohol addiction treatment cooperation plans and develop information campaigns to improve public knowledge of addiction. Other suggestions encompassed the need for improving alcohol addiction treatment education and practice for healthcare students and the development of clinical practice guidelines. The expert panel wanted the government to support an increased budget for alcohol research, treatment and community prevention projects.
Discussion

The overall aim of this thesis was to describe and explore the barriers to alcohol addiction treatment for people experiencing alcohol addiction. The results of the four studies included in this thesis highlight the fact that barriers exist at the individual, organizational and structural levels for Thai people experiencing alcohol addiction.

The major barriers to alcohol addiction treatment found in the present thesis are as follows: barriers on an individual level, which include a lack of awareness of alcohol addiction and a lack of engagement in treatment, ‘doing gender’ differences, violence in general and violence against women, and negative attitudes and stigma related to alcohol addiction; barriers at the organization level, which include healthcare providers’ experiences of stress, a lack of engagement at work, a lack of communication in collaborative practices, struggles with the use of standard methods and struggles in the treatment of women; and barriers at the structural level, which include gender-related double standards in the Thai healthcare system, unequal rights to healthcare services for people experiencing alcohol addiction, and insufficient funding and resources for beds, staff and continuing care.

Barriers on the individual level

Individual-level barriers included an unawareness of alcohol addiction and a lack of confidence in and engagement with the treatment. These barriers are based on a lack of knowledge, negative attitudes, self-agency, trust and stigma that people experiencing alcohol addiction recalled from their surroundings (Barman et al. 2011; Saunders et al., 2006).

The findings from studies I and II revealed that men and women are unaware of their drinking problem, and this lack of awareness was found to be primarily related to working environments and the value of drinking. The men experiencing alcohol addiction had strong comments about the value of drinking in terms of facilitating socializing and enhancing interpersonal relationships, particularly in the Thai work environment. The findings regarding lived experiences of alcohol addiction were also related to gender roles; the men who drank contributed to ‘doing gender’ (West & Zimmerman 1987), and the
women let go of their female roles when working outside the home. According to Thai tradition, drinking is accepted when male or female breadwinners outside the home (Jongudomkarn et al., 2012). Thai society has a patronage-driven culture regarding alcohol consumption, in which the values of the pre-conceived notion of masculinity indicate that Thai men ‘have to drink’ to meet the core cultural values of the hegemony of masculinity (Jongudomkarn et al., 2012). Additionally, alcohol consumption is a homo-social interaction that connects to male identity constructions; in male adulthood, shared alcohol consumption is a part of building and maintaining male friendships and a symbol of masculine behaviour (Bird, 1996; de Visser & Smith, 2007; Emslie et al., 2013; Moolasart, 2011; Noone & Stephens, 2008). Heavy drinking is more accepted among men than among women (de Visser & McDonnell, 2012; Griffin et al., 2013).

Being a breadwinner in Thai culture is stressful, and drinking alcohol can release stress (Rungreangkulkij et al., 2012). The women in study II had stepped away from their traditional roles as females as a result of reduced support or victimization by their partner and their own families. The female breadwinners in the present study attempted to be ‘super women’ by working hard and earning enough money to economically support their children and parents. These women had reformulated their gender identity as working women. In line with a previous study, the transformation of Thai women’s new identity involved being independent, being a breadwinner and working outside the home (Thaweesit, 2004). However, the women were devalued by their families and by society, and they perceived addiction as a source of guilt, shame, despair and fear. These findings are in accordance with those of a study stating that women are often introspective and tend to blame and degrade themselves (Thurang & Tops, 2013). Consistent with Buddhist ideology (Klunklin & Greenwood, 2005), women feel inferior to men and perceive themselves as subordinate to other family members within the domestic arena.

