PATTERN OF COGNITIVE DISTORTION AMONG AMPHETAMINE ABUSE

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PATTERN OF COGNITIVE DISTORTION AMONG AMPHETAMINE ABUSE

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ABSTRACT

This research had an objective to study model of thought of substance abusers, and to study the association between individual characteristics, automatic thought, attitude distortion, depression and cognitive distortion among a sample of amphetamine addicts undergoing rehabilitation. A total of 421 participants, aged 18-25, were selected from Thanyarak Hospital, general hospitals, private drug rehabilitation centers, and the Wiwat Pholameuang Academy. Data were collected by questionnaire during January to March, 2016. Data were analyzed using SPSS Version 21.

This study found that one-third of the sample had symptoms of depression, and over half had negative automatic thought on a regular basis (56%), while 14% had attitude distortion, and from 6 % to 19% had regular cognitive distortion in social relationships. Cognitive distortion was characterized by “should statements”, followed by “minimizing or disqualifying the positive”, and “catastrophizing”. Regarding personal achievement, 4 % to 11% of this sample of substance abusers had continuous cognitive distortion, characterized by “minimizing or disqualifying the positive” and “mental filtering.” The analysis of associations between negative automatic thought, attitude distortion and depression with cognitive distortion found statistically significant relationships at the level of $p <= 0.00$.

KEY WORDS: COGNITIVE DISTORTION/ AUTONOMIC THOUGHT / DSYFUNCTION ATTITUDE / DEPRESSTION/ AMPHETAMINE ABUSE/AGE /EDUCATION

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รูปแบบความคิดบิดเบือนของผู้เสพยาบ้า

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คณะกรรมการที่ปรึกษาวิทยานิพนธ์:บังอร เทพเทียน, ปร.ด.,ประภาพรรรณ จูเจริญ, ปร.ด.

บทคัดย่อ

การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษารูปแบบความคิดของผู้เสพยาบ้าและเพื่อศึกษาความสัมพันธ์ระหว่างคุณลักษณะส่วนบุคคลความคิดอัตโนมัติด้านลบ ทัศนคติบิดเบือน ภาวะซึมเศร้าและความคิดบิดเบือนของผู้เสพยาบ้าในสถานบำบัดรักษายาเสพติดยาบ้า กลุ่มตัวอย่างผู้เสพยาบ้าโรงพยาบาลธัญญารักษ์ โรงพยาบาลทั่วไป สถานบำบัดเอกชน และโรงเรียนวิวัฒน์พลเมืองเฉพาะเพศชาย อายุ 18 – 25 ปี จำนวน 421 คน โดยใช้การสุ่มตัวอย่างแบบเจาะจงในวิธีการเก็บรวบรวมข้อมูล เก็บข้อมูลโดยใช้แบบสอบถามตั้งแต่วันที่ 4 มกราคม 2559 ถึงวันที่ 31 มีนาคม 2559 วิเคราะห์ข้อมูลโดยโปรแกรมคอมพิเตอร์สำเร็จรูป SPSS Version 21

ผลการวิจัยพบว่า ผู้เสพยาบ้า 1ใน 3 มีภาวะซึมเศร้า ผู้เสพยาบ้ามากกว่าครึ่งมีความคิดอัตโนมัติเชิงลบเป็นประจำน้อยกว่าค่าเฉลี่ยร้อยละ 56 ผู้เสพยาบ้ามีทัศนคติบิดเบือนมากร้อยละ 14 มีความคิดบิดเบือนในด้าน (Social Relationships) ตลอดเวลา ระหว่าง 6.2-18.8 % โดยเฉพาะความคิดด้านความสัมพันธ์ทางสังคม ความคิดควรทำ (Should Statements) มากที่สุดรองลงมาคือ ลบเรื่องราวดี ๆ ขยายเรื่องราวลบ (Minimizing or Disqualifying the Positive) และการคิดแบบหายนะ (Catastrophizing) สูงกว่าความคิดบิดเบือนแบบอื่น ๆ ส่วนด้านความสำเร็จส่วนบุคคล (Personal Achievement) มีความคิดบิดเบือนตลอดเวลา 4.3 -10.7 % โดยมีความคิดลบเรื่องราวดี ๆ ขยายเรื่องราวลบ (Minimizing or Disqualifying the Positive)มากที่สุดและรองลงมาคือ การคิดแบบกลั่นกรอง (Mental filter)มากกว่าด้านอื่นๆ ผลการวิเคราะห์ความสัมพันธ์ระหว่างความคิดอัตโนมัติเชิงลบ ทัศนคติบิดเบือนและภาวะซึมเศร้ากับความคิดบิดเบือนมีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับความคิดอัตโนมัติเชิงลบ ทัศนคติบิดเบือนและภาวะซึมเศร้าที่ระดับ .00

138 หน้า

CONTENTS

CONTENTS (cont.)

LIST OF TABLES

LIST OF TABLES (cont.)

LIST OF FIGURES

CHAPTER I
INTRODUCTION

1.1 Rational

Youth abuse of addictive substances in Thailand has been a festering problem for the past three decades. Consumption of drugs and alcohol during adolescence adversely impacts on emotional and physical development into adulthood. Substance abuse is linked with problems of mental health and other chronic conditions, education and learning, efficient work performance, responsibility toward family and friends, societal rejection, and committing crime.

Despite the importance and scope of the problem, there has not been enough research into the relationship between drug abuse and mental phenomena. Also, there have not been enough studies of youth and adults in drug rehabilitation centers. Thai research into the effects of childhood (as opposed to adult) drug abuse on psychological disorder is lagging behind the field. (5) A better understanding of the mental effects of youth drug abuse should help improve treatment outcomes and efficiency.

There is some research which looked at causes of youth drug abuse, and dimensions of prevention and rehabilitation. Behavioral modification programs have not been as successful as hoped in curtailing alcohol and tobacco use among youth. There are no studies however of youth with addiction to the more dangerous drugs. Thus, Thailand has to draw on the experience of theory and practice from other counties

In 1940, many theories were advanced on the topic of treatment, but these can be grouped into a few categories. Most dealt with adult alcoholism, chronic conditions associated with alcoholism, mortality, and treatment. Many studies focused on risk factors and prevention of drug addiction, but few looked at treatment and cost-effective treatment outcomes. Later, Cognitive Behavior Therapy became more popular as an efficient way to modify drug use behavior. A more recent theory is

Cognitive Therapy which is applied for cases of depression and abnormal behavior. Cognition differs between the addict and non-addict mind and, thus, some studies have focused on the following factors which are predictors of addiction: 1) Low emotional tolerance level; 2) Greater power of the pull of the drug than the will to resist; 3) Lack of adaptive behavioral skills to manage life problems; 4) Triggers for addiction; 5) Desire for excitement and reduced boredom; 6) Reduced tolerance of unsatisfactory situations; and 7) Reduced hope for the future. Various cognitive models have been proposed for use in treatment programs. Some of these focus on cognitive processes which affect internal adjustments (e.g., schema, basic beliefs, automatic thought, and cognitive distortion) which lead to drug addiction. (6) A conceptual framework has been developed for addressing cognitive distortion in youth, and this has had some success in thought and behavior modification. (12,13) Thus, it is important to continue to refine these concepts and theories and adapt them to local challenges and treatment programs

In 1940, many theories were advanced on the topic of treatment, but these can be grouped into a few categories. Most dealt with adult alcoholism, chronic conditions associated with alcoholism, mortality, and treatment. Many studies focused on risk factors and prevention of drug addiction, but few looked at treatment and cost-effective treatment outcomes. Later, Cognitive Behavior Therapy became more popular as an efficient way to modify drug use behavior. A more recent theory is Cognitive Therapy which is applied for cases of depression and abnormal behavior. Cognition differs between the addict and non-addict mind and, thus, some studies have focused on the following factors which are predictors of addiction: 1) Low emotional tolerance level; 2) Greater power of the pull of the drug than the will to resist; 3) Lack of adaptive behavioral skills to manage life problems; 4) Triggers for addiction; 5) Desire for excitement and reduced boredom; 6) Reduced tolerance of unsatisfactory situations; and 7) Reduced hope for the future. Various cognitive models have been proposed for use in treatment programs. Some of these focus on cognitive processes which affect internal adjustments (e.g., schema, basic beliefs, automatic thought, and cognitive distortion) which lead to drug addiction. (6) A conceptual framework has been developed for addressing cognitive distortion in youth, and this has had some success in thought and behavior modification. (12,13) Thus, it is important to

continue to refine these concepts and theories and adapt them to local challenges and treatment programs

As early as 1890, William James first recognized cognitive distortion in an alcoholic patient and factors behind relapse. This led to cognitive intervention programs for treating addiction, and was applied by many others over the following decades. But research on the different cognitive models received little attention. There was more interest in automatic thought as it related to drug abuse (rather than cognitive distortion). Some researchers suggested that the difference between the cognitive models and cognitive distortion (CD) helped to illuminate the different functions and effects of these phenomena related to substance abuse.

There have been few studies of CD and substance abuse at the individual level; most merely looked at general empirical data on CD. CD is a process of biased thinking as a response to external stimuli, and generally manifest by abnormal attitudes and beliefs. Sequellae include depression, anxiety and reduce ability for self-control. Depression is associated with CD. Research into CD in particular should help improve understanding for modification and rehabilitation of the drug abuser, tailored to the different type of CD.

Beck and other cognitive researchers attempted to develop a classification system for the different types of CD as applicable to substance abusers. The next step would be to assess correlation between the types of CD and manifestations to produce a cognitive model which could be applied to youth drug abusers. Such a model should be of special help to drug addicts at risk of more severe addiction. Studies have looked at males and females (age 12-17 years) with abnormal cognition and behaviors using the DSM IV, and grouped these into the following: (1) Abnormalities related to drug use which affects emotions and behavior; and (2) Emotional and behavioral abnormalities unrelated to drug use. These studies have helped to define eight types of cognitive distortion which are predictors of difficulty in resolving life problems and risk of drug addiction: Low Tolerance of Frustration, Excitement Seeking and Low Tolerance for Boredom, Diminished Future Time Perspective, Catastrophizing, Blame and Punishment, Personalization Self - Reference, and All-or-Nothing Thinking.

Cognitive distortions

Psychologists believe that CD produces incorrect thoughts which lead to negative outlook and emotion, and clinical depression. This proposition has been studied in some depth, especially by Beck and other clinical psychologists, over two decades. CD is a response to a stimulus or trigger which is both emotional and physical. Associated abnormal emotions are noted in both adults and youth with CD. Attitudes and beliefs are skewed as well, and can lead to clinical depression and anxiety. Rohany Nasir, Zainah Ahmad Zamani studied behavior toward the family members, self-esteem, distortion and depression among youth in Indonesia and Malaysia. They found that depression associated with family obligations reduced self-esteem, with further distortion and a cycle of worsening depression.

Albert K. Liau, et al studied the association between CD (distorted attitude or beliefs) and social behavior, both overly and covertly. Their study included a sample of 52 males with delinquent behavior, and a control sample of 51 high school students age 14-18 years. The researchers found that the youth with CD had high levels of anti-social and criminal behavior (based on self-reports). In addition, some rationalized their criminal behavior as a response to carelessness of the victim in not protecting themselves or their valuables.

Chabon B, Robins CJ studied the effct of CD on anti-social behavior and found an association between CD and self-debasing attitudes and behavior. CD in youth can also be an outcome of depression (self-serving cognitive). The researchers also studied CD in cases of clinical depression who were not drug addicts and compared their sample to those with no CD symptoms. Predictably, CD was higher in those with depression than the non-pressives.

In another study, Albert K. Liau, et al compared criminal behavior by high school-age youth and found four manifestations of CD in their sample: (1) Self-centering; (2) Blaming others; (3) Minimizing/mislabeling; and (4) Assuming the worst. These findings point to the difference between cognition and behavior.

Chabon B, Robins CJ studied drugs users and found that most had mental health issues, including depression. The depressives who were not drug addicts had higher levels of CD than non-depressives. Their study also looked at prevalence of CD a sample of depressives or drug users who had suicidal tendencies (N=52). They

found a similar level of CD as in other studies. Persons who did not have clinical depression had less CD than depressives who were not drug addicts. Depression and suicidal thoughts impact on the level of CD and indicates the need for cognitive therapy (for depression that results from drug addiction).

Barriga AQ et al conducted a study of 239 school youth age 10-19 on Kurasao Island. That study found that cognitive distortion was associated with self-pity, and indirect anti-social disposition was associated with delinquent behavior, aggressive speech and behavior, and bullying. The authors defined two types of cognitive distortion: Internalizing Cognitive Distortion (which is derived from sense of self-pity, low self-esteem, anxiety and depression), and Externalizing Cognitive Distortion (which is associated with social context, reactive behavior, anti- positions, self-indulgence) and is negatively associated with empathy and ethical thought and behavior.

Alloy & Abramson (25) analyzed the findings from four experimental studies which looked at cases of depression and non-depressive cases, using the Beck Depression Inventory. That study found that non-depressives had more positive productive output but negative reactions during an emergency situation. Students without symptoms of depression did not often have negative thoughts and were generally optimistic. Beck observed the following about cognitive distortion (a) Lack of depression is linked with positive cognitive distortion; (b) Depression is a normal consequence of cognitive distortion; (c) Depression can progress to negative cognitive distortion. Slight or moderate depression indicates that the cognitive distortion is normal and there is better acceptance of reality. Positive cognitive distortion is associated with satisfaction with one's life and dreams. Psychology prescribes that prevention of cognitive distortion in an individual requires that they adopt an objective view of reality and ability to change undesirable situations or tolerate them. Increased frequency of cognitive distortion may reflect a greater effort to deal with stress (external and internal) without trying to address the source of stress in a constructive way. These individuals tend to see the external annoyance/threat as the source of their stress instead of their inability to cope. Ironically, this is then manifest in a cycle of self-blame and punishment.

Brad Bowins (27) argued that the higher the level of cognitive distortion reduced ability to adapt and sort out the real from the unreal. Blaming others is a feature of stress from cognitive distortion. Another study (28) found that most drug users have psychological problems, including depression. Studies of the prevalence of cognitive distortion were conducted among a sample of 52 drug users with suicidal thoughts. That study found that people without depression had lower cognitive distortion than the depressed. Suicidal thoughts also aggravate cognitive distortion and need to be addressed by cognitive therapy for depression related to drug addiction. Most of the questionnaires used in these studies of cognitive distortion were developed for adult populations. Thus, there are no tested tools for collecting information from youth drug addicts.

1.1.1 Cognitive Distortion and Substance Abuse

Cognitive distortion which leads to drug abuse has not been adequately studied, and the conceptual models are not very clear on this issue. (22) The approaches to understanding abnormalities in the context of drug abuse differ. (8) However, conducting a preliminary assessment of cognitive distortion in drug addicts entering treatment could help to improve the effectiveness of the therapy. Martin S. Denoff (29) studied irrational thought related to drug abuse in a sample of 78 youth (focused on alcohol and other drugs). (7) The study found that there was no rational basis for the youth's decision to use drugs. Manifestations of these individuals include Blame and Punishment, Negative Self-Evaluations, Catastrophizing and Approval

1.1.2 Amphetamine – Type Stimulants

Data for 2014 from the United Nations Office on Drugs and Crime show that mortality from drug abuse was estimated to be about 183,000 cases (range of 95,000 – 226,000). In 2012, the mortality rate was estimated to be 40 per million of the population between 15 and 64 (range from 21 to 49). For 2011, the minimum estimate for mortality showed a decline for some countries in the Asia region. It was estimated that, in 2012, there were from 162-324 million persons involved with narcotics, or 4% to 7% of the global population age 15-64 years. The most illegal drug used was marijuana, followed by cocaine, and opiate derivatives and

amphetamines. The number of drug users with heavy addictions was estimated to be between 16 and 39 million persons. The US strategy on drug abuse is more of a criminal control strategy, whereas the European countries use a public health and treatment approach, especially with the milder drugs such as marijuana.

While it is difficult to quantify the global production of ATS, the number of ATS-manufacturing laboratories that were dismantled increased from 12,571 (12,567 ATS labs in addition to four labs producing ATS in conjunction with non-ATS substances) in 2011 to 14,322 in 2012 - nearly all of these (96 percent)were manufacturing methamphetamine.

In North America, methamphetamine manufacturing has expanded again. In 2012, a large increase in methamphetamine laboratories seized was reported by the United States (12,857 in 2012 from 11,116) and Mexico (259 from 159). A significant increase in the number of amphetamine laboratories dismantled in 2012 was reported by the United States (from 57 to 84) and the Russian Federation (from 27 to 38).

For the second year, ATS seizures reached an all-time high of 144 tons, up 15 per cent from 2011, due in large part to increases in methamphetamine seizures. Over the past five years, methamphetamine seizures have almost quadrupled, from 24 tons in 2008 to 114 tons in 2012. Of the total of 144 tons of ATS seized globally in 2012, approximately half were seized in North America alone and approximately a quarter in East and South-East Asia. Large quantities of amphetamine seizures continue to be reported in the Middle East, in particular by Jordan, Saudi Arabia and the Syrian Arab Republic. Seizures of “ecstasy” have resurged after the drop in 2011. Major quantities of “ecstasy” were seized in East and South-East Asia, followed by Europe (South-Eastern Europe and Western and Central Europe). All three regions account for nearly three quarters of global “ecstasy” seizures.

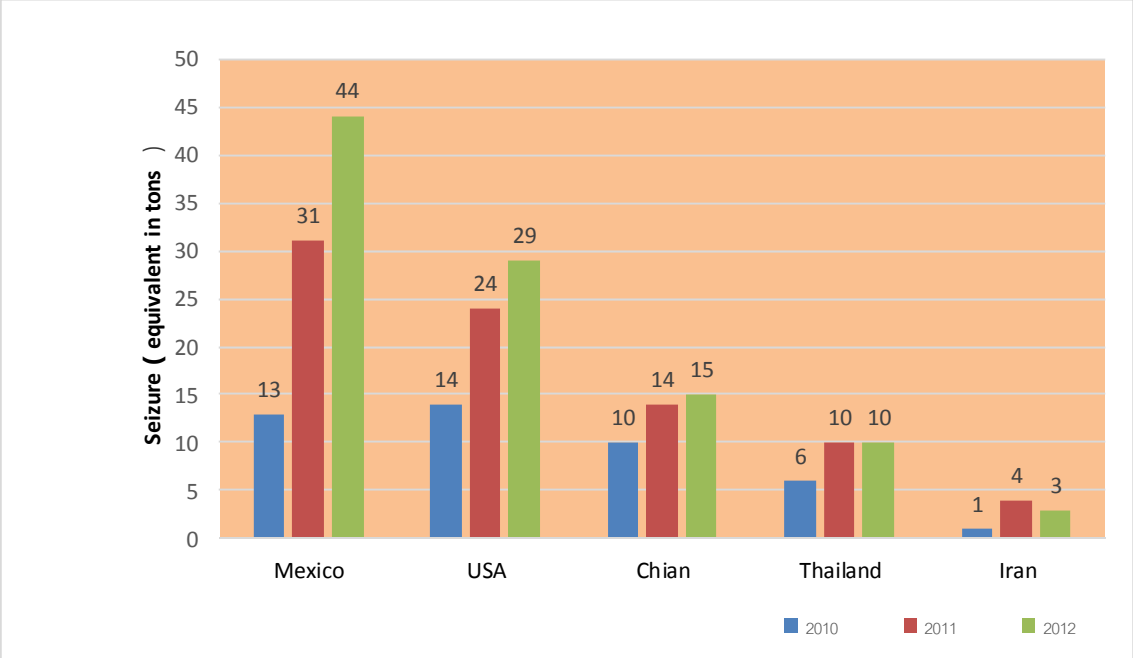

Figure 1.1 countries reporting the highest methamphetamine seizures 2010-2012
Source: UNODC annual report questionnaire and other official Source, 47,2013

Data from the graph on the quantity of methamphetamine seizures of the UNODC and other sources show that Mexico recorded the largest increase of meth from 2010-12 from 13 tons to 44 tons. In Thailand, the increase during that period was from six to ten tons. Reports of meth seizures continue to come year after year, including countries in the Middle East such as Jordan and Saudi Arabia. The United Arab Emirates reported a relatively small quantity of meth seizures in 2012 (three tons). The actual quantity of meth in circulation is projected to be many times higher than the seizures, with corresponding devastating impact on economies, societies, families and individual meth addicts. It is also difficult to estimate the actual number of meth users at any given time due to meth use being illegal and underground. The only indirect index is the number of persons entering rehabilitation for meth addiction.

In Thailand, methamphetamine use and trafficking is considered a national security issue. The 2015 report of the ONCB there were 361,054 cases of drug trafficking, with seizure of 104,805,189 pills. Again, these totals are just for those apprehended; there is an unknown number of users and traffickers not yet caught. The Drug Rehabilitation Center #3 reported that, during October to December 2014, that 220,000 were enrolled in drug rehabilitation programs. The majority of cases in

rehabilitation are voluntary; others are required to be in treatment as part of their sentence. Most cases in rehabilitation at present at meth addicts, followed by marijuana, heroin, opium and thinner addicts.

Most of those in treatment program clients in Thailand are in the Northeast Region, followed by the North. For those whose first treatment enrollment was since 2008, most were in the 15-19 year age group. It is also noteworthy that there is an increasing trend toward younger age of addiction, below 15 years. In 2008, 1.5% of rehabilitation cases were under age 15. That increased to 2.1% by 2012. Over half of all rehabilitation clients in 2012 were age between 15 and 24 years. The cases include both users and traffickers, who also are addicted. Cases come from both in-school and out-of-school populations. (98) Most cases are drawn into drug by peers, then branch to recruit more users as a source of income.

Some of the larger drug trafficking gangs take advantage of hill tribe populations (e.g., Hmong, Muser, Akha) as ‘mules’ to transport drug. Many are arrested but return to serve as mules for the drug cartel after release because it is much more lucrative than farming or wage labor. In addition, some government officials are also part of the drug trafficking operations. This opens up other avenues for drug shipments, e.g., through Suvannabhumi Airport. Illegal drug production goes on continuously as reported by the ONCB (2016). In 2015 there were a total of 298,859 drug addicts, of whom 203,619 were meth users, and 50,306 were between the ages of 15 and 24.