The men experiencing alcohol addiction were more likely to have had several previous treatment attempts, including attempts in temple clinics using Thai local wisdom methods and in hospitals. The men thought that alcohol was not the problem and that they could handle drinking by themselves. Research has found that men lack engagement and confidence in the treatment, and a previous study found that although treatment attempts did increase patients’ knowledge of alcohol addiction (Saunders et al., 2006), the prior treatments did not seem to influence the men’s drinking. However, the men experiencing alcohol addiction perceived a stigma from family and society stemming from both their addiction and the act of entering alcohol addiction treatment. The men had experienced physical problems, accidents and violence, and they returned to treatment to mend their bodies. Similarly, studies have found that
alcohol addiction is associated with a focus on physical illness rather than on addiction (Barman et al., 2011; Cunningham et al., 1993; Rapp et al., 2006). The findings from study I provided an understanding of the masculine identity, which was associated with less willingness to disclose mental or emotional illness (Schofield et al., 2000). Masculinity became a hindrance to alcohol addiction treatment because the men focused more on the physical illness than on psychosocial problems and indicated that they were forced into treatment. The treatment process had little influence on motivation, and most men still believed that they could handle drinking on their own. The men felt no confidence in their ability to stop drinking, although they perceived that the families of their significant others expected them to attend treatment and stop drinking. This finding is consistent with the results from a Swedish study reporting that pressure from significant others such as friends and family members was the factor that caused both men and women to seek alcohol treatment (Jakobsson, Hensing, & Spak, 2008).

The women in study II suffered from chronic diseases and experienced multiple health problems. Consistent with Covington (2008) and Raine (2001), the physical deterioration experiences were a source of constant worry, and the fear of early death was the basic drive for finding medical treatment. The women experiencing alcohol addiction in this study were primarily middle-aged and elderly, and they sought treatment for chronic disease conditions. Moreover, they were generally underdiagnosed with alcohol addiction, consistent with the report from Goldstein et al. (2015). However, the women seldom sought treatment to cope with physical and emotional wounds, which was also shown in previous Thai research (Ross, Sawatphanit, & Suwansujarid, 2007). Rather, women went to the temple seeking merit, as they cannot be treated in the temple. In a previous study of the Buddhist way, Thai women living with HIV attempted to provide spiritual self-care by using Buddhist beliefs to achieve peace and move on with their lives (Ross et al., 2007).

The findings from study II revealed that the women’s lived experiences included domestic violence and accidents that affected their physical and mental health. Day, Gough and McFadden, (2007) explained that alcohol can seriously damage women’s health and noted the belief that drinking is not suitable for women and sometimes leads to violent responses from their partners. The violence that people experiencing alcohol addiction confront and are involved in, particularly violence against women, often include domestic violence experienced within the family from people they care for (Tuchman, 2010: Waleewong et al. 2015). The findings in study II revealed that domestic violence directed at women experiencing alcohol addiction is related to the double standard in which men tend to oppress women both mentally and physically. Raine (2001) observed that these women are devalued and marginalized.
from their families and from society (Raine, 2001). The women in study II were afraid that people would harm them both mentally and physically; as a result, they often isolated themselves. Consistent with Young’s feminist phenomenology (1980), the women confined their bodies because of their fear of injury and often chose social isolation when experiencing mental or physical problems.

**Barriers to organization**

Organizational-level barriers related to people experiencing alcohol addiction in the Thai context were the excessive stress and demands that healthcare providers experience at work. The struggle was related to the use of standard methods, the lack of communication between professionals within the treatment programme, and the hierarchies of the healthcare system in horizontal and vertical collaborative practices and with patients and families.

The majority of healthcare providers working with alcohol addiction in Thailand are nurses, which is apparent in the samples of studies III and IV. Although nurses carry the main responsibility during the alcohol addiction treatment process, the results of the present study showed that nurses do not receive support from the agency in terms of influencing how specific treatments and care are provided within the treatment programme. Similar findings have been reported in Chile, where nurses described their insecurity in caring for patients experiencing substance and alcohol addiction. Moreover, these nurses felt uncomfortable with patient demands and struggled with multidisciplinary work, which generated stressful situations and negative feelings (Ortega & Ventura, 2013).

The nurses in the focus group interview of study III mentioned the problem of a heavier workload that involved the assignment of difficult tasks, such as registering patients who were unwilling to participate in the treatment. The nurses and nurse aides were frustrated and exhausted, and they questioned the methods used in the programme. The findings of study III can be related to a study that found that implementing MI/MET methods in alcohol addiction treatment is inappropriate when people experiencing alcohol addiction are not ready to change. It can be argued that the assumptions of low motivation and patients’ lack of readiness for change may be false and that no one is entirely unmotivated (Rollnick, Miller, & Butler, 2008). Research has shown that people experiencing alcohol addiction often abandon the programme without receiving any help from other relevant professionals with specific skills (Lovi & Barr, 2009). In line with nurses’ ethical code, as some nurses argued in the
focus group interview in study III, patients should receive equal treatment irrespective of their motivation level. The motivation to change also relies on the environment to make patients feel safe and empowered, and this motivation can be found through the mutual process of counselling (Rollnick et al., 2008).

In study III, the nurses’ focus group interview raised concerns about their lack of competency in working with the standard method, and the other healthcare providers also questioned how best to address patient relapses. Additionally, the findings from study IV illustrated that the expert panel agreed on three obstacles related to the lack of knowledge and skills of healthcare providers. The healthcare providers’ skills and attitudes may represent barriers to providing equal access to alcohol addiction treatment for all Thai citizens. The findings of the present study regarding the nurses’ role in treating alcohol and drug addiction indicated that this specialized area is often not included in nursing education curricula and practice. According to Clancy, Oyefeso, and Ghodse (2007) stated that the nature of addiction is complicated and requires specific knowledge and skills, which is consistent with previous findings that have described addiction work as vigorous. The skills used in this specific area include knowledge of interpersonal developmental theories and counselling and knowledge of the biological and medical aspects of treating addiction (Clancy et al., 2007). For example, knowledge of how to care for patients with severe co-morbidities and long-term delirium tremens (DT) and knowledge of situations involving threats or violence are needed. These results of study III and IV are consistent with those of previous researches showing that healthcare providers need more appropriate training to improve their knowledge, skills and positive attitudes towards alcohol addiction and treatment (Geirsson et al., 2005; Jeffery, Ley, Bennun, & Mccaren, 2000; Johnson, Jackson, Guillaume, Meier, & Goyder, 2011). The supervision of alcohol addiction treatment needs to include both support and advice for addressing the negative consequences of treatment, such as the high re-admission and dropout rates (Guydish, Jessup, Tajima, & Manser, 2010; Schwalbe, Oh, & Zweben, 2014). Moreover, continual coaching and feedback sessions can improve the sustainability of professional skills by implementing and safeguarding the use of specific methods (Madson, Loignon, & Lane, 2009; Schwalbe et al., 2014).

The healthcare providers in study III stated that having both males and females in the same ward was difficult to handle because it increased the risk of female patients being sexually violated, including the difficult situation of physical contact between nurse aides and female patients in the detoxification unit. Study III highlighted the importance of developing more appropriate healthcare services and treatment programmes for women experiencing alco-
hol addiction. Regarding the genders of the professionals, the majority of im-
balances among healthcare providers exist in the detoxification ward; all the
nurses were women, and all the nurse aides were men. Additionally, the man-
agement of alcohol addiction treatment for women in detoxification was not
well organized because of the low number of women entering treatment. An-
other possible explanation is that organizations might wish to save costs by
not providing a suitable ward for women (Raine, 2001). Notably, studies II
and III found that Thai women can be violated during the alcohol addiction
treatment process. Although healthcare providers in Thailand are informed of
women’s rights and needs in treatment, these violations still continue.

The findings of study III emphasize the importance of collaborative practices
as central to enhancing treatment outcomes and sharing human resources to
deliver care. This resulting focus on cooperation and collaborations has also
been proposed in previous studies on the importance of support resources and
multidisciplinary team and training (Johnson et al., 2011; Wadell & Skärsäter,
2007). The healthcare providers in study III suggested that attendance at in-
terdisciplinary team meetings should be part of alcohol addiction treatment,
as it had been previously, to facilitate the sharing of expertise and difficulties
experienced. The multidisciplinary meetings could serve as a platform for dis-
cussing patient care plans and learning about experiences of alcohol treatment
programmes from others. Multidisciplinary teams in alcohol treatment pro-
grammes could develop knowledge through regular meetings in which teams
practise decision making and share responsibilities in caring for patients, as
suggested in other studies (Cioffi, Wilk, Cummings, Warne & Harrison, 2010;
Clark, 2011).

The healthcare providers in study III indicated that another barrier was the
inadequate collaboration with families and patients in relation to whether they
were forced into treatment and how they valued the seriousness of addiction.
According to Kingston et al. (2013), relatives as the primary caregivers should
support but not force patients into treatment. Negative attitudes towards pa-
tients were reported by the expert panel in the Delphi study. Consistent with
van Boekel et al. (2013), the negative attitudes of health professionals may
reduce collaboration between professionals and patients. Nordfjaern et al.
(2010) argued that more collaboration with people experiencing alcohol ad-
diction is needed to prevent premature dropouts from treatment. Additionally,
the healthcare providers in studies III and IV noted the need for continuing
care and a suitable referral system to assist family members and other people
in participating in healthcare services; these developments were suggested
Barriers on the structural level