1.1.3 Statement of the Problem

Youth substance abuse has important implications for adult addiction since the younger age of drug initiation the greater the likelihood of full addiction as an adult. Past research of youth drug use focused on risk factors or treatment programs. The research in adults focused on rehabilitation programs and manifestations of thoughts, beliefs, the addiction process and differentials between the addict and non-addict. In addition, thought and behavioral modification programs attempted to address stressors, abnormal thought and emotion, and resulting harmful behavior. Methods which were successful in treating stress and anxiety were applied to populations of drug addicts. However, success with drug addicts was limited.

There were very few studies which looked at CD, while most treatment programs focused on automatic thought as it related to substance abuse, since that approach was simpler in practice, had less risk of adverse impact, and was more rational.

The development of a model of CD for drug addicts was important in order to tailor therapy to the special conditions and limitations of the substance abuser. This could lead to more efficient diagnosis and treatment of cognitive error in problem children and youth. There are other physical and psychological factors which also interact with the manifestations of CD which drive an individual toward substance use and abuse. Meth users, in particular, experience effects on the brain which lead to inappropriate thought and CD, which then spurs pathological emotions and behavior. Meth interferes with the reward pathway in the brain in the area of the Nuclear Acumens, VTA, and Striatum which results in excess release of Dopamine and an artificial high or euphoria. This then leads into the cycle of high, down, withdrawal and re-seeking the same high. Eventually, the demand for the high is so powerful that the addict will commit any behavior to satisfy the demand. Over time, the chronic meth user will experience a decline of brain function, and loss of ability to think and act rationally. There is a loss of self-control and an increased aggression and proneness to violence toward oneself or others. The slightest stimulus can trigger the meth addict to seek a drug fix, and at any cost.

Treatment of meth addiction can be through chemical therapy or through the bio-pscyho-social model of therapy. The latter approach is holistic in that it attempts to modify the situation of the individual vis a vis their relationship to their body, mind and environment, in a given socio-economic and cultural context. A holistic approach involves the active participation of the addict, their family, and the home community. This will include cognitive behavioral therapy (CBT), twelve-step facilitation, family therapy and psychosocial therapy. Treatment may require from 12 to 16 episodes to instill a full awareness of the addictive process, triggers, adaptations, and controls.

In Thailand, treatment programs are exploring a variety of models of psycho-social therapy. These differ based on the socio-cultural context of the addict. Some rehabilitation centers use the Matrix Program, while others use the Therapeutic Community, FAST Model, or CBT. These programs have experienced different

degrees of success and it is still not possible to predict which approach or combination of therapies will work in a given case. The 12-step facilitation, Function Family Therapy and CBT seem to show the most promise for effective treatment outcomes. A key determinant of success for youth meth addicts seems to be the accurate diagnosis of the pattern of cognitive distortion, and to tailor treatment accordingly. This could be the most efficient pathway toward addict self-awareness, understanding and control. Even though, in Thailand, the empirical evidence for this approach is still quite limited, the experience from CD-tailored programs in other countries suggest that this strategy could be effectively applied in Thailand.

1.2 Research Question

What are the models of cognitive distortion in Thai meth addicts?

1.3 Objectives of the study

1.3.1 To study models of CD in meth addicts

1.3.2 To study the relationship between individual characteristics, negative automatic thought, attitude distortion, depression, and CD among meth addicts in rehabilitation centers.

1.4 Hypotheses

1.4.1 Meth addicts with heavy CD tend to have negative automatic thought, severe attitude distortion, and depression;

1.4.2 Level of CD among meth addicts differs by age, education and marital status

1.5 Conceptual framework

This research is a descriptive study to explore models of thought, attitude and level of depression of meth addicts. This study looked at cognitive distortion in particular, and irrational thought processes as they relate to moods, decisions and behavior, and the relationship between these thought patterns with individual characteristics, and negative experience as a result of a dark view of oneself and the world. To measure cognitive distortion, the researcher adapted tools that have already been applied in similar populations in the West. These include Hollon & Kendall (1980) ATQ - 30 to assess the frequency and negative beliefs, and the Dysfunctional Attitude Scale of Weismann & Beck (1978) among other tools. Cognitive distortion is hypothesized to be linked to depression and conditional beliefs and cognitive error. The BDI is useful in measuring those who have negative emotions, cognitive distortion and low self-esteem, in conjunction with other diagnostic tools. Drug addiction may consist on a continuum from a continuous drive to get high, to only occasional use when the right external stimulus occurs. Internal brain function and the effect of the introduction of psycho-active drugs, combine to create cognitive distortion which is manifest in the following adaptive response: (1) Flight: The drug addict cannot cope with their feelings or resolve problems. Fleeing is the only perceived solution to stop using drugs. (2) Accepting the danger of drug addiction: The drug addict accepts the risk of doing harm to oneself; (3) Eccentric response: The drug addict has a constant flow of negative thoughts; (4) Short-term decision-making: The drug addict only addresses immediate needs and challenges. (5) The good old days: Fantastical memories of drug use or inappropriate relations. (26) Thus, the researcher was interested in the characteristics of cognitive distortion among meth addicts to improve understanding of the dynamics of addiction and hopefully help to improve treatment efficiency.

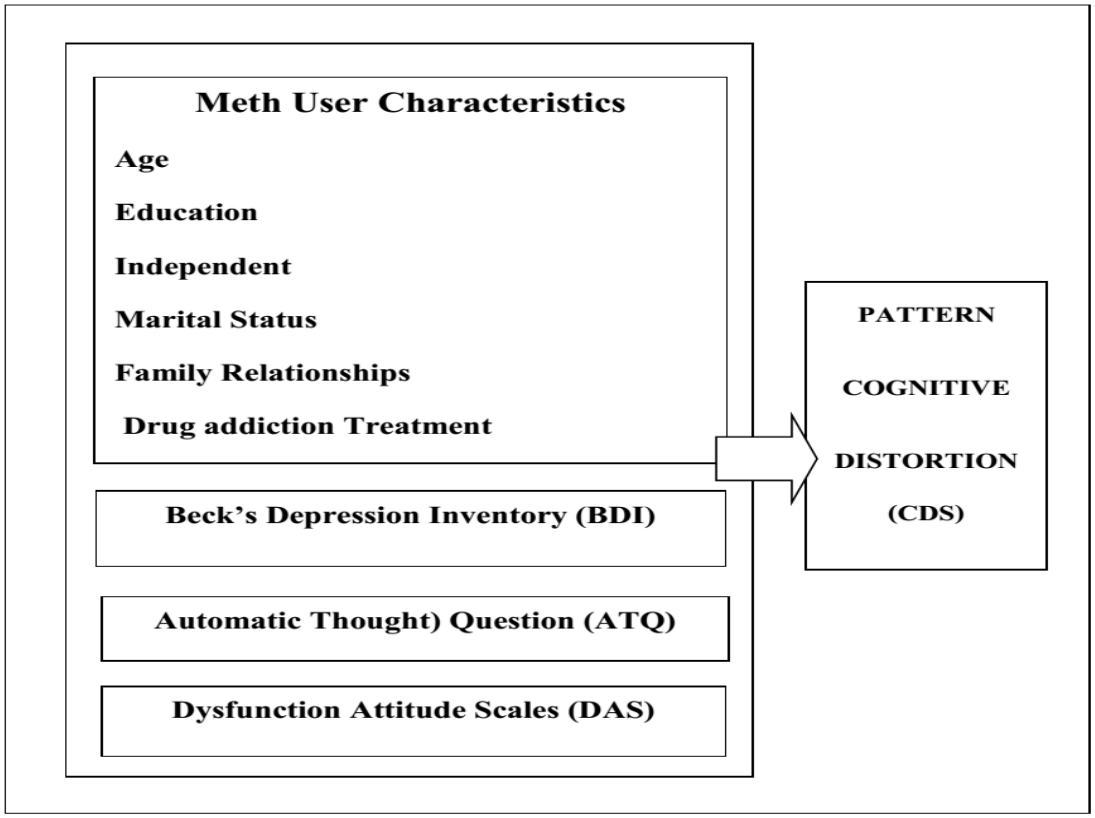

Figure 1.2 Conceptual framework

1.6 Scope of the research

This study was conducted among male, meth addicts age 18 to 24 years. The sample was drawn from clients either voluntarily or involuntarily enrolled in treatment and rehabilitation programs in public and private facilities. Data were collected during January 1 to March 31, 2016.

1.7 Variables and operational definitions

This section presents the operations of variables in the conceptual framework and other topic-related terms.

1.7.1 Independent variables:

1.7.1.1 Meth Abuser: Male meth addict in rehabilitation in hospitals, rehabilitation center, without symptoms of mental illness, and voluntarily willing to participate in the study

1.7.1.2 Age: refers to the duration from the date of birth to the time of the interview. Inclusion was limited to ages 18 to 24 years, counting from the month of birth to date of interview.

1.7.1.3 Education: refers to the highest grade of completed formal education, divided into six categories: (1) Primary; (2) Secondary; (3) Vocational; (4) Associate Arts Degree/diploma; (5) Bachelor's degree; (6) Higher than bachelor's degree.

1.7.1.4 Marital Status: refers to the relationship between the respondents and a woman at the time of the interview as (1) Single; (2) Married. Married, includes those co-habiting as if husband and wife; (3) Divorced/separated, refers to those who had registered their marriage before a registrar; (4) Widowed, refers to a person whose wife has died, and has not remarried

1.7.1.5 Working with own income: refers to being currently employed with income to support oneself in one's own right. The income may be in the form of daily, monthly or annual wages, and converted to a monthly income of the respondent.

1.7.1.6 Drug addiction Treatment: This refers to treatment for methamphetamine addiction in a given rehabilitation center, whether or not the addict has been treated elsewhere before.

1.7.2. Dependent variable:

1.7.2.1 Cognitive Distortion: refers to thoughts not based on reality and which result in problems of thinking or mood, and includes thoughts which misinterpret reality which adversely affect behavior in appropriate ways. There are ten types of cognitive distortion: 1.) Mindreading 2.)Catastrophizing 3.)All - or - Nothing Thinking 4.) Mental filter 5.) Overgeneralization 6.) Emotional reasoning 7.) Labeling 8.)Personalization 9.)Should Statements 10.) Minimizing or Disqualifying the Positive

1.7.2.2 Beck Depression Inventory (BDI) refers to a 21-item tool to assess the level of depression (Beck et al., 1979)

1.7.2.3 Automatic Thought Questionnaire (ATQ - Negative): refers to a 30-time tool to assess frequency of thought and beliefs developed by Hallon & Kendell (1980)

1.7.2.4 Dysfunctions Attitudes Scale (DAS) : refers to a 40-item tool to assess acceptance of dysfunctional attitudes by type

1.8 Benefits of the research

This research should help improve understanding of modes of cognitive distortion among methamphetamine users, and the nature of their thought process, in order to improve treatment and rehabilitation plans, and thought management to improve appropriate thought and response.

1.9 Limitations of the research

1.9.1. This study was only conducted among males, who are the majority of meth addicts in Thailand;

1.9.2 The questionnaire had a large number of items. Thus, this challenges the determination and endurance of the participant;

1.9.3 Some questionnaire items might be difficult to understand since it was translated from English;

1.9.4 Selection of the sample of respondents was problematic since this was a population of persons in criminal detention. Thus, several layers of approval were required to access the population, and it was not possible to include some of the rehabilitation centers.

1.9.5. The data only apply to the particular rehabilitation center and its inhabitants and, thus, are not necessarily generalizable.

CHAPTER II
REVIEW OF RELATED LITERATURE

This chapter is divided into the following sections:

2.1 Cognitive Distortion

2.2 Dysfunctional Attitude

2.3 Depression

2.4 Cognitive Theories and Autonomic Thought

2.5 The Brain and Addiction

2.6 Treatment and Rehabilitation of Amphetamine Addiction in Thailand

2.1 Cognitive Distortion (CD)

CD is characterized by thoughts not based in reality, and tending toward irrational negative and positive impressions of experience. CD is a form of compartmentalized thinking as opposed to a comprehensive view of things. Persons with CD tend to personalize most of their experience and suffer from irrational emotions and behavior which then can lead to adverse mental and physical health manifestations. CD first appeared in the literature in 1967 when Beck, A. T. (1967) (28) reported the results of treatment of a case of depression who had repeat thought patterns and inability to control emotions and associated behavior, which were often at cross purposes with the individual's goals. Negative emotions tend to dominate and worsen over time in the person with CD, and possibly leading to physical harm to oneself and/or others.

Distortion of reality is an interpretation of events without basis in fact. There are two types of CD: (1) Primary CD, which is characterized by self-centeredness in thought, attitude and beliefs; and (2) Secondary CD, which has its origins in anxiety and fear, and is manifest in assigning blame to others for one's condition (when it is self-inflicted). Other manifestations include cognitive error and

maladaptive behavior. Beck's psychotherapeutic approach did not address these phenomena. Instead, subsequently, Beck examined the structure and content of thought of emotionally disturbed cases and found that CD symptoms were associated with neurological disorders, as follows:

1) Negative self-image: This symptom includes irrational fear of pending disaster to oneself or seeing only (imaginary) obstacles in one's life path. There is a lack of self-acceptance as well.

2) Interpreting ordinary life experiences as uniformly negative.

3) Having negative expectations for one's prospects and the future looks bleak and full of suffering. A universally negative outlook on the world (28) with the following thought patterns:

- Surreal thoughts and interpretations, rash and irrational decision-making;
- Refusal to accept any other interpretation than negative. Repeat memories of one's suffering at the expense of others. No compensating positive thoughts.
- Narrow thought focus without seeing the larger picture. The view is that all experience is suffering and with no end.
- Exaggerated interpretation of trivial events into unrealistically large calamities or threats.
- Vengeful mindset to confront (imagined) threats.
- Rush to judgment based on inadequate information or understanding.

Many substance abusers in treatment programs initially display symptoms of CD based on internal and external triggers or stimuli, and signs of withdrawal and craving. The inference leads to CD, inferential distortion, evaluation. Demandingness, unconditional craving and demand for attention to one's needs Wayne Froggatt (2009) (30). The sufferer experiences conditions for love, comfort, success, and sense of entitlement as part of the law of the universe which cannot be contravened. This CD is manifest by irrational demands and expectations, inflexibility, aggressive beliefs and speech, e.g., "I should not have to be suffering like this" or "I should be able to do what I've done before." This CD is the backdrop for disruption of love, comfort and success which everyone sees as a priority and inherent need.

The exaggerated and negative view of the past, present and future festers until it becomes a severe source of emotional pain and severely limits the ability of the sufferer to manage life challenges and tasks. The person can only imagine negative outcomes of action. One adaptation is overgeneralization (126) of standards and classifications for oneself and others. A common thought pattern is "I can't do anything right; I am useless." This easily leads to a state of clinical depression, loss of friendships and friendliness, loss of a healthy sense of self, oversensitivity to perceived rejection, and discomfort intolerance. Inability to align one's thoughts and feelings with reality is bound to send the mood and emotions into negative patterns. (29) A typical thought cycle is "I always fail when trying something new; I am a total failure in life." This is a form of black or white thinking (29) ; i.e., there is no middle ground to recognize both one's limitations and strengths. (126)

CD can be addressed by the appropriate mental health interventions, part of which is helped the suffered to understand their condition so they can more skillfully manage their thoughts and reactions and break the cycle of negative thought patterns. The goal is to move the client to more rational thought, but this requires persistence and training. CD plays a role in address behavioral problems through externalizing. Criminology uses the concept of CD to explain deviant or delinquent behavior and dysfunctional attitudes (31,33,34) When CD is manifest in anti-social behavior it clearly has the potential to escalate into criminal activity (32) A large number of studies have documented the high prevalence of CD among convicted criminals (32,34,35) Criminology refers to portside attitudes and cognitive processing during the process of committing the criminal act (31,68) document interpretation or beliefs which encourage criminal behavior, or pro-criminal attitudes (36). The following documents studies on the different types and manifestations of CD, Beck, A. T. (28, 29,158).

CD is a symptoms of confronting internal problems with outward behavior. (32) argue that CD is a general strategy for coping (37) report the theory that CD in children and youth, and other problem youth display delinquent behavior that often increases to serious criminal acts (37). Perpetrators often sink into a state of denial or neutrality about their offensive behavior. The anti-social behavior of the CD sufferer is an attempt to counteract anticipated blame on oneself by others.

(38)There are five ways in which the sufferer tries to rid the conscience of their wrong-doing or crime: Denial of responsibility, denial of harm caused, denial of victimhood, self-victimization, and loyalty to other deviants or “the gang.”

Samenow, S. E. Gibbs, J. C. (38,39) describe Cognitive Theories as display of attitude dysfunction or inability to appropriately modified harmful attitudes (39) This pathology is also an inability to cope with blame or the outcomes of anti-social behavior (40) Sufferers are self-centered and may have grandiose ideas about their righteousness or power. This can veer off into negative behavior which is a danger to the sufferer and potential victims who are seen (delusionally) as threats or villains, or worst-case scenarios (40,41)

Bandura A et al (42) conducted a review of literature on sexual crimes in the context of Cognitive Theories. The original sexual abuse may have a variety of different root causes. But the brain’s coping mechanism invariably relied on Cognitive Theories as a way to maintain sanity. One distortion is blaming the victim, i.e., “she/he asked for it.”

Ó Ciardha, C & Ward T. (43) conducted a review of literature on sexual crimes in the context of Cognitive Theories. The original sexual abuse may have a variety of different root causes. But the brain’s coping mechanism invariably relied on CD as a way to maintain sanity. One distortion is blaming the victim, i.e., “s/he asked for it.”

Abel et al. (44) compiled the findings from studies of Cognitive Theories in sex offenders, including Implicit Theory which explains behavior as a reflexive, automatic response, and not a rational choice. This suggest a neurological pathology. The authors also cite the Judgment Model and the Schema-Based Model as distinct from Mind Theory, which is more common among children who have been pressured to not express their emotions, and then develop behavior problems as adults. (45) discuss the Implicit Theory in the context of child abuse and pedophilia. (43) proposed the hypothesis that the acts of pedophiles are outside their conscious control due to severe Cognitive Theories. (42,43) also conducted a meta-analysis of theories and impact of these pathologies and treatment outcomes. (43,44,45) also conducted a meta-analysis of theories and impact of these pathologies and treatment outcomes.

Often, the diagnosis of Cognitive Theories is based on self-administered assessment or questionnaires and, thus, there may be biases from the nature of the questionnaire or user misinterpretation (43, 44,45) Measuring distortion overlaps with belief systems, attitudinal schemas, Implicit Theories or worldviews (43,44) meta-analysis of studies on Cognitive Theories identified diagnostic tools including a "How I Think" questionnaire, Measures of Criminal Attitudes and Associates, Cognitive Distortion Measures Specific to Types, Sexual Offenses, the Abel-Becker Cognition Scale (46) and the Rape Myth Acceptance Scale. There were also studies of Pro - Criminal Attitudes which support Cognitive Theories (44)

2.1.1 Types of CD

Aron Beck (47) Beck, A. T. (1976) was the first to propose a theory of Cognitive Theories with seven classifications of thought: Arbitrary Inferences, Selective Abstraction, Overgeneralization, Magnification and Minimization, Personalization, Labeling and Mislabeling, and Dichotomous Thinking. Later, David Burns (48) a student of Aron Beck produced a more detailed thought inventory with more classifications (see table below):

Tabel 2.1 Types of Thinking

Types of Thinking	Eexamples for the Distortions
Filtering	Negative thought and outlook, filtering out the positive, with no hope
Polarized Thinking or "Black and White" Thinking	Can only see opposite sides of an issue; there is no middle ground. Sets up oneself for disappoint since the standard of acceptance is so high.
Overgeneralization	Exaggerating the relevance of an isolated event. A relatively trivial negative event is seen as inevitable in the future. Persons with this form of Cognitive Theories tend to only see one side of an issue, and usually the negative. It leads to absolutism about one's life.

Tabel 2.1 Types of Thinking (cont.)

Types of Thinking	Eexamples for the Distortions
Jumping to Conclusions	Assuming the negative or a threat when there may be none.
Catastrophizing	This form of Cognitive Theories involves a blowing out of proportion of events or perceptions, usually in a negative way.
Personalization.	This form of Cognitive Theories involves inserting oneself into a situation or perspective where one does not belong. It is a form of self-centered thinking in a negative way. The sufferer blames themselves for something they didn't do.
Control Fallacies	This Cognitive Theories sufferer allows outside forces to control their emotion, thus reducing themselves to victimhood. The feeling is helplessness and inability to act for themselves.
Fallacy of Fairness	This Cognitive Theories sufferer views as just or unjust in which the majority views the opposite.
Blaming	This form of Cognitive Theories involves exaggerated assignment of blaming oneself or others for trivial events.
Should	Persons with this form of Cognitive Theories usually use terms such as "ought" or "must" in terms of obedience to a perceived law or rule. These persons easily see themselves in violation of the rules. When others are observed violated the rules, the Cognitive Theories person will become agitated and vengeful.
Emotional Reasoning	This involves expectations that whatever we feel will happen must happen, usually in a negative way. If a person feels they should be in a bad mood, then they will be.
Fallacy of Change	This is a form of self-centeredness in which the person believes others will change to accommodate their needs.
Global Labeling	This Cognitive Theories attempts to paint a situation with an extremely broad brush to explain why the sufferer is a victim of wrongdoing. This persons too easily accepts failure and self-

Tabel 2.1 Types of Thinking (cont.)

Types of Thinking	Eexamples for the Distortions
	blame. The person is overly sensitive to criticism from others.
Always Being Right	This form of Cognitive Theories is a biased and inaccurate sense of oneself as in the right. It is an exaggerated self-righteousness. The sufferer feels they must prevail over another just for the sake of winning.
Heaven's Reward Fallacy	This is a form of martyr syndrome in which a person's sacrifice is based on the (false) belief that they will be divinely rewarded or protected from harm. A person with this form of CD is susceptible to falling under the influence of a cult leader. The negative reaction can be severe when the sacrifice does not produce the expected reward or protection.

2.1.2 Examples of Common Cognitive Theories

All-or-Nothing Thinking: Khun Sukanya has a doctoral degree in management. However, she is rejected at her first job interview. She then sees herself as a hopeless failure.

Overgeneralization: Khun Kanda lives alone and spends most of her daily life in solitary activities. Some have advised her to get out more and socialize, but Khun Kanda refuses because she believes that no one likes her or would like her.

Mental Filter: Khun Piyawan and her husband enjoy doing things as a couple. Her husband is very happy in their marriage and loves her cooking. However, one day, asked Khun Piyawan to slightly sweeten the food she was preparing to make it more delicious. But Khun Piyawan only saw the negative side to this comment and filtered out anything positive. It made her feel like she was a terrible cook.

Disqualifying the Positive: Khun Rasami showed her friend a photograph of Khun Rasami. The friend praised the photo as quite beautiful. However, Khun Rasami said the photographer enhanced the picture to make her look good. She feels is not good looking.

Jumping to Conclusions: Khun Rewadee is at a restaurant waiting for her boyfriend who is 20 minutes late. Khun Rewadee becomes anxious and suspicious, thinking that her boyfriend has done something untrustworthy. She gets up from her chair to look for him. In fact, her boyfriend is stuck in a traffic jam trying to get to the restaurant.

Magnification and Minimization: Khun Yuthapong is studying law but is not confident that he will graduate because he usually gets C's as grades. He does not think he would make a good lawyer and would have trouble in that career.

Emotional Reasoning: Khun Sumalee looks at her messy desk at work and wishes she could make it orderly. But she cannot summon the will to tidy up her desk because it looks too messy. She asks herself why she has to have a tidy desk.

Should Statements: Khun Suchada is at a restaurant waiting for the food she ordered. She is becoming impatient and is unsure whether to complain. She feels the restaurant staff should realize they are delinquent. But she also feels she ought not to complain.

Labeling and Mislabeling: Khun Patama has taken a new job. On her first day, she introduces herself to her new co-workers. But she is nervous and it shows in her shaky voice and lack of confidence. It is as if she is wearing a sign saying she is terrible. Thus, she has already branded herself as a failure, even though no one has said anything negative.

Personalization: Khun Laddawan's son is misbehaving at school. Khun Laddawan feels it must be because she is not a good mother. She feels personally guilty for her son's bad behavior.

2.1.3 Cognitive Distortion and Externalizing Problem Behavior

The only empirical way to know whether someone has CD is by their speech and action. But the diagnostic criteria need to be clear and skillfully applied for a correct determination of CD.

Petra Helmond,et al (49) conducted a meta-analysis of Cognitive Theories which focused on behavioral problems, bullying and anti-social manifestations. The authors reviewed 71 research papers including 20,685 cases which is considered a

large study (d=0.70) but few studies on Cognitive Theories treatment outcomes (d=0.27).

2.1.4 Treatment of Cognitive Distortions

Cognitive Theories is manifest as a behavior disorder which is a principle means of diagnosis and treatment (32,39,43) The meta-analyses describe efforts to modify thoughts and behavior to reduce Cognitive Theories but the success of these treatments is not clear. Some treatment strategies involve Cognitive Restructuring and Reframing to address overt disruptive behavior. Some studies show the strong link between Cognitive Theories and behavioral abnormalities

Banse et al. (50,51) Deborah Deas & Suzanne, E. Thomas. (2001) 50. Alan I. Leshner (1997) and pro-criminal dispositions, but lack data on the ability of therapists to reduce incidence and severity of the pathological behaviors

2.2 The Dysfunctional Attitude Scale (DAS)

Studies of depression by Beck (55,56,57) show that persons at risk of depression are frequently under self-imposed stress and anxiety, often rooted in incorrect beliefs about life's challenges and obstacles. The inability to adapt to and overcome these challenges may result in clinical depression (58) The DAS tool was developed to help therapists to more accurately diagnose clinical depression (53)

DAS can be used in conjunction with Beck's Cognitive Diathesis-Stress Theory to identify risk of depression in cases with only partially dysfunctional attitudes (60) Beck provided guidelines for addressing stress as a precursor to depression Beck, A. T (67)

The research of Weissman looked at abnormal attitudes (62) The DAS has been modified into DAS-A and DAS-B with 40 items each A (52) Several aspects of the DAS-A have been problematic (62) The DAS has been modified into DAS-A and DAS-B with 40 items each A (53) The criticisms are more on methodology than on content, and the samples cited in the studies are rather small (63 - 66) It is argued that the tool should be used with larger populations, e.g., 300 to 1,000 cases. More application of the tool leads to greater confidence in the results

(70) Some have said that sample sizes of 200 or more are appropriate (64,66) But it is not always easy to achieve the desired sample sizes (71) Some have said that sample sizes of 200 or more are appropriate (65) But it is not always easy to achieve the desired sample sizes (66) Despite criticisms, the DAS tools are the standard for the field, especially when applied to larger population groups. The tools are particularly validated by a study in the Netherlands (72) who found that, for women between the ages of 35 to 44 years (70) depression was associated with lower education, disability, low/no wages, and lack of a personal aide.

2.3 Depression Symptoms

There are numerous studies of the manifestation of depression Levitt, Lubin and Brooks (73) In the USA, 3% of adult cases of severe depression are treated using the Brown and Harris Model (74) Some studies combine new and recurrent cases of depression (75) A study in Iceland found that 15% of females and 10% of males had symptoms of depression.

The increase of prevalence of depression around the world has led to new models to explain this phenomenon including the Learned Helplessness Model proposed by Abramson and colleagues (58) and Beck's Cognitive Theory of Depression (56) . Cognitive Behavior Thery (58) A third theory looks at neglect and sadness as precursors (76)

Depression is manifest in lack of interest in oneself or one’s milieu. There are both physical and emotional displays of apathy and sadness (59) Other symptoms include lack of appetite, weight fluctuations, insomnia, intermittent or excessive sleep, anxiety and restlessness, fatigue, hopelessness, and low sense of self-worth. WHO has indicated that clinical depression is a disability and a major contributor to global ill health (79) Women tend to suffer more than men and there is a 75% relapse rate among treated cases within six months of conclusion of therapy and 15% eventually commit suicide (78) Significant resources are expended in the treatment and accommodation of depression (80)

2.3.1 Beck's, Cognitive Theory of Depression

Schemata are the sources of most of the problems of depression according to (56) explain schemata as a psychiatric structure which affects the reaction to experience or other stimulus, especially injury during childhood. This morphs into a negative mental pathology as the child ages and is manifest in Cognitive Errors, e.g., absolutistic/dichotomous thinking, personalization, magnification, minimization, overgeneralization, depression. Schema are the source of Cognitive Errors, Absolutistic, Dichotomous Thinking, Personalization, Magnification, Minimization, Overgeneralization, Selective Abstraction, and Arbitrary Inference.

Lewinsohn et al. (81) tried to study Cognitive Patterns based on Beck's Model of Depression in a large sample (N= 20,000) over a period of eight months. They studied self-esteem in comparison with problem beliefs and thought patterns. Depression was associated with declining self-esteem and reduced positive outlook. Measuring abnormal thought patterns in cases with depression can be approached by assessing positive and negative responses to various situations. DeMonbreun, B. G., & Craighead developed a tool for assessing persons experiencing chronic sadness (82) This tool was applied to a study of depression in war veterans. Though level of depression was high, positive response was not necessarily low.

2.3.2 Autonomic Though Questionnaire, ATQ Hollon and Kendall (83) created the Autonomic Though Questionnaire (ATQ) to measure the frequency and beliefs of negative automatic thought (AT) using a 30-item questionnaire, with each item scored from 1 to 5: 1 denotes no such thought in the past week while 5 denotes constantly having such thought in the past week. The ATQ was applied to a group of college students selected based on BDI (in which a score over 10 indicates pressured) and MMPI-D (in which a score over 25 indicates depression). The depressed had significantly higher AT scores. The BDI and MMPI-D was also positively correlated with independent measures of depression. Each tool is appropriate for different types of individuals. Yet these tools can not accurately distinguish between depression and schizophrenia. ATQ scores are positive correlated with indicators of anxiety (88) Evaluations found an ATQ Split - Half Reliability of 0.97, $p < .001$ Dobson and

Breiter (80) The advantage of the ATQ is the sensitivity of the tool (compared to the Dysfunction Attitude Scale).

2.3.3 The 100-item Dysfunction Attitude Scale (DAS)

proposed by Steven D. Hollon, Philip C. Kendall 1980 (78) is a tool used to measure adjustments of beliefs related to depression. The scale has a score ranging from 1 to 7, where 1 denotes absolute disagreement and 7 denotes absolute agreement. The score is a predictor of depression and has been evaluated for reliability and accuracy. The number of items in the tool was reduced to 40 (80) Internal consistency was rated at £« 0.87-0.93 and is useful for separating out the pathological cases from normal cases. The sensitivity of the tool is less for small samples. Some have observed that the shorter version of DAS is not as accurate as the longer version.

Eaves and Rush (85) validated Beck's Model, although Hamilton and Abramson (77) had findings contrary to Eaves and Rush. Physical and emotional manifestations may be latent or delayed in some cases of depression. Some have observed that the ATQ is a more sensitive diagnostic than DAS (80) Many cases are able to manage AT but not dysfunctional attitudes. In the study, 30% of the cases of depression had Cognitive Depression.

Norman Miller and Klee (79) tested whether those with severe depression had more CD that the non-depressed, except those with Schemata. In both groups, the BDI scores were over 17 (87) The Cognitive-Personality syndrome has its roots in painful experience after depression takes hold. Robins and Block Robins and Block (86) explained that depression occurs in different situations based on individual experience. Beck Beck (55) discussed need for collaboration and success in academics and work in the context of depression.

2.4 Cognitive Theorists

Cognitive Theorists (58) studied the relationship between depression and thought patterns, and pain arising from sad emotions. This links to the work of the Emotion (58,76) They also looked at how memory is a trigger for mental illness. The Cognitive Theories detect emotional disorders through evaluation of emotional

reactions to various situations, and relationship between negative information and emotions. The sufferer has difficulty making behavioral adaptations, but success has been reported (62) Skillful resolving stressful situations is a step toward treated negative emotions (83) Biases in thought inform areas of interest and memory as related to negative emotion (88)

A comparative study was conducted between 30 CD cases, 30 depressives and 30 normal controls. Participants were asked to report their mood at two months following treatment using the Attributional Style Questionnaire (87)

The Dysfunctional Attitudes Scale (62) The Dysfunctional Attitudes Scale (The Automatic Thoughts Questionnaire) (83) nquiry the symptoms, sadness and depression.. (88) The comparative study found that the CD cases had large mood swings. Sadness was related to AT in the cases with depression. Calming of emotions reduced the AT score. A diagnosis of CD occurred more often than in cases of depression and controls. The ATQ helps to differentiate CD cases from other non-specific psychiatric disorders. Depression and psychiatric disorders are similar and may overlap

2.4.1 Development of Negative Automatic Thought (AT)

Repeat experience of life's misfortunes often lead to a state of depression, including negative AT. (75) Inability to control negative AT in childhood can produce a negative self-image into adulthood (76) This inhibits ability to adjust and manage life challenges, ultimately leading to chronic depression (75,76,77)

Hollon, Steven D.et.al. (78) conducted a study to evaluate the ATQ and DAS in terms of sensitive and specificity of diagnosis, among a sample of 69 outpatients. The researchers were interested in cases of unipolar and bipolar disorder, depression and substance abuse.The investigators found cases of Substance Abuse Disorder and General Psychiatric Disorder. There were differences in the diagnostics in identifying cases of depression.

2.4.2 General Criticisms of Cognitive Models

The study on the Helplessness Model and Beck's Cognitive Model Abramson (1992) tried to apply the model among children with negative self-image

and delinquent behavior who were at risk of depression. Use of the diagnostic tools of Rose and Abramson's (1992) (90) show that negative AT in childhood is a precursor for depression (91) Childhood thoughts are classed as core beliefs and cognition beliefs. Pathological beliefs leas to withdrawal from society. Negative AT is a result of faulty reasoning and can lead to Cognitive Distortions (Errors in Thinking or Cognitive Distortions) (91,159) Childhood thoughts are classed as core beliefs and cognition beliefs. Pathological beliefs leas to withdrawal from society. Negative AT is a result of faulty reasoning and can lead to Cognitive Distortions (Errors in Thinking or Cognitive Distortions (48) Burns defined seven types of Cognitive Distortions in cases of depression and ten types of thinking errors.

Krantz and Hammen (93) applied a Cognitive Bias Questionnaire (CBQ) to classify cases of depression with distortion, depression without distortion, distortion without depression and neither depression or distortion. This tool helps to identify the Negatively Biased but not Cognitive Errors. (95) studied risk of self-schemas as associated with depression and adverse life events. Other diagnostics include the Hamilton Rating Scale for Depression (HRS-D) which is used for adults to assess level of depression. The BDI is not recommended for diagnosing cases of depression.. (89) observed that it was difficult to obtain high specificity of cognitive change diagnostics as cognition is highly variable depending on emotion in the context of reality and depression.

Hsiao Tien Wang et al. (2012) (96) studied models of positive and negative thought among a sample of 970 Taiwan university students and how the models affected performance, health and happiness. Currently, the trend is more toward negative thought patterns than the positive. Positive thought was associated with better teamwork among the students. Negative thought was associated with less teamwork and poorer performance.

2.5 Drug Addiction

2.5.1 Definition of addiction

Drug addiction takes a horrible toll on society and the economy in most countries around the world. There are high rates of relapse, and some see addiction as a chronic condition, i.e., not curable

Alan I. Leshner (97) studied the mesolimbic reward system and the ventral tegmentum nucleus accumbens, limbic system and orbitofrontal cortex in the context of substance abuse. The brain's circuitry is altered by sustained and heavy addictive drug use. Addiction is usually a progressive process and treatment strategies have not been very success. Some programs rely on psychobiologica to manage cases.

George F. Koob , Michel Le Moal (98) defined addiction as a chronic condition of worsening drug dependence. There are both hereditary and acquired factors which contribute to vulnerability for addiction

Nora D. Volkow, Marisela Morales. (99) studied changes in brain cells among drug addicts in the context of heredity and socio-cultural facilitating factors for addiction. The focus was on Dopamine (DA) neurons in the ventral tegmental area (VTA) and nucleus accumbens (NAc) and how drug use affects the reward system of the brain.

Prapapan Jucharoen (100) found that all addictive substances affect the brain of the user. At first the user becomes psychologically addicted to the feeling of pleasure ('rush') from the drug. However, chronic use produces a physical dependence which overshadows any pleasure the drug used to produce in the user. When a person experiences sadness or frustration in their life, they may turn to addictive drugs to self-medicate and mitigate the emotional pain. The letdown after the drug effect wears off leads to a feeling that the drug is needed again. That cycle is a common pathway to addiction.

The National Institute on Drug Abuse (2007) (101) defined addiction as having biological, psychological, and socio-cultural dimensions. Addiction involves a change in the structure of the brain's reward system. Gabriel Horn FRS FRCP (2008) (101) focused on the central nervous system of the drug addict, including the

peripheral nervous, adrenaline and noradrenaline effects on dopamine release, and how that produces euphoria

Gabriel Horn FRS FRCP (102) focused on the central nervous system of the drug addict, including the peripheral nervous, adrenaline and noradrenaline effects on dopamine release, and how that produces euphoria

2.5.2 Three types of addiction: Social, Psychological and Physical

Someone who is genetically vulnerable to becoming addicted to drugs may find themselves (or seek) an environment where drug use is popular, encouraged, and not condemned. Some people seek out drugs to counter the effects of depression, loneliness, or other problems in life. Social acceptance and psychological dependence on regular intake of drugs is almost certain to produce physical addiction in those with a genetic predisposition to becoming addicted. The younger the age of drug use, the more likely that physical addiction will become permanent.

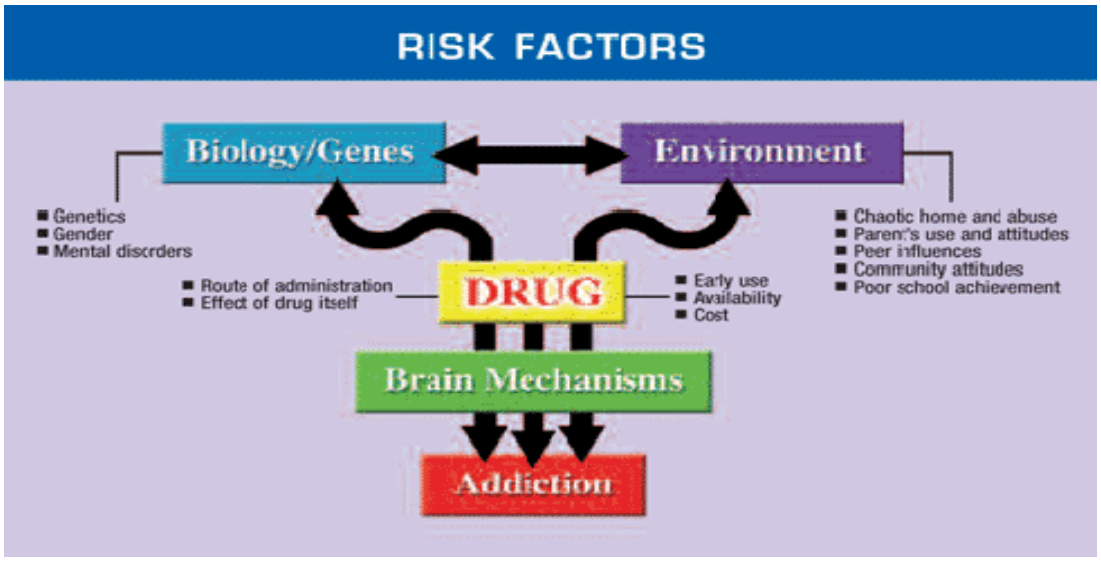

Figure 2.1 Risk Factors of Drug Addiction

Source: Nation institute on drug Abuse. (2014)

2.6 Status of treatment and Rehabilitation of Amphetamine Addiction in Thailand

2.6.1 Background

Methamphetamine (meth) is an addictive drug but also used for treatment of certain conditions (ADHD, obesity) and was first synthesized in 1887. Meth was first marketed by Smith Kline and French pharmaceutical company as an inhaler to widen the brachia (Benzedrine Inhaler). When its addictive properties were discovered, production and use was limited. In 1993, Gordon A. Ales found that meth could be used to treat sleepy sickness, obesity and depression and CNS disorders (103)

Meth was used for soldiers who had to stay awake and alert for extended periods. This led to a resurgence in use around the world in the post-war period. In the 1970's, in the USA, meth was classified as a controlled, illegal substance. However, production and sale continued through underground channels.

In Thailand, meth was improperly used to treat cases of depression, or by students who were preparing for exams. Use in Thailand expanded significantly during the period from 1958-67, and was classified as a psycho-active drug in 1975. The MOPH classified meth as a Level 1 addictive substance. Clinical studies of meth in Thailand were conducted by

Phanupa Kittiratpaibun (105) and these have contributed to guidelines for treating meth addiction. The numbers of meth cases admitted to Thai hospitals has increased steadily along with patients with conditions associated with meth addictive (e.g., paranoid delusion).

Wasu Chantasak (106) conducted a retrospective study of records of 209 patients (age 20 to 29 years) diagnosed with Amphetamine Psychosis at the Somdet Chao Phraya Hospital in 1998.

Rangkana Raksnga et al (107) studied psychological symptoms of 401 meth addicts in Thanyarak Hospital, of whom 91 had psychological pathology, and most were males between the ages of 12 and 57 years

Wada K1, Fukui S. (108) studied 233 meth addicts in Japan and found that males had more adverse psychological sequlae than females.

Yui K, Ikemoto S, Ishiguro T, Goto K. (108) studied psychological symptoms of meth addicts and explored the neurobiological effects of release of dopamine and the progression to psychological disorders.

2.6 2 Dose Effects of Amphetamines

Tabel 2.2 Dose Effects of Amphetamines

Physical	Low Dose	High Dose
	• Increases in Systolic and Diastolic Blood Pressure • Sweating • Palpitations • Chest Pain • Shortness of Breath • Headache Tremor • Hot and Cold Flushes • Increases in Body Temperature Increases in Systolic and Diastolic • Euphoria • Elevated Mood • Sense of Wellbeing • Increased Alertness and Concentration • Reduced Fatigue •Increased Talkativeness • Improved Physical Performance	•High Blood Pressure •Rapid or Abnormal Heart Action • Seizures • Cerebral Hemorrhage • Jaw Clenching and Teeth-Grinding •Nausea and Vomiting • Confusion • Anxiety and Agitation • Performance of Repetitive Motor Activity • Impaired Cognitive and Motor Performance •Aggressiveness, Hostility and Violent Behavior • Paranoia Including Paranoid Hallucinations • Common Delusions Including Being Monitored with a Hidden Electrical Device, and Preoccupation with Bugs ’on the Skin

Source : Clinical Treatment Guidelines For Alcohol and Drug Clinicians:2007

2.6.3 Long term Use Can Result in Number of Physical and Psychological Effects Including

- Weight loss and nutritional deficiency
- Dysmenorrhea and amenorrhea
- Shock, convulsions
- Loss of appetite
- Dizziness, loss of memory
- Increased severity of dependence on meth
- Reduced mental function
- Mood swings
- Depression
- Psychological disorders and distortion
- Easily frightened, losing one's way
- Difficulty in sleeping

2.6.4 Types of Amphetamine Use

Experimental Use: This is more common among older adolescents and young adults and is an exploration of new experience and result of peer pressure.

Recreational Use: This is done to reduce boredom and may occur more at weekends or special occasions, or before participating in sports activities.

Circumstantial Use: This is characterized by use to help one get through rigorous work, such as long-haul truck driving, performing physically demanding tasks, or help with weight loss.

- Intermittent or Binge Use
- Regular Use
- Poly-drug Use: Meth addicts often combine meth with alcohol or marijuana.

Amphetamine dependence is defined in the DSM-IV guidelines as displaying three or more criteria:

Drug resistance

a) Increased dosage is required to achieve the same drug effect
b) There is withdrawal when drug intake is reduced

Withdrawal symptoms

a) Group of symptoms

b) Need to use a similar stimulant as an alternate to the primary drug

- There is more or longer use than the addict originally intended
- The addict has tried to quit or reduce intake but failed
- Increasing amount of time is spent acquiring the drug
- The addict increasingly has trouble fulfilling social and work obligations
- The addict continues to use the drug despite obvious adverse mental and physical health impacts

2.6.5 Symptoms of detoxification from meth

The following are typical symptoms of the meth addict undergoing detoxification (American Psychiatric Association, 1997)

- Fatigue
- Insomnia
- Hypersomnia
- Mentally agitated
- Increased hunger
- Inappropriate brightness, dreams

2.6.6 System of management of drug addicts

2.6.6.1 Treatment must be voluntary, in either public or private facilities;

2.6.6.2 Addicts are held accountable according to the relevant law for adults and minors;

2.6.6.3 Rehabilitation is mandated by the 2002 law through either through confinement in a rehabilitation center (for four to six months but not to exceed three years) or through out-patient programs**.**

2.6.7 Steps in treatment includes physical

Examination, diagnosis, detoxification, rehabilitation and evaluation of treatment outcomes on the mental and physical health of the addict. The following are four major steps:

2.6.7.1 Pre-Admission: This involves taking a history of the case and family members in order to motivate the addict to enter treatment and comply with the examination and interview. The addict is then registered, and the physical exam is conducted including X-rays, blood and urine analysis and weight measurement.