Structural-level barriers related to people experiencing alcohol addiction in Thailand were found in the present thesis. The findings contribute to a broader perspective on the health and welfare of people experiencing alcohol addiction in Thailand. According to study IV, healthcare providers’ skill and attitude can represent barriers for providing the equal accessibility and acceptability of alcohol addiction treatment for Thai citizens. Healthcare providers function as gatekeepers for people experiencing alcohol addiction, and healthcare providers therefore need appropriate training to reach their full theoretical and practical potential when working with people experiencing alcohol addiction. Moreover, the findings showed an incomplete referral system within healthcare services for people experiencing alcohol addiction and risky drinkers. The findings of study IV contribute to the belief that the UHC in Thailand needs to define alcohol addiction treatment in registered care packages and establish alcohol addiction treatment in geographically distributed healthcare services. Moreover, the UHC’s insufficient funding to hospitals for alcohol addiction treatment has increased demands for treatment (Panpiemras et al., 2011). Sharing resources within healthcare services should be considered at different levels of the healthcare system in Thailand in accordance with the consensus of the expert panel.

In the present Delphi study (study IV), the expert panel agreed on the importance of facilitating equal rights to treatment for people experiencing alcohol addiction, with the purpose of reducing alcohol consumption and alcohol-related harm. These findings were consistent with those of an earlier study suggested that individual engagement could be promoted by screening for risky drinking behaviours and by delivering brief interventions in primary care (Panaretto, 2010). The findings from study IV addressed the major difficulties that have been found in recruiting and retaining patients experiencing alcohol addiction in treatment, which may be related to the proximity, available beds and economic costs of travelling to treatment facilities. The experts also agreed that ‘no charge’ treatment should be provided for patients. Since 2008, Thailand has provided compulsory treatment for people experiencing drug addiction (but not for people experiencing alcohol addiction), and the number of patients seeking drug treatment has increased since this policy was implemented (Kerr et al., 2014; Kamarulzaman & McBrayer, 2015).

The findings of studies II-IV describe how Thai females experiencing alcohol addiction face a gender-related double standard with respect to alcohol consumption. Structural-level barriers were related to the availability of treatment
for females and the patriarchal nature of Thai society, which comprises hierarchical organizations and social relationships that keep men in power and endows them with more privileges than women (Acker, 2006). These findings are consistent with the gender-related double standard, which results in negative attitudes towards women experiencing alcohol addiction and still exists in certain parts of society, as described by Raine (2001). Treatment for females experiencing alcohol addiction is also linked to the patriarchal nature of Thai society (Klunklin & Greenwood, 2005). Alcohol addiction treatment in Thailand is primarily tailored to suit men’s needs, and women experiencing alcohol addiction in Thailand are often marginalized in society and lack sufficient access to healthcare providers. This can theoretically be attributed to ‘doing gender’, which is facilitated by the political system and organizations through the existing inequality related to gender (Bogren, 2011, West & Zimmerman, 2009). Additionally, becoming aware of ‘doing gender’ in organizations appears necessary to make major improvements in ‘undoing gender differences’ (West & Zimmerman, 1987) and providing equal rights to healthcare services for women and men. The result in this thesis suggested that alcohol addiction treatment services can be improved by addressing gender differences and healthcare provider skills and knowledge in relation to addiction.

The results in studies II and III indicated that violence against women experiencing alcohol addiction is part of their lived experiences and might also arise in treatment, as well as in the family and in society. Healthcare services typically provide general rather than gender-specific services, but such sensitivity is particularly required when addressing domestic violence. Research has found that women are embarrassed to discuss their drinking problems with men in the group because of women’s experiences of sexual and physical violence (Rungreangkulkij et al., 2012). Another study suggested that the oppression of women in alcohol addiction treatment is a phenomenon that manifests differently across different contexts depending on a region’s history and factors such as resource availability as well as the legal mechanisms that either support or further marginalize women (Mkandawire-Valhmu & Stevens, 2010). This thesis found that the gender-related double standard has implications for alcohol addiction treatment opportunities for women at the structural, organizational and individual levels. According to women’s lived experiences, healthcare providers of both sexes and expert opinions, violence against women experiencing alcohol addiction is a reality.
Trustworthiness

Three qualitative data collection methods and four types of samples were used to describe and explore the barriers to alcohol addiction treatment for people experiencing alcohol addiction. When evaluating the qualitative data collected in the present thesis, one must consider its trustworthiness. Trustworthiness comprises four criteria: credibility, dependability, transferability and confirmability (Elo et al., 2014; Shenton, 2004).