2.6.7.2 Detoxification (detox): This may involve a transition off the primary drug using a less addictive substance (e.g., methadone, traditional medicines) or total abstinence. Some clients may undergoing detox as an out-patient. Other physical ailments are also treated at this time, and the client is given health education.

2.6.7.3 Rehabilitation: This is a process of adapting one's physical and mental state to prepare for a strong life without addictive drugs. The client is assisted with counseling to help them re-enter society with appropriate personality and behavior. This process may include group activities, Buddhist studies, recreation and occupational therapy.

2.6.7.4 After-Care : After the client completes treatment and rehabilitation and returns to the community, there is periodic follow-up to provide reinforcement to remain drug-free. The follow-up may be through home visits, phone, or appointments to return to the treatment facility. There is a hotlines for recovering addicts to call if they face a crisis.

2.6.7 Thai experience in treating meth addiction

2.6.7.1 Fast Model: This is an efficient 4-month approach to reduce addiction with involvement of family members and a therapeutic community.

2.6.7.2 Matrix Program: This is an out-patient treatment program which relies on a behavior modification strategy over an intensive two-week period with ten core activities.

2.6.7.3Twelve-Step Facilitation: This is the classic 12-step program developed to treatment alcohol addiction and also other forms of addiction.

2.6.7.4 Buddhism Motivation Interviewing-Cognitive Behavior Therapy: This method combines principles of the 12-step approach with Buddhism. Addicts are treated in groups through a series of five therapeutic sessions of two-hours each. The Phra Mongkut Klao Hospital has adapted the Minnesota Model of treatment to the Thai context, with community reinforcement.

2.6.7.5 Therapeutic Community (T.C.): This approach sets up a model society within the community to change the facilitating environment for drug use into a healthier environment. Community members work as a team in coordination with law enforcement to combat addictive drug use and marketing.

2.6.7.6 Motivation Enhancement Therapy: This approach attempts to tap into inner motivation of the drug addict to find the determination to quick drugs. The technique is to conduct Motivational Interviews in combination with Brief Interventions, one to four times, lasting five minutes to one hour. This approach was developed to treat alcoholism.

2.6.7.7 This is a form of psycho-social therapy which educates the addict on the source and cause of the addiction, and enlists the addict's active cooperation in treatment.

2.6.7.8 Psychodynamic Psychotherapy: This approach appeals to the subconscious brain of the drug addict to implant a form of conditioning as second nature to reduce craving and relieve sources of distress.

2.6.7.9 Behavior Therapy: This strategic attempts to manipulate behavioral triggers which lead to drug use and reverse the process. The goal is to achieve greater control over one's emotions and calls to action which govern self-abusive behavior.

2.6.7.10 Cognitive Behavior Therapy: This is a popular approach to a variety of behavioral problems and attempts to get at the root of negative self-image, hostility to one's environment, and lack of positive outlook toward the future. The approach attempts to correct the CD that is based on a false interpretation of reality. With change of understanding, then behavior should improve. The case must understand and accept his/her addiction as a behavioral disorder which needs to

change. This method has been used to treat depression and other mental disorders. This strategy can be used to treat problem behaviors which are stimulated by internal and external triggers.

2.7. Research on AT and CD

Khun Ladda Saenha (110) studied depression and negative AT among 709 adolescents in the last year of high school in Mahasarakham Province. That study found that 69% of the sample had some symptoms of depression and deviation from normal thought patterns. However only 3% had symptoms of severe depression.

Khun Kanika Siththipongse (111) studied treatment outcomes of a program to address negative AT among a group of 16 drug addicts and a control group of eight persons. An evaluation of the outcomes found a signification reduction in negative AT and improved self-image after the intervention.

Khun Thapanik Payamongkol (112) studied a treatment program for 32 first year high school students with negative AT enrolled at Prince Royal Academy. There was a comparison group of 16 controls. That study found that the intervention significantly reduced negative AT and aggressive behavior.

Khun Athanya Buntham (113) studied depression in 40 alcoholics and association with negative AT. Cases were assessed by the BDI and ATQ. The study found a strong and significant correlation between negative AT and depression in this population.

Rick E.Ingram and Kathleen S. Wisnicki (114) used the ATQ and BDI to study depression and AT among 197 male and 283 female psychology students at San Diego University. That study did not find a significant association between AT and depression.

Alan E. Kazdin (115) studied negative AT in 250 male and female children (age 6-13years) with risk for depression and no-risk children using the ATQ. Some of the children at risk of depression had aggressive behavior and suicidal thoughts. The study found significant relationships between negative AT, low self-esteem and depression.

Leili Amirsardri, ShafieAzari (116) studied the relationship between religious orientation and CD among 250 students at Uremia Azad University in 2012 and 2013. That study found a significant relationship between orientation and CD.

P.Marton, S.Kutcher (117) studied CD in three groups of adolescent high school students, including 69 with depression, 48 without symptoms of depression, and 34 with symptoms of cognitive disorder. The study used DSM-III criteria and the DAS and BDI. The Cronbach Alpha score for the tool ranged from 0.88 to 0.92. The study found that CD scores were high in all three groups, and youth with depression and CD needed cognitive therapy to prevent worsening of the condition or relapse. Inventory)

Kadir Özdel (118) evaluated CD (Think Errors) in the context of society and individual success in Turkey. The objective was to assess psychological attributes and level of CD. The sample included 225 who were research trainees at Diskapi Yildrim Beyazit and 100 cases of depression. The researcher used the BDI, CDS, the State Trail Anxiety Inventory (STAI) DAS, ATQ, and the Structure Clinical Interview DSM - IV Axis I Disorder (SCID-I). The study found that there was prevalence of Generalized Anxiety Disorder (GAD) and Specific Phobia (SP) (12%), Dysthymic Disorder (DD) (11%). The sample showed patterns of Catastrophizing, Labeling, Personalization, Interpersonal and Personal Achievement, and differences for Should Statements and Minimizing or Disqualifying the Positive in terms of Interpersonal and Personal Achievement. The study validated the predictive power of the CD and depression diagnostics.

Yong Zhang (119) studied the relationships between CD, Type D personality, family environment, and depression in a cross-sectional study of Chinese adolescents, classified by Age, Gender, Parents' Education Levels, Parents, Age, Family Structure (intact or single parents), and Household Income (Reflection of Socioeconomic Status). The researcher used the Test-Revised (LOT-R), Type D Personality Scale -14 (DS14) Family Environment Scale (FES), Self - Depression Scale (SDS). That study found that youth with depression and negative world view were more likely to come from lower-income families. CD was predictive of depression.

Tracy Kempton (120) studied CD and psychological diagnosis in adolescents to explore the patterns of CD. Cases came from the psychiatric department of a hospital and include 135 cases. Cases were grouped by those with depression only, those with depression and drug addiction, and those with cognitive abnormalities and drug addiction. The study used the Children's Negative Cognitive Errors Questionnaire (CNCEQ) and found that adolescents with multiple diagnoses had the highest scores. One in four had CNCEQ Subscales indicating depression. Diagnosis of CD was variable by group.

Rohany Nasir (121) studied CD and depression in 316 male and female Malaysian adolescent's age 12 to 18 years. The study used the Briere's Cognitive Distortion Scale (CDS) to assess CD and the Reynolds Adolescent Depression Scale (RADS). That study found that there was a statistical relationship between CD and depression, including self-critique, self-blame, helplessness, hopelessness and preoccupation with danger.

Zainah Ahmad Zamani (122) presented data at the Malaysian NADA national conference on the role of the family, CD, and appropriate care for clients in rehabilitation programs. The researcher used the FACES III questionnaire, the Cognitive Distortion Scale (CD) and Resilience Scale. That study found that moderate family role was associated with low CD. High level of rehabilitative care had impact on CD.

Salhah Abdullah (123) studied two groups of rape victim's age 12 to 18 years: 81 personal reports and 38 judicial determination cases. The researcher used the CDS, BDI, and Rosenberg Self-Esteem Scale (RSES). The study found that CD (Self -Criticism, Self-Blame, Helplessness, Hopelessness and Preoccupation with Danger) was predictive of depression, and that Self - Esteem, Self-Blame, Self - Criticism and Hopelessness Positively Contribute Helplessness were predictive of depression.

Aysel Esen Cobin (124) studied cases of CD and stress among 391 male and female college students using the Cognitive Distortion Scale and Stressful Experience Scale. That study found that students practiced self-blame, and used imagination and avoidance to cope with stress.

Kai - YeinTeo, Yee - How Say (125) studied prevalence of depression and CD in college students from 40 institutions using the BDI, ATQ and several self-designed questionnaires. Prevalence of depression was 21%. Prevalence varied by sex and field of study. Severity of depression was significantly associated with CD (r = 0.821) and use of addictive drugs.

Roger Covin (126) studied cognitive errors to assess CD using the CDS, ATQ - N, ATQ - P, BDI - II, DASS - 21, DAS, PANAS, Shipley Institute for living Scale, STAI. The study compared CD by academic success at the collegiate level (N=318). That study found that the CDS diagnostic tool had an internal consistency of 0.91 and high level of confidence (P=0.01).

This review has shown the wide range of diagnostic tools that are available for assessing CD, including the ATQ, BDI, CDS and DAS.

CHAPTER III
IMPLEMENTATION OF THE STUDY

This research had the objective to study cognitive patterns, attitudes and depression among drug users (methamphetamine) by conducting a descriptive cross-sectional sample survey. Data were collected during January 4 to March 31, 2016.

3.1 Sample population

The population universe for this study is 50,306 amphetamine addicts, age 18 to 24, who were undergoing rehabilitation, in 2015 (ONCB, 2016).The sample for this study was obtained as follows.

The desired sample size was calculated using the methods described by Yamane (1976) and applying 95% confidence interval in the following formula:

$$n = \frac{N}{1+Ne2}$$

n = desired sample size

N = total number of drug users in treatment

e = confidence level = 0.05

$$n = \frac{50,306}{1 + (50,306 \times 0.05 \times 0.05)}$$

n = 397

- The number of the sample was derived by applying the formula 397 preson. The selection criteria for the sample are as follows:

- male, age between 18 and 25 years

- undergoing treatment/rehabilitation for drug addiction during January – March, 2016

- Does not have mental illness or nervous disorder

- Voluntarily agrees to participate in the research

The exclusion criteria include the following:

- Does not have enough time to fill out the questionnaire
- Parent/guardian does not permit participation in the study

Sampling Technique

The research selected potential respondents using purposive sampling of 1,494 rehabilitation client's age 18-25 years during January to March and age to obtain the prescribed sample size of 421 persons (or 30.4% of the total).

3.2 Location of data collection

The research reviewed prospective sites to conduct data collection. The researcher contacted treatment and rehabilitation facilities for drug addiction by phone to request permission to conduct data collection.

1)Voluntary admission sites Thanyarak Hospital (Khon Kaen branch), Thanyarak Hospital (Songkhla branch),Chumpae District Hospital (Khon Kaen Province), North Region Treatment Community (Ban Phra Metta)Chiang Mai had a total of 417 clients. A sample of 164 (39.2%) of the total was drawn for data collection.

2)Compulsory admission sites Army Recruit Training Center No.23 (Wiwat Polamuang Center, Khon Kaen), Army Recruit Training Center No. 26 (Nakorn Ratchasima), Wiwat Polamuang Center, 4th Calvary Department (Saraburi Wiwat Polamuang Center, 1st Navy Division (Chonburi Wiwat Polamuang Center, 2nd Navy Division (Chonburi), Wiwat Polamuang Center, 3rd Navy Division (Chonburi), Wiwat Polamuang Center, Regimental Special Forces Division 1 (Petchburi) Wiwat Polamuang Center, Bodindecha Camp (Yasothorn) had a total of 1,077 inmates. A sample of 257 (23.9%) was selected for data collection.

Tabel 3.1 Location of the Sample Population

Location of the Sample Population	(1)	(2)	Percent
1.Thanyarak Hospital (Khon Kaen branch)	259	122	47.1
2.Thanyarak Hospital (Songkhla branch)	93	8	8.6
3.Chumpae District Hospital (Khon Kaen Province)	20	5	25
4.North Region Treatment Community (Ban Phra Metta) Chiang Mai	45	29	64.4
5.Army Recruit Training Center No.23 (Wiwat Polamuang Center, Khon Kaen)	120	35	29.1
6.Army Recruit Training Center No. 26 (Nakorn Ratchasima)	120	47	39.1
7.Wiwat Polamuang Center, 4th Calvary Department (Saraburi)	120	21	17.5
8.Wiwat Polamuang Center, 1st Navy Division (Chonburi)	120	31	25.8
9.Wiwat Polamuang Center, 2nd Navy Division (Chonburi)	87	9	10.3
10.Wiwat Polamuang Center, 3rd Navy Division (Chonburi)	130	50	38.46
11.Wiwat Polamuang Center, Regimental Special Forces Division 1 (Petchburi)	260	18	6.92
12.Wiwat Polamuang Center,Bodindecha Camp (Yasothorn)	120	46	38.3
Total	1,494	421	28.1

Remark (1) The number of meth addicts who received services;

(2) The sample of meth addicts who met the inclusion criteria of the study

3.3 Duration of implementation

The study spanned a period of 1 year two months. The duration of this study is scheduled from June 1, 2015 to August 31, 2016. Data collection was conducted during January 4 to March 31, 2016. 2559 with data collection conducted during three months

3.4 Data collection

The researcher received approval from the Mahidol University ethical review board: MU-SSIRBN0.2015/472(B2)Certificateof Approval No.2015/405.0401. The researcher then implemented the following steps:

A. Preparation for data collection

- Review understanding of the questionnaire to prepare the respondent, and provide clarification and explanation as needed;
- Define the time frame and location for data collection;
- Coordinate with the rehabilitation center to obtain permission for data collection;

B. Prepare the data collection assistants in some in some rehabilitation centers with the following requisite qualifications to assist with the research:

- Had experience and skill in implementing treatment/rehabilitation of drug addiction, and had worked in this field for at least two years;
- Works in one of the following: Thanyarak Hospital (Khon Kaen, Songkhla branches), or the North Thailand Treatment Community (Ban Phra Metta) in Chiang Mai.

- The researcher gave a complete orientation for the data collection assistants to ensure they understood the content of the questionnaire, method of filling out the questionnaire, and how to respond to questions about the questionnaires in order to minimize any problems that might arise.

3.4.1. The researcher presented a letter of introduction issued by the Drug Addiction Studies Program of the ASEAN Institute for Health Development of Mahidol University to the twelve sample locations and requested their cooperation in the study.

3.4.2. After receiving approval to conduct data collection, the researcher met with the chief administrator of the institution to explain the purpose of the study, and the method and duration of data collection.

3.4.3. The researcher and data collection assistants then collected the data from persons who met the inclusion criteria using interviews to administer the questionnaire. The researcher explained the purpose and content of the questionnaire to the participant. All participants signed an informed, voluntary consent form before responding to the questionnaire.

3.4.4. The researcher compiled all the questionnaires and examined them for completeness before coding the data using Epi Info (Version 3.2) followed by statistical analysis.

3.5 Data collection tools

This study used a questionnaire to collect the data. The questionnaire was adapted from other tested tools identified during the review of related literature. Previous research helped inform the conceptual framework and provided guidelines for construction of the questionnaire in this study. The questionnaire consists of 129 items, divided into the following five sections.

3.5.1 Section 1: Individual characteristics of the drug user. This includes 18 items about personal characteristics, the family, relationships and history of drug use and rehabilitation.

3.5.2 Section 2: Beck's Depression Inventory (BDI). This includes 21 items which are used to assess the level of depression. There are 15 questions on mental status, and six questions about physical symptoms. Each item is scored on a scale from 0 to 3 (from low/no severity to very high severity of depression). The total possible score is 63, and scores are classified by level of depression as follows:

0 - 10	Normal (no depression)
11 - 16	Mild Mood Disturbance
17 - 20	Border line Clinical Depression
21 - 30	Moderate Depression
31 - 40	Severe Depression
Over 40	Extreme Depression

3.5.3 Section 3: Autonomic Thought Negative Question (version 2) (Hollon & Kendall, 1980) (78) .This section has 30 items and probes for beliefs and frequency of thoughts. There are four dimensions of this instrument as follows: (1) Personal Maladjustment and Desire Change (PMDC) including Questions 7,10,14,20, 26; (2) Negative Self-Concept and Negative Expectations (NSNE) including Questions 2,3,9,21,23,24,28; the components in this dimension are consistent with the score as measured by the BDI; (3) Low Self-Esteem (LSE) including Questions 17 and 18; and (4) Helplessness including Questions 29 and 30. Each item is scored on a 5-point rating scale. Scores are grouped as follows

Score of 1 denotes no negative thoughts

Score of 2 denotes some negative thoughts on occasion

Score of 3 denotes having negative thoughts rather often

Score of 4 denotes having negative thoughts often

Score of 5 denotes having negative thoughts all the time

The minimum and maximum scores for this diagnostic are 30 and 150, respectively. The researcher divided the scores into the following four groups:

Group 1: Min to ($\bar{x}$ - SD) = 66 - 92, little negative thought

Group 2: ($\bar{x}$ - SD) + 1 to $\bar{x}$ = 93 - 124, slight frequency of negative thought

Group 3: 3 ($\bar{x}$) + 1 to ($\bar{x}$ + SD) = 125 - 155 rather high frequency of negative thought

Group 4: ($\bar{x}$ + SD) + 1 to Max = 156 - 266, high frequency of negative thought

3.5.4 Section 4: Dysfunction Attitudes Scale (DAS) (Weismann Beck, 1978) (62). This section has 40 items and is a measure of cognitive distortion. This includes distortion of thoughts of oneself and others. Distorted thoughts have the potential to cause harmful behavior toward oneself and/or others. There are seven dimensions of this measure including Approval, Love, Achievement, Entitlement, Perfectionism, Omnipotence and Autonomy. The scores are on a scale from 1 to 7,
Criteria for assigning scores on a 7-point scale as follows:

Score of 1 denotes agree with all statements

Score of 2 denotes agree with most statements

Score of 3 denotes agree with some statements

Score of 4 denotes indifferent opinion of the statement

Score of 5 denotes disagree with some statements

Score of 6 denotes disagree with most statements

Score of 7 denotes disagree with all statements

The minimum and maximum scores for this diagnostic are 40 and 280, respectively. The researcher divided the scores into the following four groups:

Group 1: Min to ($\bar{x}$ - SD) = 40 - 105, denotes high level of Dysfunction Attitudes

Group 2: ($\bar{x}$ - SD) + 1 to $\bar{x}$ = 106 - 136, denotes rather high level of Dysfunction Attitudes;

Group 3: ($\bar{x}$)+1 to ($\bar{x}$ + SD) = 137 - 166, denotes lower level of Dysfunction Attitudes;

Group 4: ($\bar{x}$ + SD) + 1 to Max = 167 - 265, denotes very low level of Dysfunction Attitudes;

3.5.5 Section 5: Cognitive Distortion Scale (CDS). (126) This diagnostic is the 'Type of Thinking' scale developed by Roger Covin. The tool has 20 items, and each item is assessed vis a vis social relationships (with friends, loved ones, family) and personal achievement (in tests, work). The questionnaire has ten examples of thought, including: Mindreading, Emotional reasoning, Catastrophizing, All or Nothing Thinking, Overgeneralization, Labeling, Personalization, Should Statements, and Minimizing or Disqualifying the Positive. Cognitive distortion related to social relationships is measured by Questions 1, 4, 6, 7, 9, 11, 13, 16, 18, 20 ; while personal achievement is measured by Questions 2, 3, 5, 8, 10,12,14,15,17,19. The scores are on a scale from 1 to 7,Actual scores were grouped as follows:

Score of 1denotes never had that thought in the situation; frequency level of 1

Score of 2 denotes had that thought in the situation; frequency level of 2

Score of 3 denotes had that thought in the situation; frequency level of 3

Score of 4 denotes had that thought in the situation; frequency level of 4

Score of 5 denotes had that thought in the situation; frequency level of 5

Score of 5 denotes had that thought in the situation; frequency level of 6

Score of 5 denotes had that thought in the situation; frequency level of 7

The minimum and maximum scores for this diagnostic are 20 and 140, respectively. The researcher divided the scores into the following four groups:

Group 1 Min to ($\bar{x}$ - SD) = 20 - 50, denotes low cognitive distortion

Group 2 ($\bar{x}$ - SD) + 1 to $\bar{x}$ = 51 - 59, denotes rather low cognitive distortion

Group 3 ($\bar{x}$) + 1 to ($\bar{x}$ + SD) = 60 - 77, denotes rather high cognitive distortion

Group 4 ($\bar{x}$ + SD) + 1 to Max = 78 - 123, denotes high cognitive distortion

3.6 Tests of the quality of the data collection instrument

3.6.1.Validity: The researcher assessed content validity of the instrument. First the researcher translated components that were adapted from the original source from English to Thai. A bi-lingual expert compared the English and Thai versions for accuracy. The research advisor and other experienced resource persons reviewed the questionnaire content.

3.6.2.Reliability: The researcher used Cronbach's Alpha test to assess reliability of the questionnaire after administering the tool to a sample of 30 persons. The following is the formula for calculating the measure of reliability

Table 3.2: Results of the Test of Reliability of the Questionnaire Cronbach's Alpha Coefficient

Diagnostic	Before deployment N = 30	Sample the study N = 421
1.Beck's Depression Inventory (BDI)	.812	.865
2.Autonomic Thought Negative Question (ATQ)	.846	.930
3.Dysfunction Attitudes Scale (DAS)	.861	.930
4.Cognitive Distortion Scale (CDS) (Type of Thinking Scale)	.811	.864

3.7 Data analysis

Data were entered into a computer using Epi Info (Version 3.2) and then analyzed using SPSS (Statistical Package for the Social Sciences for Windows, Version 21) as follows:

3.7.1 Section 1: Descriptive statistics (percent, mean, range, minimum, maximum) were used to assess the individual characteristics of the sample (age, education, marital status, occupation, income, relationships, and history of drug use and rehabilitation).

3.7.2 Sections 2 - 4 of the questionnaire: Depression, automatic thought and attitude distortion. The research used descriptive statistics to analyze the data, including percentages, means, range, correlation analysis to assess association among interval-scale variables and the Kolmogorov - Smirnov Test as a Test of Normality)

3.7.3 Chi-square to test the association between cognitive distortions, automatic thought, attitude and depression

3.7.4 Correlation analysis to test for the relationship between the ten types of cognitive patterns and individual success

CHAPTER IV
RESULTS

This research is a descriptive cross-sectional study with the objective to analyze the mode of thought, attitudes, and symptoms of depression of male methamphetamine (meth) users. Data were collected during January to March, 2016 using questionnaires. Data were analyzed using descriptive statistics, Chi-Square, correlation coefficients, and the Kolmogorov - Smirnov test (Test of Normality). This chapter is divided into three sections: (1) Individual data on the drug users; (2) Thoughts, attitudes, and depression; and (3) Statistical association between individual characteristics and thoughts, attitudes and symptoms of depression.

The data are presented, Analyzed and discussed along with the tables of the data. Tools used for the analysis include mean, standard deviation, minimum, maximum, range, and median, and Quartile Deviation.

Part 1: Results of analysis of the individual characteristics, economic status, family relationships, cognitive patterns, attitudes and depression;

Part 2: Results of the analysis of the correlation between interval scale variables;

Part 3: Results of tests of association between individual characteristics, economic status, family relationships, negative automatic thought, attitude distortion, Depression, cognitive distortion using Chi-Square.

Part 1: Results of analysis of the individual characteristics, economic status,family relationships, cognitive patterns, attitudes and depression;

4.1: Individual data on the drug users

The sample consists of 421 meth users. Individual data include socio-economic status, family relationships and history of meth use and rehabilitation.

Table 4.1: Individual Characteristics of the Drug Users

General Information	N = 421	Percent
Age (years)		
18-21 years	169	40.1
22-25 years	252	59.9
Mean = 21.33 SD = 2.10 Max = 25 years Min = 18 years		
Education		
Primary	148	35.2
Secondary	216	51.3
Vocational	41	9.7
Associates degree/diploma	8	1.9
Bachelor’s degree	8	1.9
Working and have independent income		
yes	297	70.5
no	124	29.5

Table 4.1: Individual Characteristics of the Drug Users (cont.)

General Information	N = 421	Percent
Occupation (N=297)		
General wage labor	204	68.68
sales	52	17.50
agriculture	33	11.11
government civil servant	2	0.67
other	6	2.04
Monthly income (N=297)		
< = 9,000 baht	225	75.8
Over 9,000 baht	72	24.2
Median = 9,000 Max = 90,000 Min = 1,500		
Marital status		
Never married	310	73.7
married	99	23.5
separated/divorced	9	2.1
widowed	3	0.7

The sample is all males, age between 18 and 25 years (mean 21). Over half had high school education and one-third had only primary education Most had jobs and independent income mostly from work in general wage labor However only one-fourth had monthly income higher than the median of 9,000 baht. Three-fourths of the sample were never married.

Table 4.2: Family and Relationships of the Drug Users

General Information	N = 421	Percent
Number of household members		
Live alone	3	0.7
2 - 5	300	71.3
6 - 10	118	28.0
Mean = 4.78 SD = 1.66 Max = 10 Min = 1		
Currently living with:		
Not living with parent(s)	87	20.6
father or mother	104	24.7
father and mother	230	54.7
Family relationships (multiple response allowed)		
Caring for each other	388	92.2
Eager to provide mutual support	374	88.8
Members can discuss personal problems	366	86.9
together	160	38.0
Members have conflict of opinions		

Remarks: Percentages of family relationships are out of 100%

The sample lives in households with an average of five members. Of those, over half live with parents. The atmosphere in the household is loving and supportive in most cases; few have chronic conflict.

Table 4.3: History of Meth Use and Rehabilitation

General Information	N = 421	Percent
Age at first meth use		
10 - 15 years	185	43.9
16 - 24 years	236	56.1
Mean = 16.07 SD =2.3 Max = 24 years Min = 10 years		
Duration of use of meth		
<= 3 years	140	33.3
> 3 years	281	66.7
Mean = 4.89 SD.= 2.57 Min = 0 Max= 14		
Method of drug use (multiple response allowed)		
Oral pill	16	3.8
inhaled	409	97.1
injection	21	5.0
Frequency of use		
1-3 times/week	241	57.3
Every day	107	25.4
Every other day	73	17.3
Last use		
Over 3 months ago	178	42.3
In the past 3 months	243	57.7
Quantity of meth at last use		
1-2 pill	291	69.1
> 2 pills	130	30.9
Median = 2 Q.D.=1 Min =1, Max = 40		
Method of consumption at last use		
Oral pill	5	1.19
inhaled	408	96.9
injection	8	1.9

Table 4.3: History of Meth Use and Rehabilitation (cont.)

General Information	N = 421	Percent
Any co-addictions?		
yes	349	83.0
no	72	17.0
Co-use or alternate use when not using meth (multiple response allowed)		
cigarettes	315	74.8
alcohol	163	38.7
drinks with boosters	66	15.7
caffeine drinks	62	14.7
cough medicine	16	3.8
pain medication	7	1.7
tranquilizer	5	1.2
sleeping pills	4	1.0
Ice	41	9.7
marijuana	30	7.1
thinner	13	3.1
Krathom leaves	12	2.9
heroin	10	2.4
codeine	2	0.5
Ever treated for drug addiction		
yes	198	47.0
no	223	53.0
Number of times treated for drug addiction (N=198)		
1 time	110	55.6
2 - 4 times	77	39.0
5 - 11times	11	5.4

Table 4.3: History of Meth Use and Rehabilitation (cont.)

General Information	N = 421	Percent
Last place of treatment (N = 198)		
Army Recruit Training Center	59	30.0
General hospital	49	25.0
Thanyarak Hospital	44	22.0
Rehabilitation camp	21	11.0
Buddhist monastery	14	7.0
Correctional facility	7	3.0
Psychiatric hospital	4	2.0
Nature of last treatment (N = 198)		
Counseling	132	66.7
Two types	54	27.3
Oral medication	12	6.0

Remarks: Drugs used with or in place of meth are calculated as a percent for each item.

The average age at first meth use was 16 years (range of 10 to 24). Age started using methamphetamine at least 10 years. Over half had used meth for less than three years, and most smoke the drug Over half take meth 1 to 3 times a week. (17 %) Most had used meth in the three months prior to the survey and the common dose was two pills or more, and almost all inhaled the drug almost all inhaled the drug.

More than 80 percent use Other addictive substances used concurrently or in place of meth include mostly cigarettes and/or alcohol drinks with boosters, and caffeine drinks, Followed by ten percentage use Ice Co-use or alternate use when not using meth .

Half of the sample had never gone through a course of treatment for meth addiction. Those who had, mostly received rehabilitative treatment at the Army Recruit Training Center, and this mostly consisted of counseling more than oral medication.

4.2 Beck's Depression Inventory

For this research, Beck's Depression Inventory was used (29) The inventory consists of 21 questions, and each item is scored from 0 to 3. The scores are divided into four levels

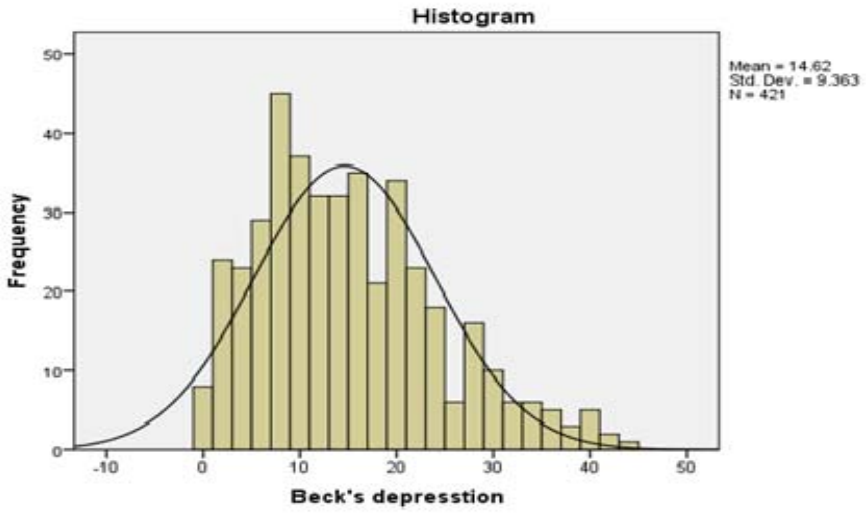

Figure 4.1: Beck's Depression Inventory depression of Meth Users

The distribution for depression scores for the sample is non-normal (Kolmogorov - Simonov 1.775 p - valve = 0.004) The mean depression score is 14.62 with S.D. of 9.36

Table 4.4: Shows Number and Percent of Beck's Depression Inventory

Beck's Depression Inventory	Number	Percent
0 - 10 These ups and downs are considered normal	166	39.5
11 - 16 Mild mood disturbance	99	23.5
17 - 20 Borderline clinical depression	55	13.1
21 - 30 Moderate depression	73	17.3
31 - 40 Sever depression	25	5.9
Over 40	3	0.7

The scores are divided into six levels: 1-10 (normal), 11-16 (mild mood disturbance), 17-20 (borderline clinical depression), 21-30 (moderate depression), 31-40 (severe depression) and over 40 (very severe depression); minimum score of 0 and maximum of 44 Using this scale, one-third of the sample of meth users in this study had symptoms of clinical depression

4.3 Automatic Thought Questionnaire (ATQ)

This study also used the Automatic Thought Questionnaire diagnostic of Kendell and Steven D.Holl which has 30 question and measures frequency and belief. (78) Each item has four components as follows: (1) Personal Maladjustment and Desire Change (PMDC) (2) Negative Self-Concept and Negative Expectations (NSNE) (3) Low Self-Esteem (LSE) (4) Helplessness including Questions

Table 4.5 : Means, Minimum and Maximum of Negative Automatic Thought

Automatic Thought	Degree	Number of questions	Min	Max	Mean	SD
Personal Maladjustment and Desire Change	Frequency	5	5	24	12.43	3.61
	Belief	5	5	25	12.27	3.42
Negative Self – concept / Expectations	Frequency	7	7	33	14.11	4.87
	Belief	7	7	33	13.97	4.31
Low self Esteem	Frequency	2	2	10	3.28	1.54
	Belief	2	2	10	3.23	1.50
Helplessness	Frequency	2	2	10	3.59	1.71
	Belief	2	2	10	3.52	1.56
Summary	**Frequency**	**30**	**32**	**147**	**61.62**	**16.64**
	Belief	**30**	**34**	**138**	**62.36**	**18.20**

The table shows the frequency distributions of the scores for negative automatic thought and beliefs, and the mean scores for both are not distinctly differ

Table 4.6: Automatic Thought Level by Four Types

Automatic Thought Level	Number	Percent
Frequency		
Low Automatic Negative Thought (32-45 Score)	64	15.2
Slightly Low Automatic Negative Thought (46-61Score)	167	39.7
Slightly High Automatic Negative Thought (62-76 Score)	126	29.9
High Automatic Negative Thought (77-147 Score)	64	15.2
Belief		
Low Automatic Negative Thought (34-44 Score)	57	13.5
Slightly Low Automatic Negative Thought (45-62 Score)	188	44.7
Slightly High Automatic Negative Thought (63-79 Score)	111	26.4
High Automatic Negative Thought (80-138 Score)	65	15.4
Overall		
Low Automatic Negative Thought (66 – 92 Score)	70	16.6
Slightly Low Automatic Negative Thought (93 – 124 Score)	164	39.0
Slightly High Automatic Negative Thought (125-155 Score)	118	28.0
High Automatic Negative Thought (156- 266 Score)	69	16.4

The researcher divided the scores for negative automatic thought into four groups. The analysis shows that the lowest score was 32 and the highest score was 147. This analysis found that approximately one in seven of the drug users in this study had a high automatic thought level and scores were similarly low across groups. Scores for belief in negative automatic thought ranged from 34 to 138, and there were no distinct differences across groups. Overall, automatic thought score was an average of about 124; over half the sample had automatic thought scores under the average.

4.4 Dysfunctional Attitude Scale

This research applied the Dysfunctional Attitude Scale (DAS) of Arlene Weissman to assess the attitudinal health of the sample. This scale has 40 items with possible scores ranging from 40 to 280. The seven dimensions of each item refer to: Approval, Love, Achievement, Perfectionism, Entitlement, Omnipotence and Autonomy. A score of 1 denotes that the meth addict agrees fully with the item, whereas a score of 7 denotes absolute disagreement. . Data were analyzed by score group using $\bar{x} \pm 1SD$

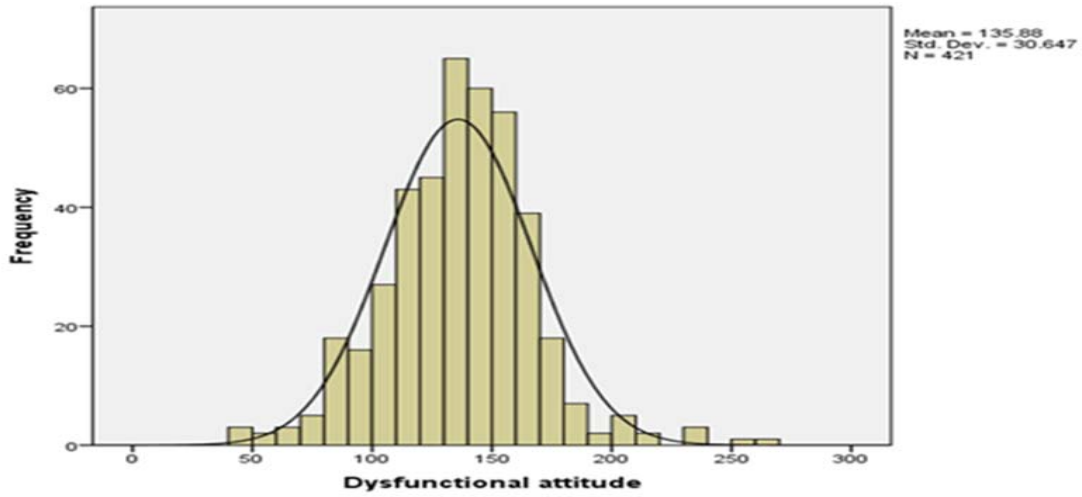

Figure 4.2: Attitude Distortion of Meth Users

The distribution of the sample for dysfunctional attitude is normal (Kolmogorov – Simonov 1.16 p - valve = 0.130); mean score of 135.88, S.D. 30.65

Table 4.7: Dysfunctional Attitude Level by Group

Dysfunctional Attitude Level	Number	Percent
High Dysfunctional Attitude (40 - 105 Score).	60	14.3
Slightly High Dysfunctional Attitude (106 - 136 Score)	149	35.4
Slightly Low Dysfunctional Attitude (137 - 166 Score)	169	39.2
Non Dysfunctional Attitude (167 - 265 Score).	47	11.2

The researcher allocated dysfunctional attitude scores by four groups. The scores ranged from 40 to 265; 14% had a high score for dysfunction while 11% had no dysfunctional attitude. Most of the sample falls into the moderate groups for attitude dysfunction.

4.5 Cognitive Distortion (Type of Thinking Scale)

To analyze the patterns of cognitive distortion of this sample of meth addicts, this research applied the Type of Thinking Scale developed by Roger Covin. The scale has 20 items, and each item has two dimensions: (1) Social relationships (vis a vis friends, family members); and (2) Personal achievement (vis a vis testing, work). The questionnaire has ten examples of thought, including: Mindreading, Catastrophizing, All or Nothing Thinking, Overgeneralization, Emotional reasoning, Labeling, Personalization, Should Statements, and Minimizing or Disqualifying the Positive. Items are rated on a 7-point scale (“1” denotes never having the thought whereas “7” denotes always having the thought). . Data were analyzed by score group using $\bar{x} \pm 1SD$

Table 4.8: Cognitive Distortion by Social Relationships

Social Relationship	Never		Sometime		All the time	
	N	%	N	%	N	%
1.Mindreading	197	46.8	193	45.8	31	7.4
2.Catastrophizing	141	33.5	216	51.3	64	**15.2**
3.All- or- Nothing Thinking	206	48.9	186	44.2	29	6.9
4.Mental filter	202	48.0	188	44.7	31	7.4
5.Overgeneralization	216	51.3	166	39.4	39	9.3
6.Emotional reasoning	211	50.1	184	43.7	26	6.2
7.Personalization	239	56.8	147	34.9	35	8.3
8.Labeling	185	43.9	202	48.0	34	8.1
9.Should Statements	146	34.7	196	46.6	79	**18.8**
10.Minimizing or Disqualifying the Positive	130	30.9	222	52.7	69	**16.4**

The research analyzed the degree of Cognitive Distortion (never, sometimes, all the time) among meth addicts vis a vis social relationships. “All the time” Cognitive Distortion was highest for Should Statements, Minimizing or Disqualifying the Positive, and Catastrophizing, respectively

Table 4.9: Cognitive Distortion by Personal Achievement

Personal Achievement	Never		Sometime		All the time	
	N	%	N	%	N	%
1.Mindreading	214	50.8	179	42.5	28	6.7
2.Catastrophizing	184	43.7	208	49.4	29	6.9
3.All- or- Nothing Thinking	205	48.7	187	44.4	29	6.9
4.Mental filter	217	51.5	166	39.4	38	**9.1**
5.Overgeneralization	265	62.9	138	32.9	18	4.2
6.Emotional reasoning	202	48.0	190	45.1	29	6.9
7.Personalization	193	45.8	203	48.3	25	5.9
8.Labeling	202	48.0	195	46.3	24	5.7
9.Should Statements	232	55.1	160	38.0	29	6.9
10.Minimizing or Disqualifying the Positive	157	37.3	219	52.0	45	**10.7**

The researcher analyzed the level of CD by personal achievement among the sample of meth addicts. The analysis shows that Minimizing or Disqualifying the Positive had the highest proportion of always experiencing CD, followed by Mental Filter. Least CD was reported for Overgeneralization and Labeling.

Table 4.10: Cognitive Distortion by Social Relationship and Personal Achievement

The Type of Thinking	Social Relationship			Personal Achievement		
	Mean	**SD**	**Rank**	**Mean**	**SD**	**Rank**
Mindreading	2.85	1.63	6	2.79	1.51	7
Catastrophizing	3.51	1.82	**3**	2.95	1.57	**2**
All - or - Nothing Thinking	2.80	1.65	9	2.80	1.57	6
Mental filter	2.87	1.65	5	2.85	1.70	4
Overgeneralization	2.81	1.65	8	2.31	1.51	10
Emotional reasoning	2.82	1.51	7	2.83	1.60	5
Labeling	2.64	1.70	10	2.91	1.54	3
Personalization	2.99	1.59	4	2.79	1.52	7
Should Statements	3.55	1.85	2	2.70	1.58	9
Minimizing or Disqualifying the Positive	3.60	1.77	**1**	3.22	1.66	**1**

The researcher analyzed means and standard deviation of scores for CD by ten dimensions. The results show that the meth addicts are most likely to manifest Minimizing or Disqualifying the Positive for both social relationships and personal achievement. There are similar mean scores for the dimensions of Mindreading, Catastrophizing, All - or - Nothing Thinking, Mental Filter, Overgeneralization, (Emotional reasoning), and Personalization. Means are inconsistent between the two groups for Labeling and Should Statements.

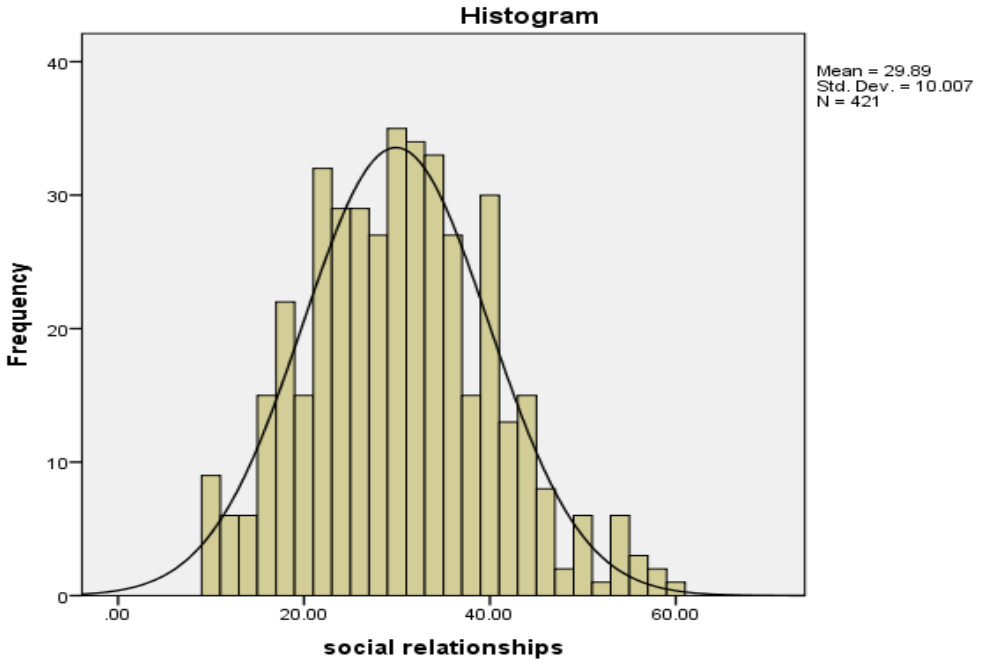

Figure 4.3: Cognitive Distortion and Social Relationships

The distribution of the sample for social relationships is normal (Kolmogorov - Smimor 0.94 p - value 0.33).

Table 4.11: Cognitive Distortion and Social Relationships by Four Groups

Type of Thinking Level (Social Relationships)	Number	Percent
Non Thinking Distortion (10-18 score)	74	17.6
Sometime Thinking Distortion (19-28 score)	147	34.9
Often Thinking Distortion (29-37 score)	119	28.3
Always Thinking Distortion (38-60 score)	81	19.2

The researcher analyzed Cognitive Distortion with social relationships. The results show that the Cognitive Distortion score for the meth addicts ranged from 10 to 60. About 18% of the sample had no Cognitive Distortion while 19% had constant Cognitive Distortion , while 35% and 28% had sometimes or often Cognitive Distortion , respectively.