Credibility

According to Shenton (2004), credibility is related to the confidence associated with data and the interpretation of them. It is important to consider the interviewer who conducted the individual interviews and the focus groups in studies I, II and III. To enhance the credibility of the research, reflexivity should apply to the researcher’s influence on the data collection and analysis processes (Polit & Beck, 2008). I am a registered nurse (RN) with a prior background working with patients experiencing alcohol addiction, and I previously worked in the specialty hospital where the data were collected for studies I, II and III. I may have introduced a possible risk of pre-existing assumptions and power relation issues during the interviews, especially in the analysis process of the focus group materials, due to my previous background. However, I maintained an open mind, listened carefully and maintained awareness of my experiences during the data collection and analysis.

To enhance credibility, selecting the most appropriate method is essential (Elo et al., 2014). In studies I and II, I used a phenomenological descriptive methodology to describe and understand the lived experiences of men and women with alcohol addiction. The descriptive phenomenology method was suitable for working with individuals experiencing alcohol addiction. The phenomenological descriptive method is compatible with a sample of people experiencing alcohol addiction, who can be defined as vulnerable persons, in the data collection and data analysis (Dahlberg et al., 2008). Participants should participate genuinely in order to enhance credibility; they should be willing to speak freely during the data collection. The participants voluntarily took part in all studies, and they had the opportunity to decline participation at any time before the results were published (Polit & Beck, 2008; Shenton, 2004).

In study III, focus group interviews were used to collect data, and content analysis (Graneheim & Lundman, 2004) of the transcribed text was performed. The focus group enabled the participants to engage in conversations
on topics related to the aims of the study. Additionally, the focus group facilitated the interactions of participants within the group with the support of the moderator (Krueger & Casey, 2015). Possible risks associated with the focus group interview included issues of dominance during the group process. However, the group discussions were arranged in five groups with similar professionals and experiences in alcohol addiction treatment. The risk associated with selective focus group interviews is that I might not have facilitated the group conversation because of my lack of experience serving in the moderator role. The group discussions could have provided new and interesting information of which I was unaware. However, the co-author who was experienced with focus groups helped me taking note through the session.

In study IV, a Delphi study was conducted due to the lack of evidence related to possible barriers to alcohol addiction treatment in a more general sense. The strength of a Delphi approach can be assessed based on how accurate and credible the expert validations are for the area under study. The findings of a Delphi study rely on the expert panel recruitment process and the response rate in each round, which in this case were 70% in the first round and 97% in the second and third rounds. According to Shenton (2004), credibility refers to ensuring that the instrument and measurement are accurate. Concerning the internal validity of the Delphi study, the results became more valid through the three survey rounds as a result of expert opinions. The expert panel generated ideas for open-ended questions and had the opportunity to make decisions and provide judgements on a Likert scale in the second and third rounds. A possible limitation of the findings of this Delphi study is that it generated rather broad statements about the barriers rather than in-depth explanations (Hsu & Sandford, 2007; Keeney et al., 2011).

The purposive sampling was suitable for qualitative research, where the researcher is interested in participants who have much knowledge about the topic (Elo et al., 2014). In all four studies, the purposive sampling and snowball sampling methods identified participants who had rich knowledge of the research topic under study (Elo et al., 2014; Shenton, 2004). Research strengths can be assessed based on the presence of a well-defined sample, data collection and data analysis (Clarr, 1991). The inclusion criteria and the recruitment processes of the four studies were established to gain enriched data and knowledge of an understudied research area in Thailand. In studies I, II, and III, the recruitment process was facilitated by the head nurse; thus, there is a risk that some participants may have found it difficult to refuse participation, and other patients and professionals may have wished to participate but were not selected.
Dependability

According to Shenton (2004), dependability refers to the reliability and stability of data. All of the meaning units and statements in studies I and III were translated into English by a native professional translator. In studies II and IV, I performed the translation myself, and the Thai supervisor validated that the Thai meaning was accurately represented in the English version. The participants’ subjective experiences and essential aspects of the findings were discussed with the group of supervisors at every step. The strength of studies I and II are that the data provided sufficient variation and accuracy according to an internal data analysis performed by the Thai supervisor (JK) based on reading the first versions of the transcripts and checking the participants’ descriptions in their own language. Additionally, there were repeated discussions of the material with Swedish supervisors who were experienced in conducting research focusing on participants’ subjective experiences, and one of them (GÖ) has both practice and research experience in the alcohol field.

In the Delphi study, reliability was enhanced via three main approaches: first, the decision-making process was anonymous; second, the mail conversation avoided face-to-face interaction; and third, the expert panel involved an appropriate sample size. The high response rates in the second and third rounds could have increased the reliability of the study (Keeney et al., 2011; Hsu & Sandford, 2007). The difficulty in the Delphi process was maintaining the experts’ motivation to cooperate with all three rounds of the Delphi process. The possible risks in the Delphi study were the high dropout rate in each round and its time-consuming nature. In the first round, the response was lower than that in the second and third rounds because of the geographical dispersion of experts in all parts of Thailand. In the second and third rounds, the response rate was high because they mostly lived in the north-eastern part of Thailand, and I telephoned the experts when I did not receive a reply after three weeks.

Confirmability

To enhance the confirmability and accuracy of the process, the study concerns included determining the accuracy of information provided to the researcher by the participants and examining how the researcher interpreted the data (Shenton, 2004). Before publication, the results of study III were presented to healthcare providers at the special hospital at which the study was performed. The healthcare providers who participated in this seminar recognized our interpretation of the results; thus, the face validity of the study was confirmed. The data analysis and the preliminary description in studies I, II, III and IV were presented at a PhD seminar and at international conferences.
As a possible weakness of study II, most of the interviews with women were performed last in my PhD because it was very difficult to find females experiencing alcohol addiction, as few women received treatment in hospitals. However, a strength of study II was that I was more experienced in using phenomenology than I had been earlier in the research process.

The difficulty in the collection of data related to Thai culture is expressed through ‘Kreng jai’ (the hierarchy of social rules that tightly controls social life in Thailand) (Klunklin & Greenwood, 2005). The majority of people experiencing alcohol addiction, including both the men and women in my study, were quite silent and polite, possibly because of the influence of ‘Kreng jai.’ Although I had previous experience conversing with patients, it was difficult for me to use the additional questions to encourage the participants to more fully engage in the conversation, especially with the men experiencing alcohol addiction. Therefore, I conducted a second interview with some of the men.

Transferability

Transferability is the potential to extend or transfer the findings or the extent to which the findings are relevant and appropriate for other settings (Shenton, 2004). Studies I and II provide detailed descriptions from men and women diagnosed with alcohol dependence, which could enable researchers or healthcare providers who are interested in transferring the results into similar contexts to find new knowledge from the Thai context. Female nurses are the primary professionals who work with alcohol addiction at all levels of healthcare services in Thailand. Although it may be difficult to recruit other professionals, these participants represent the authentic context in the healthcare system of Thailand (studies III and IV). The findings from the expert panel could be considered transferable to other parts of Thailand because those other parts share a distribution of expertise and staff in the alcohol addiction treatment field that is similar to that included in study IV. Moreover, the findings regarding the barriers to alcohol addiction treatment at the individual, organizational and structural levels could be transferable to other developing countries facing similar context-related problems, such as the organization of the healthcare service system and the gender-related double standards related to drinking culture, work life and domestic responsibilities.
Description of contributions

The topic of my thesis, barriers to alcohol addiction treatment, was formulated before I applied to the PhD programme as well as during the programme in cooperation with my supervisors: Associate Professor Gunnel Östlund, Professor Henrik Eriksson and Dr. Jureerat Kijjompon. Jureerat Kijjompon supervised the data collection process in Thailand and ensured accurate translations from English to Thai and from Thai to English. I was solely responsible for collecting the data in the four studies. The data analysis and preliminary results were discussed in supervisory meetings on Skype or in Sweden and Thailand. The first draft was written by KH under the supervision of GÖ and HE. In further drafts of manuscript I, HE and JK read the manuscript and suggested improvements. In manuscripts II, III, and IV, KH provided a draft of the description of the introduction, methods, results and discussion herself; however, GÖ contributed to the English and scientific language in all article sections. HE made improvements to the theoretical aspects and concepts, including relating the results to nursing research perspectives. JK contributed by reading the raw data and reflecting on the findings in relation to the Thai context, methodological considerations and scientific standards.
Conclusions

The findings of this thesis suggest that changes have to be made on at least three levels of Thai society to cope with the increasing problem of alcohol addiction. On the structural level, equal rights to health for people experiencing alcohol addiction, availability, accessibility, acceptability and quality to treatment need to be improved, especially for women.

In order to improve equal rights to health for people experiencing alcohol addiction in Thailand, knowledge of alcohol addiction, stigma and domestic violence-related issues needs to be improved in the healthcare service system. Formal training and nurse educational programmes are needed to reach the theoretical and practical potential of nurses and of other healthcare providers working in alcohol addiction.