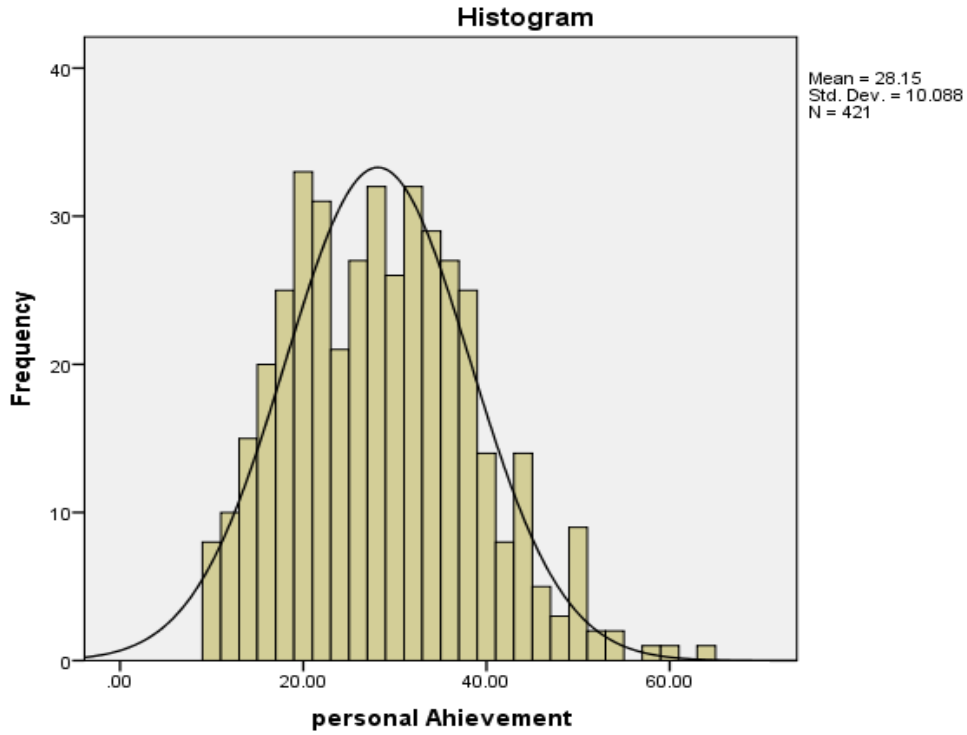

Figure 4.4: Cognitive Distortion by Personal Achievement

The distribution of the sample is non-normal as the value of Kolmogorov – Smimor was 1.45 p – value 0.05.

Table 4.12: Cognitive Distortion by Personal Achievement

Type of Tanking Level (Personal Achievement)	Number	Percent
Non thinking distortion (10-20 score)	64	15.2
Sometime Thinking distortion (21-30 score)	158	37.5
Often Thinking distortion (31-39 score)	132	31.4
Always thinking distortion (40-63 score)	67	15.9

The researcher analyzed Cognitive Distortion score by personal achievement. The results show that the scores ranged from 10 to 63. One in seven (15%) of the sample of meth addicts had no Cognitive Distortion while 16% had Cognitive Distortion all the time. About one-third had Cognitive Distortion either sometimes or often.

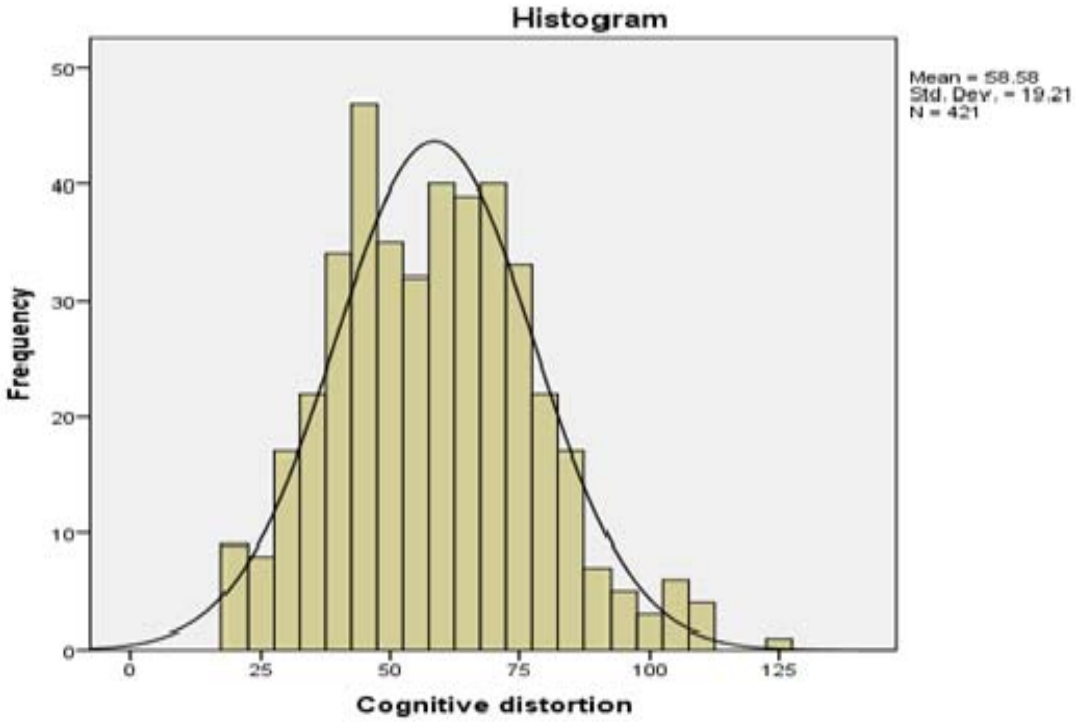

Figure 4.5: Distribution of Cognitive Distortion among the Sample

The distribution of the sample is normal: Kolmogorov - Smimor 1.120 p - value 0.12

Table 4.13 : Cognitive Distortion by Group

Cognitive Distortion Level	Number	Percent
Non Distortion (20 - 50 score)	157	37.3
Sometime Thinking Distortion (51 - 59 score)	62	14.8
Often Thinking Distortion (60 - 77 score)	137	32.5
Always Thinking Distortion (78 - 123 score)	65	15.4

The researcher divided the Cognitive Distortion scores into four levels. The results show that the scores ranged from 20 to 123. About one in seven meth addicts in this sample had Cognitive Distortion all the time.

Table 4.14 Distribution Analysis using the Kolmogorov-Smirmov Test

Variable	Mean	SD	K-S	P-value
Cognitive distortion	58.58	19.21	1.12	**0.12**
- Social Relationship	29.89	10.0	0.94	**0.33**
- Personal Achievement	28.14	10.0	1.42	**0.05**
Autonomic Thought Questionnaire	123.98	32.32	1.42	0.03
- Frequency	1.97	0.56	0.34	0.00
-Belief	2.02	0.53	7.38	0.00
Dysfunctional Attitude Scale	135.88	30.64	1.16	**0.13**
Beck's Depression Inventory	14.62	9.63	1.77	0.00

The researcher analyzed the distribution of the interval-scale variables using the Kolmogorov-Smirmov test. The results show that the Cognitive Distortion distribution was normal for Cognitive Distortion and dysfunctional attitude

Part 2: Results of the analysis of the correlation between interval scale variables;

This part examines correlation of the different types of Cognitive Distortion by social relationships and personal achievement.

Table 4.15: Correlation Coefficients for 10 Types of Cognitive Distortion and social relationships

social relationships	Mindreading	Catastrophizing	All- or- Nothing Thinking	Mental filter	Overgeneralization	Emotional reasoning	Labeling	Personalization	Should Statements	Minimizing or
Mindreading	1									
Catastrophizing	.35**	1								
All - or - Nothing Thinking	.29**	.21**	1							
Mental filter	.25**	.31**	.25**	1						
Overgeneralization	.25**	.39**	.25**	.37**	1					
Emotional reasoning	.27**	.25**	.27**	.41**	.42**	1				
Labeling	.28**	.21**	.26**	.31**	.34**	.38**	1			
Personalization	.31**	.28**	.21**	.41**	.39**	.35**	.35**	1		
Should Statements	.24**	.26*	1.2*	.16**	.20**	.21**	.17**	.32**	1	
Minimizing	.30**	.28**	.22**	.37**	.34**	.27**	.27**	.42**	.38**	1

** Correlation is significant at the 0.01, * Correlation is significant at the 0.05 level

The analysis now turns to the relationship between thought patterns and social relationships of the meth addicts. There are statistically significant ($p<0.01$) relationships for all the thought patterns except for “Should Statements and All or Nothing Thinking” and “Should Statements and Catastrophizing”, which were significant at the 0.05 level of confidence.

Table 4.16: Correlation Coefficients between 10 Types of Cognitive Distortion and Personal Achievement

Personal Achievement	Mindreading	Catastrophizing	All- or- Nothing Thinking	Mental filter	Overgeneralization	Emotional reasoning	Labeling	Personalization	Should Statements	Minimizing or
Mindreading	1									
Catastrophizing	.34**	1								
All-or-Nothing Thinking	.38**	.25**	1							
Mental filter	.32**	.36**	.37**	1						
Overgeneralization	.24**	.31**	.25**	.41**	1					
Emotional reasoning	.31**	.34**	.31**	.32**	.41**	1				
Labeling	.41**	.29**	.38**	.46**	.39**	.39**	1			
Personalization	.29**	.28**	.33**	.45**	.39**	.46**	.48**	1		
Should Statements	37**	.25**	.35**	.40**	.34**	.31**	.49**	.39**	1	
Minimizing	.23**	.26**	.30**	.33**	.16**	.25**	.26**	.29**	.35**	1

** Correlation is significant at the 0.01 level (2-tailed) , * Correlation is significant at the 0.05 level (2-tailed)

The relationship between the ten thought patterns and personal achievement is significant at the 0.01 level for all 10 dimensions.

Table 4.17: Correlation Coefficients for CD, ATQ, DAS and BDI Scores

Variable	Cognitive Distortion Scale	Autonomic Thought Question	Dysfunction Attitude Scale	Beck Depression Inventory
Cognitive Distortion Scale	1			
Autonomic Thought Question	0.33**	1		
Dysfunction Attitude Scale	- 0.25**	- 0.12*	1	
Beck Depression Inventory	0.22**	0.51**	- 0.10*	1

** Correlation is significant at the 0.01.* Correlation is significant at the 0.05

The data from the table show that CD has a statistically significant correlation with negative automatic thought, dysfunctional attitude, and depression.

Part 3:Results of tests of association between individual characteristics, economic status, family relationships, negative automatic thought, attitude distortion, Depression cognitive distortion using Chi-Square.

Only independent variables with significant associations are included.

Table 4.18: Associations between Cognitive Distortion Meth Addict Characteristics

Cognitive Distortion	Non N=157		Sometime N=62		Often N=137		Always N=65		Chi - square	P-value
	N	%	N	%	N	%	N	%		
Beck's Depression Inventory										
Normal/Mild mood	113	72.0	40	64.5	73	53.3	39	60.0	18.03	0.00
Borderline clinical	21	13.4	10	16.1	17	12.4	7	10.8		
Depression	23	14.6	12	19.4	47	34.3	19	29.2		
Negative Autonomic Thought Question										
Low	39	24.8	8	12.9	13	9.5	10	15.4	38.75	0.00
Slightly Low	73	46.5	29	46.8	44	32.1	18	27.7		
Slightly high	32	20.4	18	29.0	46	33.6	22	33.8		
High	13	8.3	7	11.3	34	24.8	15	23.1		
Dysfunctional Attitude Scale										
High	16	10.2	5	8.1	19	13.9	20	30.8	38.32	0.00
Slightly high	51	32.5	25	40.3	47	34.3	26	40.0		
Slightly low	61	38.8	27	43.5	64	46.7	13	20.0		
Non	29	18.5	5	8.1	7	5.1	6	9.2		

The test of the association between cognitive distortion with the other characteristics of the meth addicts found that there was a statistically signification association between these variables. There was also a signification association between cognitive distortion and depression, automatic thought and attitude distortion ($p <= 0.00$)

CHAPTER V
SUMMARY, DISCUSSION AND RECOMMENDATIONS

This study was a descriptive, cross-sectional research study with the objective to study models of cognitive distortion (CD), attitude distortion, automatic thought, depression, and the relationship between age, education, marital status, and economic status with the type of CD, attitude distortion, automatic thought and depression. The sample population included 421 persons. The data were collected by questionnaire and analyzed using SPSS descriptive statistics. The following is a summary of methods, findings and recommendations.

Objectives of the research

- To study models of CD;
- To study the relationships between individual characteristics and negative automatic thought, dysfunctional attitudes, depression and CD among meth addicts in treatment and rehabilitation centers.

Research hypotheses

- Meth addicts with severe CD will also have negative automatic thought, dysfunctional attitudes and depression at a severe level;
- Different age, education and marital status of meth addicts will be associated with different negative automatic thought, dysfunctional attitudes, depression and CD.

Study population and sample

Data were collected by questionnaire from a sample of residents of drug addiction treatment and rehabilitation centers. The sample was comprised of 421 male amphetamine addicts age 18-24 years. Data collection was conducted during January to March, 2016 at Thanyarak Hospital branches in Khon Kaen and Songkhla Provinces, Chumpae District Hospital, the TC North therapeutic community (Ban Phra Metta,Chiang Mai Province), and the Wiwat Pholamuang Academy network of nine

institutions in Khon Kaen, Nakorn Ratchasima, Saraburi, Chonburi, Petchburi, and Yasothorn Provinces. Participants were selected using purposive sampling.

Data collection instruments

Data were collected by questionnaire with the following five sections:

(1) Individual characteristics (18 items)

(2) Beck's Depression Inventory (BDI) (21 items)

(3) Autonomic Thought Negative Questionnaire, Version 2, by Hollon & Kendall (1980) (30 Items)

(4) Dysfunction Attitudes Scale (DAS) by Weismann Beck (1978) (40 items)

(5) Cognitive distortion module (20 items)

Data collection

After permission was obtained from all 12 participating institutions, data collection was conducted over three months during January to March, 2016. Out of 500 questionnaires distributed, 421 (84.2%) were complete and included for data analysis. Participation in the survey was totally voluntary and data management ensured strict confidentiality

Data entry and analysis

Data were computerized using Epi Info, Version 3.2, and then analyzed using SPSS. Data in the first section (individual characteristics) were analyzed using descriptive statistics. Data from Sections 2 to 5 were analyzed using descriptive statistics, correlation analysis, and the Kolmogorov - Smirnov Test of Normality. To test for association between individual characteristics and CD, the researcher applied the Chi-Square Test. Correlation analysis was used for higher-level analysis of association between CD, automatic thought, attitudes and depression.

5.1 Summary of findings

- Over one-third of the sample (37%) scored in the range of 17 - 44, which is indicative of clinical depression;
- Over half (56%) had negative automatic thought scores at a low level;
- About two-fifths (39%) had low to moderate dysfunctional attitude scores;
- One-fifth (19%) reported CD nearly all the time;

- The sample experienced CD in social relationships nearly all the time;
- Should Statements were the most common manifestation of CD, followed by Minimizing or Disqualifying the Positive;
- For personal achievement, CD for this sample of meth addicts was characterized by Minimizing or Disqualifying the Positive more than other manifestations;
- Different age, education and marital status of meth addicts was not associated with different negative automatic thought, dysfunctional attitudes, depression and CD.

5.1.1 Individual characteristics of the sample of meth addicts

Most (60%) of the sample of male meth addicts ranged in age from 22 to 25 years; mean age was 21. About half (51%) had completed high school education, and 70% had employment and income of their own (three-fourths made 9,000 baht per month or less). About three-fourths (74%) were single. Before entering rehabilitation, most (71%) lived in a household with two to five family members. Over half lived with parent(s) and described the home environment as loving and supportive. Most felt they could consult family members if they had personal problems. Only 38% said there was conflict in the household. (44%) of the sample were 16 when they first used meth, while the youngest age at first use was 10 years. Two-thirds had been using meth for more than 3 years, and nearly all (97%) smoked the drug. Over half (57%) used meth 1 to 3 times per week, and most used one or more pills at last dose. Fully 83% used legal drugs in combination with meth (e.g., tobacco, alcohol, stimulant drinks or cough medicine). Illegal drugs used with meth include Ice and marijuana. This is the first treatment/rehabilitation for about half (53%) of the sample. Most of the therapy is counseling or counseling with some chemical medication (67%).

5.1.2 Depression

One-third of the sample score within the range of 31-40 points, indicating presence of clinical depression.

5.1.3 Negative automatic thought

About one out of seven of the sample had high levels of negative automatic thought, while an equal proportion had very low frequency of negative automatic thought. This study found that the sample had negative automatic thought for beliefs but there were no distinct differences among groups. Overall, the mean score for negative automatic thought was 123.98 and more than half the sample of meth addicts had negative automatic thought under this mean (56%).

5.1.4 Dysfunctional attitudes

Fully 14% of the sample had dysfunctional attitude scores while 11% did not have scores indicating dysfunctional attitudes. Most of the meth addicts had moderate levels of dysfunctional attitudes while 39% had lower scores and 35% had higher scores.

5.1.5.Cognitive Distortion (CD)

1.) For the dimension of social relationships, CD in this sample was characterized by Should Statements all of the time for 19% of the sample, followed by Minimizing or Disqualifying the Positive all the time (12%) and Catastrophizing for 15%.

2.) For the dimension of personal achievement, CD was characterized by Minimizing or Disqualifying the Positive all the time for 11% of the sample, followed by Mental Filter (9%). Lowest manifestations of CD were for Labeling (6%) and Overgeneralization (4%).

The mean and standard deviation for CD across the ten manifestations was greatest for Minimizing or Disqualifying the Positive for both dimensions. Other manifestations of CD, Mindreading, Catastrophizing, All - or - Nothing Thinking, Mental Filter, Overgeneralization, Emotional Reasoning, and Personalization had similar means and score rankings. The CD characteristics of Labeling and Should Statements had inconsistent mean scores and considerably different ranking.

5.1.6 Kolmogorov-Smirmov Test of Normality

The scores of variables for cognitive distortion and dysfunctional attitudes had normal distributions.

5.1.7 The correlation analysis of the ten characteristics of CD for the dimension of social relationships found that almost all ten thought characteristics had statistically significant correlations at the level of p< = 0.01. The only exception was the correlations of Should Statements with Catastrophizing and All-or-Nothing Thinking, which were significant at the level of p< = 0.05.

5.1.8 The correlation analysis of the ten characteristics of CD for the dimension of personal achievement found that all ten thought characteristics had statistically significant correlations at the level of p< = 0.01.

5.1.9 The correlation analysis of CD with personal characteristics, economic status, and family relationships found that all three characteristics did not have a statistically signification correlation with CD.The correlation analysis of CD, negative automatic thought, dysfunctional attitude and depression found that the correlations between these variables were significant at the level of p< = 0.00.

5.2 Discussion

Age

The clustering of male meth addicts between the ages of 22-25 is consistent with the data from the 2011National Survey on Drug Use and Health (127) in North Carolina, USA which found that most addicts were age 18 – 25 years, whereas the study of Rebecca McKetin et.al (131) documented an age range of 16-54 years (83%) among a sample of 158 addicts, with mean age of 31 years. Suzette Glasner - Edwards, et al. (132) studied a group of addicts age 18 or older. The New Zealand Health Survey (NZHS) (137) documented an age range of meth addicts from 16 to 64 years, while a study in Europe found an age range of 15-34 years (156). These data are consistent with the study of Pithak Surayajai and Bang-on Supreeda (135) who found that their sample of meth addicts was all males with age ranging between 22 and 25 years (60%), and with the study by Banjong Phathong (136) who documented an age range between 15 and 24 years for 50% of their sample of meth addicts. The age data for this study of meth addicts is consistent with the data from the ONCB which indicates a clustering between the ages of 18 and 24 years (50%) (139) .

Most start rehabilitation in the 15-19 age group. The relatively young age of meth addiction is explained by the fact that adolescence is a time for experimentation and following the peer group. However, early age of initial drug use is associated with risk of serious addiction in early adulthood.

Educational Attainment

This study found that most the meth addicts had completed only high school, which is different from the findings of M Suresh Kumar, Dr. Subha Kuma (138) who found in their sample that 63% had completed college and one-fifth had only high school. By contrast, this study's findings are consistent with the study by Suzette Glasner-Edwards, et al (132) who found that, in their sample of 526 addicts, one-third had high school education. On the other hand, the study by Perry N Halkitis (141) found that, among homosexual meth addicts, most (72%) had completed college education, while Diana B.Petitti Stephen et.al (142) found that most of the addicts in their sample had vocational education or less. The study by Chalermsri Rachanajan (148) found that most of the meth addicts in her sample had only vocational level education. Thus, there may be some causative association between education level and risk for meth addiction.

Economic Status

Two-thirds (69%) of the sample worked in wage labor and made less than 9001 baht per month. This finding is similar to the study of Suzette Glasner-Edwards, et al (132) which found that 60% of its sample of 526 meth addicts worked in wage labor. By contrast, Diana B.Petitti Stephen et.al (142) found that meth or cocaine addicts had higher incomes than the Thai addicts with 64% reporting an income ranging from $20,000 to $35,000 per year. The ONCB reports that meth addicts tend to spend an increasing amount of their income on drugs as their addiction worsens, and this reduces their ability to meet daily or monthly financial obligations. This increased level of poverty isolates the addicts from social services and job opportunities. Some addicts become estranged from family and friends and, thus, lose that source of support. In this way, the meth addicts descends into a repeat cycle of poverty and rejection.

Marital Status

Most of this sample of Thai meth addicts was single, and that is consistent with the study by Barbara K. Campbell, Michael J. Stark (143) in their sample of 100 drug addicts (58% single) and with the study of alcohol abuse by Diana Dinescu, University of Virginia among 2,400 pairs of twins. The latter study found that married persons consumed less alcohol than their single counterparts. Data from the National Institute on Alcohol Abuse and Alcoholism (133) found that 6% of married persons were heavy drinkers while 10% of single persons were heavy drinkers. This pattern is also true for use of marijuana. However, these studies were cross-sectional and, thus, it is not possible to infer causality between drug use and marital status (145).