The knowledge of the lived experiences of men and women with alcohol addiction related to the masculine working culture represents a novel contribution of the present study. This knowledge needs to contribute to the Thai people in general and to the healthcare providers and relatives who are trying to support individuals experiencing alcohol addiction.

Thai women encounter complicating aspects related to the Buddhist religion, which does not allow for alcohol drinking, and the patriarchal society. According to Thai traditional views, women should work at home and may drink there but not in public. The women in the present study suffered from the gender dilemma, public stigma, physical and mental health problems and insufficient support from family and society.

Women with experiences of domestic violence and alcohol addiction voiced the need for available and specific support in the hospital. The identified barriers to alcohol addiction treatment related to women represent challenges to the organization and structure regarding equity of access to healthcare services based on gender differences.
Future directions

To gain comprehensive views of barriers to alcohol addiction treatment among the different levels of healthcare services, future studies are necessary. For example, I plan to further examine the gender aspects and sociocultural factors for people experiencing alcohol addiction. It would also be valuable to study how individuals experiencing alcohol addiction gain access to and respond to treatment in primary and secondary healthcare services. Another study could focus on nurses’ agency and competences related to working with alcohol addiction treatment.

The findings of the present thesis addressed the barriers to alcohol addiction related to the imported standard programmes and the effectiveness of their implementation in the Thai context. Imported programmes need to be further explored. Additionally, alcohol addiction specifically designed for women needs to be further explored.

Future studies should also focus on the Thai working culture and explore the areas in which alcohol consumption exists parallel to working. Additionally, I would like to identify the socioeconomic and educational differences among these local working cultures.
Summary in Swedish

Bakgrund: Riskbruk av alkohol kan starkt påverka livet för individer och familjer, inklusive ge negativa konsekvenser för social välfärd och psykisk hälsa. I Thailand är det få personer med riskbruk av alkohol som uppsöker sjukvården och på så sätt kommer i kontakt med behandlingsinsatser.

Syfte: Det övergripande syftet var att undersöka de hinder som finns före, under och efter alkoholbehandling bland människor som lever med alkoholberoende och att studera professionellas erfarenheter av att arbeta med alkoholbehandling. Denna avhandling ingår i Forskarutbildningen i hälsa och välfärd som drivs av Akademin för hälsa, vård och välfärd vid Mälardalens högskola.

Metoder: Avhandlingen omfattar fyra kvalitativa studier som använt tre olika metoder för datainsamling. Individuella intervjuer användes i studie I och II, som analyserades med Deskriptiv fenomenologi. Fokusgruppintervjuer användes i studie III, Delphi metodik i studie IV och innehållsanalys användes för att kondensera resultaten. Strategiskt urval tillämpades för att hitta delta- gare till de fyra studierna, inkluderade var 13 män (studie I) och 12 kvinnor (studie II), 32 professionella (studie III) och 32 experter från alkoholbehandlingsområdet (studie IV). De professionella var främst sjuksköterskor (studie III och IV), vilka utgör den största gruppen som arbetar med alkoholbehandling i Thailand.

Resultat: Resultat i denna avhandling belyser hinder före, under och efter alkoholbehandling för människor som lever med alkoholberoende. De identifierade hinder återfinns på individ-, organisation- och struturellnivå i det thailändska samhället. I hinder på individnivå ingår en omedvetenhet om effekterna av alkoholmissbruk både bland patienterna, anhöriga och i samhället där kvinnor och män hanteras olika i förhållande till behandlingen, i familjen och i arbetslivet. Den enskilde upplever stigma i samband med alkoholmissbruk bl.a. relaterade till Buddismens levnadsregler. Patienterna upplever bristande förtroende för och engagemang i alkoholbehandlingen. Hinder som åter- fanns på organisationenivå var relaterade till de professionellas brist på engagemang och brist på kommunikation inom de olika delarna av verksamheten.
både i vertikala och horisontella samarbeten, dessutom saknades ett välfungerande samarbete både med patienter och deras anhöriga. Särskilda svårigheter uppstod när kvinnor fanns på avdelningen och sjuksköterskorna upplevde stora svårigheter med att hantera de evidensbaserade metoder som användes utan tillräcklig utbildning eller handledning. På den strukturella nivån återfanns hindren i det patriarkala samhället, där jämställdhet mellan könen saknas och tillräckliga resurser och finansiering från Hälsoministeriet i Thailand försöker att göra förbättringar som kommer människor som lever i alkoholberoende till godo. Framförallt saknas skydd för kvinnorna som ibland kan komma att utnyttjas sexuellt både i hemmet och i alkoholbehandlingen. Dock beskriver kvinnorna att de använt alkohol som en självklar del i det manligt kodade arbetslivet att de känt en styrka i att kunna vara den som försörjer familjen samtidigt som de skäms för att vara en dålig mor.

**Slutsats:** I Thailand har alkoholmissbruk och dess negativa konsekvenser blivit en het fråga på grund av alkoholens effekter på hälsa och välfärd för den enskilde och dess närstående. Denna avhandling lyfter fram svårigheterna att få vård, behandling och socialt stöd till människor som lever med alkoholberoende. Våra resultat i denna avhandling är överförbara till andra asiatiska samhällen och för de länder som liksom Sverige importerar evidensbaserade metoder som utvecklats i andra kontextuella sammanhang.
การดื่มแอลกอฮอล์มีผลกระทบต่อระบบสวัสดิการสังคมและสุขภาพในระดับบุคคล,ครอบครัวและระดับประเทศปัญหาสำคัญที่เกิดขึ้นในประเทศไทยพบว่าผู้ที่มีความเสี่ยงต่อการติดสุรา มีอัตราการเข้ารับบริการด้านสุขภาพต่ำมากเปรียบเทียบกับผู้ที่ไม่ติดสุราของประเทศ การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาอุปสรรคที่มีต่อการรักษาผู้ติดสุราในประเทศไทย

ระเบียบวิธีวิจัยของการศึกษานั้นประกอบไปด้วยการวิจัยเชิงลูกภาพ(Qualitative study) สามระเบียบวิธีการวิจัยได้แก่การศึกษาทั้งนี้และสองใช้ระเบียบวิธีวิจัย Phenomenological descriptive study รวบรวมข้อมูลโดยการสัมภาษณ์เป็นรายบุคคล (Individual interview) การศึกษาที่สามเก็บรวบรวมข้อมูลโดยวิธีคุณภาพ (Content analysis) และการศึกษาที่สี่ เก็บรวบรวมข้อมูลโดยวิธีเดลฟี (Delphi study) วิเคราะห์ข้อมูลเชิงเนื้อหา (Content analysis) ซึ่งการศึกษาทั้งสิ้นส่วนตัวอย่างแบบเจาะจง(Purposive sampling) ได้กลุ่มตัวอย่างในการศึกษา ทั้งหมด สอง สามและสี่เรียงตามลำดับ คั่งขึ้น ผู้ชายติดสุรา 12 ราย, ผู้หญิงติดสุรา 13 ราย, บุคคลการสาธารณสุขที่มีประสบการณ์ในการดูแลผู้ติดสุรา 32 ราย และผู้เชี่ยวชาญในการดูแลผู้ติดสุรา จำนวน 32 ราย

ผลการศึกษาพบว่าอุปสรรคต่อการรักษาผู้ติดสุรามีดังนี้ คือ อุปสรรคในระดับบุคคล องค์กร และโครงสร้างทางสังคม อุปสรรคในระดับบุคคล คือ การขาดความตระหนักในการดื่มสุรา, ขาดการดูแลโดยคำนึงถึงเพศสภาพ, มลทินสังคม (Stigma) และความเชื่อมั่นและความพร้อมต่อการรักษาอุปสรรคในระดับองค์กร ได้แก่ความสุกพัฒนาในองค์กร ความร่วมมือในองค์กร ระหว่างผู้บริหารกับ
บุคลากรสาธารณสุข ระหว่างบุคลากรสาธารณสุขด้วยกัน บุคลากรสาธารณสุขกับญาติผู้ป่วย และบุคลากรสาธารณสุขกับผู้ป่วย อุปสรรคในระดับโครงสร้างได้แก่ การป้องกันผู้ติดสุรากับระบบบริการสาธารณสุขมีสองมาตรฐาน คือการให้บริการผู้ป่วยที่ไม่คำนึงถึงความแตกต่างทางเพศสิทธิในการเข้าถึงบริการสาธารณสุขของผู้มีความเสี่ยงต่อการติดสุรา และขาดทรัพยากรที่สำคัญในการรักษาผู้ติดสุรา ได้แก่ งบประมาณ จำนวนเตียง เจ้าหน้าที่ และระบบการรักษาที่ต่ำเนื่อง

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