Family Relationships

The majority of the sample (88-92%) said their family environment was loving, supportive, and open to discussion of problems if they occur. In contrast, a study by Benjamin P.Bowser Carl O Word, Toby Seddon (152) found that only 38% had supportive and balanced families. Allan R. Anderson and Carolyn S. Hery (153) found an association between family relationships and adolescent drug use as did Kanokrat Jamwatakul (140), Pawinee Yuprasern (150), Chalermsri Ratchanajan (148) and Wanchai Thammasajakan (151) though most drug users reported the family environment as warm, loving and supportive. By contrast, Shilts, Lee (144) studied alcoholics and drug addicts and found that 22% and 54%, respectively, reported conflict and stress in the family. Also, Peggy L. Ferguson (145) found that drug addiction was associated with parasitic relationships in the family, and Pajongjit Inthasuwan (147) found that 83% of drug addicts had problems with their family and family obligations. The different contexts and societies of these studies could explain the contradictory findings. The study by Tanita Hiranthep et al (149) is noteworthy for its findings on lack of relapse among recovering addicts who were more successful in staying drug-free if they had strong family support.

History of Treatment/Rehabilitation

Over half (53%) of the sample had never been in a drug rehabilitation program before, even though most had been using meth for three years or more. This

finding is consistent with the study by Perry N. Halkitis, Kelly A. Green, and Paris Mourgues (141) who found that only 60% of their sample had been treated for addiction in the past. Average duration of treatment in Thailand is 30 days. By contrast, the Wiwat Pholamuang Academy confines the drug addicts to a compulsory, in-patient four-month program (Fast Model). That program involves counseling, group therapy, and training in remaining drug-free. The Ban Metta therapeutic community managed by the Chumpae District Hospital is a one-month program of detoxification, and cognitive behavioral therapy. Branches of Thanyarak Hospital in Khon Kaen and Songkhla use the Fast Model. Programs in California use a Matrix Institute Treatment Programs and Cognitive Behavioral Therapy, supplemented by group education, counseling after-care planning, aversion therapy, and medication. There is also the Iowa Case Management model that is used in some programs.

Depression

As noted, about one-third of meth addicts in this study had symptoms of clinical depression. This finding is consistent with the study of college students by Steven D.Hollon, Philip C. Kendall (78) who found that depression was associated with personal maladjustment, negative self-concept, and negative expectations. Roberts, R. E., Attkisson, C. C. and Rosenblatt, A. (128) found that cases with depression had a history of family discord or violence. Drug use disrupts the release of Serotonin, Norepinephrine and Dopamine, and this is associated with reduced ability to control moods and, eventually, depression. As published in the Current Opinion in Psychiatry, a study by Davis L1, Uezato A, Newell JM, Frazier E (130) found that from 27-40% of substance abusers had depression, and Deykin, J C Levy (134) found prevalence of depression (in a sample of 424 individuals age 16-19) of 7% for alcohol abusers and 9% for other addictive substances. Many studies have demonstrated the relationship between alcohol abuse and depression. Rebecca McKetin et.al (131) studied depression in 400 meth addicts age 16-54 and found 82% had some symptoms of depression, and those findings are consistent with the study by Ladda Saenha (110) who found that, among deviant 6^{th} year high school students, 14% had slight depression, while 20% had moderate depression and 3% had severe depression. In the McKetin study, meth addicts explained that their drug use was an adaptation to life

challenges, a sense of desolation, stress, sorrow, low self-esteem, and low sense of self-worth. A study by Pajongjit Insuwan (147) found that non-addicted youth were more knowledgeable about addictive substances, had a positive self-image, and had high self-awareness. Those findings are consistent with the study by Yong Zhang (119) who found that youth with depression had low self-image, came from lower-income families, had internalizing behavior, and had emotional disorders (98).

Negative Automatic Thought

Fully 16% of the sample in this study reported having considerable negative automatic thought on a regular basis, and this can lead to clinical depression, bipolar disorder and personal/professional failure. These findings are consistent with the study of Hsiao Tien Wang (96) which looked 970 college students age 18-22 years in Taiwan. The research found that negative automatic thought adversely affected participation in group activities and academic performance, and led sufferers to withdraw from social activities and fear close relationships. Ladda Saenha (110) studied depression and negative automatic thought in 709 6^{th} year high school students and found a correlation with level of depression. Kannika Sithipong (111) and Thanpanik Payamongol (112) found an association between youth delinquent behavior and negative automatic thought, while Athanya Buntham (113) studied the relationship between depression and negative automatic thought among chronic alcohol abusers and also found a positive correlation between both phenomena. That finding is consistent with the study by Mark A. Lau & Emily A. Haigh (146) of depressives and non-depressives, and found that negative emotions could not be triggered among those who never had depression (91). Rick E. Ingram and Kathleen S. Wisnicki (114) and Alan E. Kazdin (115) found an association between moderate depression and negative automatic thought.

Dysfunctional Attitudes

In this sample of Thai male meth addicts 14% reported a high level of dysfunctional attitudes, and that finding is consistent with the study of Linda D. Nelson, et.al. (154) who studied cases with adjustment malfunction and depression. The researcher found a statistical relationship between dysfunctional attitudes and

depression. L. Esther de Graaf, et.al (52) summarized the findings of Teasdac (58) about dysfunctional attitudes, and observed that abnormal beliefs can trigger depression. This is consistent with the study by Siavash Talepasand (160) who found that dysfunctional attitudes were an antecedent to depression (schema) and had their roots in childhood trauma.

Cognitive Distortion (CD)

This study found that 19% of the sample had CD all the time, while 28% had CD some of the time. This finding is consistent with Brenda Chabona, Clive J. Robinsa (155) who attempted to prove that persons without depression had lower CD than depressives who were not drug addicts. The level of CD in cases of depression and those with suicidal tendencies may be prescriptive for cognitive therapy, especially among drug abusers. This is consistent with Marton, S. Kutcher (117) who reported that youth with depression had higher CD levels. Kadir Özdel (118) found a six-fold higher level of CD in cases with one of six types of mental disorder, compared with those without disorders. CD cases display Mental Filtering, Overgeneralization, Catastrophizing, Emotional Reasoning, and All-or-Nothing Thinking. In the present study, Minimizing or Disqualifying the Positive was detected in 16% of the sample, and this is consistent with detection of CD in youth in the study by Tracy Kempton (120) and Aysel Esen Cobin (124) who looked at the relationship between CD, stress, and life difficulty in 391 college students. Students cope by using imaginary tricks, avoidance, and seeking social support. Kai - YeinTeo, Yee - How Say (125) studied depression and CD among university students in Malaysia and found that 23% had symptoms of clinical depression (BDI and ATQ) and also found that severity of depression correlated with level of CD and drug use. Finally, the study by Roger Covin (126) found an association between CD, depression, anxiety and mood disorders.

The present research has helped to illuminate the linkage between automatic thought of Thai male meth addicts and other psychological manifestations. Frequency of negative thought contributes to the level of depression, ability to cope with dysfunctional attitudes declines, and CD increases.

5.3 Limitations of Data Collection

Some participants may have lacked confidence in being fully honest in response to some of the questionnaire items if they were in one of the compulsory rehabilitation programs. This might have impacted on internal consistency of response. The addicts are already on guard about admitting to their meth addiction and, thus, might be guarded in their responses. Also, the treatment/rehabilitation centers may not have recognized the importance of the study and, thus, did not provide full cooperation. Some may have been concerned that the research would reflect negatively on their institution and, thus, did not fully cooperate.

5.4 Recommendations

Over one-third of the sample in this study (37%) did not have CD, while 63% had CD some of the time. There was a statistically significant relationship between automatic thought dysfunctional attitudes and depression. Based on the findings of this study, the following are recommendations:

- Treatment and rehabilitation programs should encourage assessment of CD among the cases to improve understanding of the cognitive patterns and prevalence among meth addicts, and the relationship to problem behavior;
- Determining the type of the CD can improve efficiency of treatment and rehabilitation by tailoring interventions to case profiles and reduce relapse;
- The data from this research can be useful for treatment and rehabilitation programs for male meth addicts and improve understanding by program staff of what the addict is experiencing and what to expect. In this way, programs will be better equipped to help cases with CD to prevent or control problem attitudes and behavior, and these will serve as life skills when the recovering addict returns to the community and improve treatment outcomes;

Future studies should include qualitative data collection methods (e.g., in-depth interviews) in conjunction with interventions to address the different types of CD.

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APPENDICES

APPENDIX A

Research Questionnaire

Cognitive Models of Drug Users

Preliminary explanation:

1. You are kindly requested to answer every item in this questionnaire completely and truthfully. Please express your thoughts frankly. You do not have to enter your name or address on the questionnaire.

2. This questionnaire was created to study cognitive models of methamphetamine users as part of a Masters of Arts degree program of Mahidol University.

3. This questionnaire has 129 items in the following five sections:

Section 1: General information: 18 items

Section 2: Depression: 21 items

Section 3: Automatic throught: 30 items

Section 4: Dsyfuntion Attitudes: 40 items

Section 5: Cognitive Distotion: 20 items

The researcher is very grateful for taking your valuable time to fill out this questionnaire.

Section 1 General Information

Explanation: Mark an √ in the brackets [ ] which reflects your answer, or write the answer in the space provided. Please be as truthful as possible.

1.Age…….years ……months (up to the date of filling out this questionnaire)

2. Education

[ ] 1. Less than high school [ ] 2. High school [ ] 3. Vocational

[ ] 4. Associate Arts, Diploma [ ] 5. Bachelors [ ] 6. Higher than bachelors

3. Are you currently working, and receive your own income?

[ ] 1.yes [ ] 2. No/in school/head of household (skip to Item 6)

4. What is your occupation?

[ ] 1. Farming [ ] 2. Sales [ ] 3. Government worker [ ] 4.Wage labor

[ ] 5 other…….

5. Monthly income……

6. Marital status [ ] 1. single [ ] 2. married [ ] 3. Divorced/separated

[ ] 4. widowed

7.Number of household members…….(including yourself)

8.Who are you living with?

Specify by relation to you (e.g., father, mother, brother, sister, etc.) ……

9.How are the relations among members of your household?

9.1 Loving and considerate	[ ] 1.Yes	[ ] 2.No
9.2 Caring	[ ] 1.Yes	[ ] 2.No
9.3 Eager to provide assistance	[ ] 1.Yes	[ ] 2.No
9.4 There is conflict	[ ] 1.Yes	[ ] 2.No
9.5 Open to discussion of problems	[ ] 1.Yes	[ ] 2.No

10.How old were you when you first starting using methamphetamines? …….. years

11.What was your frequency of methamphetamine use

[ ] 1.1-3 times/week [ ] 2. Every other day [ ] 3. Most days of the week

12. Last use of methamphetamines times: ……(day/month/year) Number of pills taken….

13. Method of use of methamphetamines

13.1oral pill [ ] 1.Yes [ ] 2. no

13.2 smoking [ ] 1.Yes [ ] 2.No

13.3 injection [ ] 1.Yes [ ] 2.No

14.Did you use other addictive drugs concurrently with methamphetamines or in place of methamphetamines?

[ ] 1. yes [ ] 2.no (skip to Item 16)

15. What drugs did you use concurrently with methamphetamines or in place of methamphetamines? (multiple response allowed)

[ ] 1. cigarettes [ ] 2. alcohol [ ] 3. Coffee/tea

[ ] 4. Energy tonic [ ] 5 marijuana [ ]6. Heroin [ ] 7 thinner

[ ] 8.sleep medication [ ] 9. tranquilizer [ ] 10 pain medication [ ] 11 cough medicine

[ ] 12.Krathom leaves [ ] 13. codeine [ ] 14 other……

16.Did you ever enter rehabilitation for drug addiction?

[ ] 1.Yes……times [ ] 2. Never (skip to Section 2)

17. Last place of rehabilitation ……

18.Type of rehabilitation

[ ] 1. Oral medication [ ] 2. counseling [ ] 3. Both methods

Section 2 Beck's Depression Inventory This depression inventor can be self-scored. The Scoring scale is at the end of the questionnaire.

1.

0 I do not feel sad.

1 I feel sad

2 I am sad all the time and I can't snap out of it.

3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.

1 I feel discouraged about the future.

2 I feel I have nothing to look forward to.

3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2 As I look back on my life,all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.

1 I don't enjoy things the way I used to.

2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything

5.

0 I don't feel particularly guilty

1 I feel guilty a good part of the time.

2 I feel quite guilty most of the time.

3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.

1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.

2 I would like to kill myself.

3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I every was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12.

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me unattractive.

3 I believe that I look ugly.

15.

0 I can work about as well as before.

1 It takes an extra effort to get started at doing something

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16.

0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.

1 I have lost more than five pounds.

2 I have lost more than ten pounds.

3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches ,pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I have almost no interest in sex.

3 I have lost interest in sex completely.

Section (ATQ*) Listed below are a variety of thoughts that pop into people's heads. Please read each thought and indicate how frequently, if at all, the thought occurred to you over the last week. Please read each item carefully and circle the appropriate answers on the answer sheet in the following fashion Z1= "not at all" ,2="sometimes",3="moderately often",4="often" ,and 5="all the time"). Then, please indicate how strongly, if at all, you tend to believe that thought, when it occurs. On the right hand side of the page, circle the appropriate answers in the following fashion Z1="not at all",2="somewhat",3="moderately",4="very much", and 5="totally).

Frequency	Items	Degree of Belief
1 2 3 4 5	1) I feel like I'm up against the world	1 2 3 4 5
1 2 3 4 5	2) I'm no good.	1 2 3 4 5
1 2 3 4 5	3) Why can't I ever succedd?	1 2 3 4 5
1 2 3 4 5	4) No one understands me.	1 2 3 4 5
1 2 3 4 5	5) I've let people down.	1 2 3 4 5
1 2 3 4 5	6) I don't think I can go on.	1 2 3 4 5
1 2 3 4 5	7) I wish I were a better person	1 2 3 4 5
1 2 3 4 5	8) I'm so weak.	1 2 3 4 5
1 2 3 4 5	9) My life's not going the way I want it to	1 2 3 4 5
1 2 3 4 5	10) I'm so disappointed in myself.	1 2 3 4 5
1 2 3 4 5	11) Nothing feels good anymore.	1 2 3 4 5
1 2 3 4 5	12) I can't stand this anymore.	1 2 3 4 5
1 2 3 4 5	13) I can't get started.	1 2 3 4 5
1 2 3 4 5	14) What's wrong with me?	1 2 3 4 5
1 2 3 4 5	15) I wish I were somewhere else.	1 2 3 4 5
1 2 3 4 5	16) I can't get things together.	1 2 3 4 5
1 2 3 4 5	17) I hate myself.	1 2 3 4 5
1 2 3 4 5	18) I'm worthless.	1 2 3 4 5
1 2 3 4 5	19) Wish I could just disappear.	1 2 3 4 5
1 2 3 4 5	20) What's the matter with me?	1 2 3 4 5
1 2 3 4 5	21) I'm a loser.	1 2 3 4 5
1 2 3 4 5	22) My life is a mess.	1 2 3 4 5
1 2 3 4 5	23) I'm a failure.	1 2 3 4 5
1 2 3 4 5	24) I'll never make it.	1 2 3 4 5
1 2 3 4 5	25) I feel so helpless.	1 2 3 4 5
1 2 3 4 5	26) Something has to change	1 2 3 4 5
1 2 3 4 5	27) There must be something wrong with me	1 2 3 4 5
1 2 3 4 5	28) My future is bleak.	1 2 3 4 5
1 2 3 4 5	29) It's just not worth it.	1 2 3 4 5
1 2 3 4 5	30) I can't finish anything	1 2 3 4 5

Section 4 (DAS) This questionnaire lists different attitudes or beliefs which people sometimes hold. Read **each** statement carefully and decide how much you agree or disagree with the statement. For each of the attitudes, indicate to the left of the item the number that ***best describes how you think.*** Be sure to choose only one answer for each attitude. Because people are different, there is no right answer or wrong answer to these statements. Your answers are confidential, so please do not put your name on this sheet.

To decide whether a given attitude is typical of your way of looking at things, simply keep in mind what you are like ***most of the time.***

1 = Totally agree
2 = Agree very much
3 = Agree slightly
4 = Neutral
5 = Disagree slightly
6 = Disagree very much
7 = Totally disagree

_____ 1. It is difficult to be happy unless one is good looking, intelligent, rich, and creative.

_____ 2. Happiness is more a matter of my attitude towards myself than the way other people feel about me.

_____ 3. People will probably ***think less of me*** if I make a mistake.

_____ 4. If I do not do well all the time, people will not respect me.

_____ 5. Taking even a small risk is foolish because the loss is likely to be a disaster.

_____ 6. It is possible to gain another person's respect without being especially talented at anything.

_____ 7. I cannot be happy unless most people I know admire me.

_____ 8. If a person asks for help, it is a sign of weakness.

_____ 9. If I do not do as well as other people, it means I am a weak person.

_____ 10. If I fail at my work, then I am a failure as a person

_____ 11. If you cannot do something well, there is little point in doing it at all.

_____ 12. Making mistakes is fine because I can Learn from them.

_____ 13. If someone disagrees with me, it probably indicates he does not like me.

_____ 14. If I fail partly, it is as bad as being a complete failure.

_____ 15. If other people Know what you are really link, they will think less of you.

_____ 16. I am nothing if a person I love doesn't love me.

_____ 17. One can get pleasure from an activity regardless of the end result.

_____ 18. People should have a chance to succeed before doing anything.

_____ 19. My value as a person depends greatly on what others think of me.

_____ 20. If I don't set the highest standards for myself, I am likely to end up a second-rate person.

_____ 21. If I am to be a worthwhile person, I must be the best in at least one way.

_____ 22. People who have good ideas are better than those who do not.

_____ 23. I should be upset if I make a mistake.

_____ 24. My own opinions of myself are more important than others' opinions of me.

_____ 25. To be a good, moral, worthwhile person I must help everyone who needs it.

_____ 26. If I ask a question, it makes me look stupid.

_____ 27. It is awful to be put down by people important to you.

_____ 28. If you don't have other people to lean on, you are going to be sad.

_____ 29. I can reach important goals without pushing myself.

_____ 30. It is possible for a person to be scolded and not get upset.

_____ 31. I cannot trust other people because they might be cruel to me.

_____ 32. If others dislike you, you cannot be happy.

_____ 33. It is best to give up your own interests in order to please other people.

_____ 34. My happiness depends more on other people than it does on me.

_____ 35. I do not need the approval of other people in order to be happy.

_____ 36. If a person avoids problems, the problems tend to go away.

_____ 37. I can be happy even if I miss out on many of the good things in life

_____ 38. What other people think about me is very important.

_____ 39. Being alone leads to unhappiness.

_____ 40. I can find happiness without being loved by another person.

Section 5 THE TYPES OF THINKING SCALE

1. MIND READING

People will sometimes assume that others are thinking negatively about them. This might occur even though the other person has not said anything negative. This is sometimes called mindreading. To illustrate this, please read the following passages:

A. Sonya is having coffee with her boyfriend Jim. Jim is quiet, and Sonya asks if anything is wrong. Jim replies that he is 'Okay.' Sonya does not believe Jim. She starts to think that he is unhappy with her.

B. Bob has been working on a project for weeks. He finally gives the final product to his boss, and is curious about his boss' opinion of his work. After a few days pass, Bob starts to worry that his boss thinks he is incompetent.

Please estimate how often you engage in Mindreading when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Mindreading when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

2. CATASTROPHIZING

People can make negative predictions about the future. When there isn't much evidence for these predictions, it is called Catastrophizing. To illustrate, please read the following passage:

A. John is in his first year of university. He just received a 70 on his Biology exam. He immediately starts to worry that he will end up with a low grade in the course, and that he'll have a tough time getting into medical school.

Instructions: We would like to find out about the different types of thinking you use. In this questionnaire, you will read about 10 types of thinking. You will be given a description of each thinking type. You will also read two case examples that help explain the thinking type. There will always be two case examples: one dealing with

social relationships (such as friends, partners and family) and one that deals with personal achievements (such as passing a test or failing a task at work). These case examples are used to help you understand how each type of thinking might look in a real life scenario.

Your task is to try and understand the thinking type that is described. Then, you are asked to estimate how often you use that type of thinking. You will be asked to think about how often you use that type of thinking in the two domains previously described (social and achievement scenarios). Please take time to think about your answers.

B. Tina's boyfriend just gave her some feedback about their relationship. He told her that he would like to spend a little more time with his friends. Based on his feedback, Tina starts to predict that they will start to become distant, and eventually break-up.

Please estimate how often you engage in Catastrophizing when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Catastrophizing when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Catastrophizing when in achievement situations (such as school or work).

3. ALL-OR-NOTHING THINKING

When people make evaluations, they can view things as being "either-or." For example, a concert can be considered to be either good or bad. On the other hand, people can also see shades of gray when making evaluations. For example, a concert can have some negative aspects, but be considered fairly good overall. When a person considers something as being either good or bad, we call that all-ornothing thinking. To illustrate this point further, please read the following passages:

A. Brian gets a B+ on an exam. He is disappointed because it was not an A. He tends to view success on exams as follows: 'I either do great, or my performance is a failure.

B. Erin is the type of person who either likes a person, or dislikes them. You're either in her "good book" or you're not.

Please estimate how often you use All-or-Nothing Thinking when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Catastrophizing when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

4. EMOTIONAL REASONING People can believe something to be true because it "feels" that way. To illustrate, please read the following passages:

A. Kim's friends told her that she could not come to the concert with them because they were unable to get enough tickets for everyone. Kim knows they probably didn't exclude her on purpose, but she feels rejected. Therefore, part of her believes she was rejected.

B. Ted's boss told him that his performance at the company has been good. Yet, Ted wonders if he could have done better. In fact, he feels like a failure. Consequently, he starts to believe he is a failure.

Please estimate how often you engage in Emotional Reasoning when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Emotional Reasoning when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

5. LABELING

People can label themselves as being a certain kind of person. If this occurs after something bad happens, it is called labeling. To illustrate, please read the following passages:

A. While at a social event, John asks a woman if she would like to dance. She turns him down. As a result, John considers himself to be a loser.

B. During class, Allison's teacher asks if anyone knows the answer to a question. Allison raises her hand and gives an answer. Her teacher says 'Unfortunately, that is incorrect. Does anyone else know the answer?' Allison tells herself that she is a moron.

Please estimate how often you engage in Labeling when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Labeling when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

6. MENTAL FILTER People sometimes have a filter for information. When there is positive and negative information, they only focus on the negative information. This is called Mental Filtering. To illustrate, please read the following passages:

A. Lauren overhears her new boyfriend , Tom, telling his friends about her. He says 'Yeah, things are going great so far. She's really smart and fun to be with, and we have a lot in common. She can be a bit demanding at times, but that's OK.' Although Tom had mostly positive things to say, Lauren dwelled on the one negative comment, and felt bad.

B. Ed is a high school student. He is reading comments from his teacher regarding his recent essay. His teacher wrote 'Ed, you have an excellent way of expressing ideas. I really enjoy the way you write. However, you should try and make better transitions

from one idea to another.' Despite the fact that Ed clearly performed well, he could only think about the one piece of criticism, and felt poorly about himself.

Please estimate how often you engage in Mental Filtering when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Mental Filtering when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

7. OVERGENERALIZATION When a negative event occurs, people might assume more bad things are going to happen. They see the negative event as the start of a pattern. To illustrate, please read the following passages: A. Janet's boyfriend just broke up with her. She thinks to herself: 'I am never going to get into a stable relationship.'

B. William recently failed his math exam. He thinks to himself: 'I'll probably fail the exams in my other courses as well.'

Please estimate how often you engage in Overgeneralization when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Overgeneralization when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

8. PERSONALIZATION

People can believe they are responsible for negative things, even though they're not. In other words, they take a negative event, and assume they are the cause of it. This is called Personalization. To illustrate, please read the following passages:

A. Sally's company did not get an important contract. Although many people worked hard on this project, she assumes that it is her fault.

B. Chris' best friend has been in a bad mood lately, and it has been hard to get in contact with him. Chris assumes that he must have personally done something wrong to make his friend act this way.

Please estimate how often you engage in Personalization when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you engage in Personalization when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

9. SHOULD STATEMENTS People sometimes think that things should or must be a certain way. To illustrate, please read the following passages:

A. "Billy is upset with getting an 85 on his exam because he thinks he should get at least a 90. He often has these thoughts for many things (e.g., he feels he should never drop a pass when playing football; his room should be organized a certain way)."

B. "Anne believes that she must be funny and interesting when socializing."

Please estimate how often you tend to make Should Statements when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you tend to make Should Statements when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

10. MINIMIZING OR DISQUALIFYING THE POSITIVE

People can sometimes ignore the positive things that happen to them. This is called Minimizing or Disqualifying the Positive. To illustrate, please read the following passages:

A. "Brenda works as a real estate agent. Her boss recently told her that she did a wonderful job on a recent sale. In her head, she dismisses her achievement because she probably 'just got lucky.'

B. "Cory is getting ready for a big first date. His friends tell him he looks good. He dismisses their complement because he thinks they're just trying to be nice."

Please estimate how often you tend to Minimize or Disqualify the Positive when in social situations (like when you're with friends, partners or family):

1 2 3 4 5 6 7

Never Sometimes All The Time

Please estimate how often you tend to Minimize or Disqualify the Positive when in achievement situations (such as school or work).

1 2 3 4 5 6 7

Never Sometimes All The Time

แบบสอบถาม เลขที่..

แบบสอบถามเพื่อการวิจัย

รูปแบบความคิดของผู้เสพติดยาบ้า

คำชี้แจง

1. ขอความอนุเคราะห์ให้ท่านตอบแบบสอบถามให้ครบทุกข้อตามความเป็นจริง แสดงความคิ
อย่างอิสระ และไม่ต้องลงชื่อ ที่อยู่ในแบบสอบถาม

2.แบบสอบถามนี้ จัดทำขึ้นเพื่อการศึกษาวิจัยรูปแบบความคิดของผู้เสพติดยาบ้าซึ่งเป็นส่ว
ของการศึกษาหลักสูตร ปริญญาศิลปศาสตรมหาบัณฑิต (วิทยาการเสพติด) บัณฑิตวิท
มหาวิทยาลัยมหิดล

3.แบบสอบถามชุดนี้ประกอบด้วยข้อคำถามทั้งหมด 129 ข้อ มี5 ส่วน คือ

ส่วนที่ 1: แบบสอบถามข้อมูลทั่วไปจำนวน 18 ข้อ

ส่วนที่ 2: แบบสอบถามภาวะซึมเศร้าจำนวน 21 ข้อ

ส่วนที่ 3:แบบสอบถามความคิดอัตโนมัติ จำนวน 30 ข้อ

ส่วนที่ 4:แบบสอบถามทัศนคติจำนวน 40 ข้อ

ส่วนที่ 5:แบบสอบถามความคิด จำนวน 20 ข้อ

ผู้วิจัยขอขอบพระคุณทุกท่านที่ได้สละเวลาอันมีค่า ในการตอบแบบสอบถามฉบับนี้

ส่วนที่ 1 แบบสอบถามข้อมูลทั่วไป

คำชี้แจง ให้ใส่เครื่องหมาย √ ลงในช่อง [ ] หน้าข้อความที่ตรงกับข้อมูลของท่านหรือเติมข้อความลงในช่องว่าง กรุณาตอบแบบสอบถามตรงกับความเป็นจริงของท่านมากที่สุด

1.อายุ…….ปี ……เดือน(นับถึงวันที่ท่านทำแบบสอบถาม)

2. ระดับการศึกษา

[ ] 1. ต่ำกว่ามัธยมศึกษา [ ] 2. มัธยมศึกษา [ ] 3. อาชีวศึกษา (ปวช./ปวส.)

[ ] 4. อนุปริญญา / ประกาศนียบัตร [ ] 5. ปริญญาตรี[ ] 6. สูงกว่าปริญญาตรี

3.ท่านทำงานและมีรายได้เป็นของตนเองหรือไม่

[ ] 1. มี [ ] 2. ไม่มี /นักเรียน / พ่อบ้าน แม่บ้าน (ข้ามไปตอบข้อที่ 6)

4.ถ้าท่านทำงานและมีรายได้เป็นของตนเอง ท่านทำอาชีพอะไร

[ ]1.เกษตรกร [ ] 2. ค้าขาย [ ]3.รับราชการ [ ]4.รับจ้างทั่วไป [ ]5อื่นๆระบุ……

5.ท่านมีรายได้เดือนละ……

6.สถานภาพสมรส[ ]1. โสด [ ]2.คู่ [ ]3.หย่า/แยก [ ] 4. หม้าย

7.ในครอบครัวของท่านมีสมาชิกอยู่ในครอบครัวกี่คน…….(รวมถึงผู้ตอบคำถาม)

8.ปัจจุบันท่านอาศัยอยู่กับใครบ้าง (ตัวอย่าง เช่น พ่อ แม่ พี่น้อง เป็นต้น)

กรุณาระบุเป็นความสัมพันธ์กับท่าน……..

9.ความสัมพันธ์ภายในครอบครัวของท่านเป็นอย่างไร

9.1 มีความรักใคร่ให้โอกาสกันดี [ ]1.ใช่ [ ]2.ไม่ใช่

9.2มีความเอื้ออาทรต่อกัน [ ] 1.ใช่ [ ] 2.ไม่ใช่

9.3กระตือรือร้นในการช่วยเหลือกันและกัน [ ] 1.ใช่ [ ] 2.ไม่ใช่

9.4 มีความขัดแย้งทางความคิด [ ] 1.ใช่ [ ] 2.ไม่ใช่

9.5 สามารถปรึกษาหารือเมื่อมีปัญหา [ ] 1.ใช่ [ ] 2.ไม่ใช่

10.ท่านเริ่มใช้ยาบ้าครั้งแรกเมื่ออายุ……ปี

11.ความถี่ของการใช้ยาบ้าเป็นอย่างไรในแต่ละครั้ง

[ ] 1.1-3 ครั้ง/สัปดาห์ [ ] 2. วันเว้นวัน [ ] 3. เกือบทุกวัน/สัปดาห์

12.เสพยาบ้าครั้งสุดท้ายเมื่อไร……(วัน/เดือน/ปี)จำนวนที่เสพ…เม็ด วิธีการที่ท่าน เสพ…….

13.ท่านมีวิธีการเสพอย่างไรบ้าง

13.1ด้วยการรับประทาน [ ] 1.ใช่ [ ] 2.ไม่

13.2 ด้วยการสูบ [ ] 1.ใช่ [ ] 2.ไม่ใช่

13.3ด้วยการฉีด [ ] 1.ใช่ [ ] 2.ไม่ใช่

14.ท่านมีการใช้ยาเสพติดตัวอื่นร่วมกับยาบ้าหรือใช้แทนช่วงที่ไม่ได้เสพยาบ้าหรือไม่

[ ] 1.ใช้ [ ] 2.ไม่ใช้ (ข้ามไปตอบข้อที่ 16)

15.ท่านใช้ยาเสพติดตัวใดร่วมกับยาบ้าหรือใช้แทนช่วงที่ไม่ได้เสพยาบ้า (ตอบได้มากกว่า 1 ข้อ

[ ] 1.บุหรี่ [ ] 2.เครื่องดื่มที่มีแอลกอฮอล์ [ ] 3.เครื่องดื่มชากาแฟ

[ ] 4.เครื่องดื่มผสมยากระตุ้น[ ] 5 กัญชา[ ]6.เฮโรอีน [ ] 7สารระเหย

[ ] 8.ยานอนหลับ[ ] 9.ยาคลายเครียด[ ] 10 ยาบรรเทาอาการปวด [ ] 11 ยาแก้ไอ

[ ] 12.กระท่อม [ ] 13.โคเคน [ ] 14อื่นๆ……

16.ท่านเคยเข้ารับการบำบัดเรื่องยาเสพติดหรือไม่

[ ] 1. เคย……ครั้ง [ ]2.ไม่เคยเลย (ข้ามไปตอบส่วนที่ 2)

17. สถานที่ท่านเข้ารับการบำบัดครั้งล่าสุด ระบุสถานที่เข้ารับการบำบัดครั้งล่าสุด……

18.ลักษณะการบำบัดครั้งล่าสุด

[ ] 1.การให้ยารับประทาน [ ] 2. การให้คำปรึกษาพูดคุย [ ] 3.ได้รับทั้ง 2 อย่าง

ส่วนที่ 2 แบบสอบถามด้านอารมณ์

คำชี้แจ้ง ให้ใส่เครื่องหมาย xลงบนหมายเลขหน้าข้อความที่ท่านต้องการตอบให้สมบูรณ์ตร
ความเป็นจริงของท่านมากที่สุด

ข้อ 1. [0] ฉันไม่รู้สึกเศร้า [1] ฉันรู้สึกเศร้า

[2] ฉันรู้สึกเศร้าตลอดเวลาและไม่สามารถสลัดความรู้สึกนั้นออกไปได้

[3] ฉันรู้สึกเศร้าและไม่มีความสุขเหลือเกินจนทนไม่ไหว

ข้อ 2. [0] ฉันไม่หมดกำลังใจต่ออนาคต [1] ฉันรู้สึกหมดกำลังใจต่ออนาคต

[2] ฉันรู้สึกว่าไม่มีอะไรที่ต้องเดินหน้าต่อ

[3] ฉันรู้สึกว่าอนาคตช่างสิ้นหวังและสิ่งต่าง ๆ ไม่อาจปรับปรุงให้ดีขึ้นได้

ข้อ 3. [0] ฉันพึงพอใจในสิ่งต่างๆ เหมือนที่เคยเป็นมา

[1] ฉันไม่พอใจกับสิ่งต่างๆตามแบบที่ฉันเคยเป็น

[2] เมื่อมองย้อนกลับไปดูชีวิตของฉันทั้งหมดที่เห็นคือความล้มเหลวมากมาย

[3] ฉันรู้สึกว่าตัวเองเป็นคนที่ล้มเหลวอย่างแท้จริง

ข้อ 4. [0] ฉันพึงพอใจในสิ่งต่างๆ เหมือนที่เคยเป็นมา [1] ฉันไม่พอใจกับสิ่งต่าง ๆตามแบบที่ฉันเคยเป็น

[2]ฉันไม่ได้รับความพึงพอใจอย่างแท้จริงกับสิ่งใดอีกเลย

[3] ฉันไม่พึงพอใจหรือรู้สึกเบื่อกับทุกสิ่ง

ข้อ 5. [0] ฉันไม่ได้รู้สึกผิด [1] ฉันรู้สึกผิดในบางเวลา

[2]ฉันรู้สึกผิดแทบตลอดเวลา [3] ฉันรู้สึกผิดตลอดเวลา

ข้อ 6. [0] ฉันไม่ได้รู้สึกเหมือนฉันกำลังถูกลงโทษ[1] ฉันรู้สึกว่าฉันอาจถูกลงโทษ

[2] ฉันคาดว่าจะถูกลงโทษ [3] ฉันรู้สึกว่าฉันกำลังถูกลงโทษ

ข้อ 7. [0] ฉันไม่รู้สึกผิดหวังในตนเอง [1] ฉันรู้สึกผิดหวังในตนเอง

[2] ฉันขยะแขยงตัวเอง [3] ฉันเกลียดตัวเอง

ข้อ 8. [0]ฉันไม่ได้รู้สึกว่าฉันแย่กว่าใคร ๆ [1] ฉันพร่ำว่าตัวเองในความอ่อนแอและความผิดพลาด [2]ฉันโทษตัวเองตลอดเวลาสำหรับความผิดของฉัน

[3]ฉันโทษตัวเองสำหรับทุก ๆ สิ่งที่ไม่ดีที่เกิดขึ้นมา

ข้อ 9. [0] ฉันไม่มีความคิดที่จะฆ่าตัวตายเลย [1]ฉันมีความคิดจะฆ่าตัวตายอยู่ แต่ไม่ได้ทำให้สำเร็จ [2] ฉันอยากจะฆ่าตัวตาย [3]ฉันเคยจะฆ่าตัวตายถ้าหากมีโอกาส

ข้อ 10. [0] ฉันไม่ได้ร้องให้มากกว่าปกติ [1] ตอนนี้ฉันร้องให้มากกว่าที่เคย [2] ฉันร้องให้

ตลอดเวลาในตอนนี้ [3] ฉันเคยสามารถร้องให้ได้ แต่ตอนนี้ฉันร้องให้ไม่ได้แม้อยากจะร้องก็ตาม

ข้อ 11. [0] ฉันไม่ไม่ได้โกรธเคืองในสิ่งต่าง ๆ มากกว่าที่เคยเป็นมา [1] ฉันโกรธเคืองมากขึ้นกว่าปกติเล็กน้อย [2] ฉันมักขุ่นเคืองหรือโกรธอยู่บ่อยครั้ง [3]ฉันรู้สึกโกรธเคืองอยู่ตลอดเวลา

ข้อ 12. [0] ฉันไม่เคยหมดความสนใจในบุคคลอื่น ๆ [1] ฉันมีความสนใจในบุคคลอื่น ๆ น้อยลงกว่าที่เคยเป็น [2] ฉันแทบหมดความสนใจในบุคคลอื่น ๆ

[3] ฉันหมดความสนใจในบุคคลอื่น ๆ อย่างสิ้นเชิง

ข้อ 13. [0] ฉันตัดสินใจได้ดีเหมือนที่เคยทำมา [1] ฉันเลื่อนการตัดสินใจออกไปมากกว่าที่เคยทำ [3] ฉันไม่สามารถตัดสินใจอะไรได้อีกเลย

ข้อ 14. [0] ฉันไม่รู้สึกว่าฉันดูแย่ลงกว่าที่เคยเป็นมา [1] ฉันวิตกกังวลว่าฉันดูแก่หรือไม่สวย

[2] ฉันรู้สึกว่ามีความเปลี่ยนแปลงแบบถาวรในรูปร่างหน้าตาของฉันทำให้ฉันไม่สวย

[3] ฉันเชื่อว่าฉันดูขี้เหร่

ข้อ 15. [0] ฉันสามารถทำงานได้ดีพอ ๆ กับที่เคยทำ [1] ต้องใช้ความพยายามมากกว่าเดิมในการเริ่มต้นทำบางสิ่งบางอย่าง [2] ฉันต้องผลักดันตัวเองอย่างหนักเพื่อจะทำสิ่งต่าง ๆ

[3] ฉันไม่สามารถงานใด ๆ ได้เลย

ข้อ 16. [0]ฉันนอนหลับได้เหมือนที่เคยเป็นมา[1]ฉันนอนหลับไม่ดีเท่าที่เคยเป็นมา

[2]ฉันตื่นเร็วขึ้นกว่าปกติ 1-2 ชั่วโมงและหลับต่อได้ยาก

[3]ฉันตื่นเร็วขึ้นหลายชั่วโมงเทียบกับที่เคยเป็นและไม่สามารถหลับต่อได้

ข้อ 17. [0] ฉันไม่รู้สึกเหนื่อยกว่าปกติ [1] ฉันรู้สึกเหนื่อยง่ายกว่าที่เคยเป็นมา

[2] ฉันรู้สึกเหนื่อยจากการทำสิ่งใดๆ เกือบทุกสิ่ง

[3] ฉันรู้สึกเหนื่อยเกินกว่าที่จะทำอะไรได้

ข้อ 18. [0]ความรู้สึกอยากอาหารของฉันไม่ได้แย่ลงกว่าปกติ

[1]ความรู้สึกอยากอาหารของฉันไม่ดีเท่าที่เคยเป็นมา

[2]ความรู้สึกอยากอาหารของฉันแย่ลงไปมากในตอนนี้

[3]ฉันไม่มีความรู้สึกอยากอาหารอีกเลย

ข้อ 19 [0]น้ำหนักของฉันไม่ลดลง[1] น้ำหนักของฉันลดลง1-2กิโลกรัม

[2] น้ำหนักของฉันลดลง3–5กิโลกรัม[3]น้ำหนักของฉันลดลง5 กิโลกรัม

ข้อ 20. [0]ฉันไม่วิตกกังวลเกี่ยวกับสุขภาพของฉันมากกว่าปกติ[1]ฉันวิตกกังวลเกี่ยวกับปัญหาทางร่างกายอย่างเช่น ความเจ็บปวดต่าง ๆ ท้องไส้ปั่นป่วนหรืออาการท้องผูก

[2]ฉันวิตกกังวลเกี่ยวกับปัญหาทางร่างกายและยากที่จะนึกถึงเรื่องอื่นได้อีก

[3] ฉันรู้สึกกังวลเหลือเกินเกี่ยวกับปัญหาทางร่างกายจนไม่สามารถคิดถึงเรื่องอื่นใดได้อีก

ข้อ 21 [0] ฉันไม่สังเกตพบความเปลี่ยนแปลงความสนใจเกี่ยวกับเรื่องเพศของฉัน

[1] ฉันสนใจในเรื่องเพศน้อยลงกว่าที่เคยเป็นมา [2] ฉันแทบจะไม่มีความสนใจในเรื่องเพศ [3] ฉันหมดความสนใจในเรื่องเพศไปโดยสิ้นเชิง

ส่วนที่ 3 แบบสอบถามความด้านคิดอัตโนมัติ

คำชี้แจง กรุณาอ่านแต่ละความคิดที่เกิดขึ้นกับท่านในสัปดาห์ที่ผ่านมาและระบุความถี่ และระดับความเชื่อโดยใส่เครื่องหมาย √ลงในช่อง [ ]หลังข้อความให้ตรงกับความเป็นจริงของท่านมากที่สุด

ระดับความถี่					ข้อความ	ระดับความเชื่อ				
ไม่เคยเลย	บางครั้งบางคราว	ค่อนข้างบ่อย	บ่อย	ตลอดเวลา		ไม่เคยเลย	มีบ้าง	ปานกลาง	มาก	มากที่สุด
					1.ฉันรู้สึกว่าฉันประสบปัญหาในโลกนี้					
					2.ฉันไม่มีส่วนดีเลย					
					3.ทำไมฉันไม่เคยประสบความสำเร็จ					
					4.ไม่มีใครเข้าใจฉันเลย					
					5.ฉันทำให้คนอื่นผิดหวัง					
					6.ฉันไม่คิดว่าฉันจะสามารถก้าวเดินต่อไปได้					
					7.ฉันปรารถนาว่าฉันจะเป็นคนที่ดีกว่านี้					
					8.ฉันรู้สึกอ่อนแอเหลือเกิน					
					9.ชีวิตฉันกำลังไม่เป็นไปตามที่ฉันต้องการ					
					10.ฉันผิดหวังไม่พอใจในตัวฉันมาก					
					11.ไม่มีอะไรทำให้ฉันรู้สึกดีเลย					
					12.ฉันไม่สามารถทนต่อไปได้อีกแล้ว					
					13.เกิดอะไรที่ผิดพลาดขึ้นกับฉัน					
					14.ฉันปรารถนาที่จะไปอยู่ที่อื่น					

ระดับความถี่					ข้อความ	ระดับความเชื่อ				
ไม่เคยเลย	บางครั้งบางคราว	ค่อนข้างบ่อย	บ่อย	ตลอดเวลา		ไม่เคยเลย	มีบ้าง	ปานกลาง	มาก	มากที่สุด
					13.เกิดอะไรที่ผิดพลาดขึ้นกับฉัน					
					14.ฉันปรารถนาที่จะไปอยู่ที่อื่น					
					15.ฉันไม่สามารถบรรลุสิ่งต่างๆพร้อมๆกัน					
					16.ฉันเกลียดตัวเอง					
					17.ฉันเป็นคนไม่มีค่า					
					18.ฉันปรารถนาว่าให้ตัวฉันหายไป					
					19.ฉันไม่สามารถเริ่มต้นใหม่ได้					
					20.นี่มันเกิดอะไรขึ้นกับฉัน					
					21.ฉันคือผู้แพ้					
					22.ชีวิตฉันยุ่งเหยิง					
					23.ฉันเป็นคนล้มเหลว					
					24.ฉันไม่สามารถทำสิ่งใดๆได้เลย					
					25.ฉันรู้สึกสิ้นหวังจริง					
					26.บางสิ่งบางอย่างจะต้องมีการเปลี่ยนแปลง					
					27.ต้องมีบางสิ่งที่ผิดพลาดเกิดขึ้นกับตัวฉัน					
					28.อนาคตของฉันสิ้นหวัง					
					29.ฉันไม่มีคุณค่าคู่ควรอะไรเลย					
					30.ฉันไม่สามารถทำอะไรให้สำเร็จได้เลย					

ส่วนที่ 4 แบบสอบถามด้านทัศนคติ

คำชี้แจง แบบสอบถามนี้เป็นการสอบถามทัศนคติที่มีต่อบุคคล เหตุการณ์ต่างๆ คำตอบจะไม่มีถูกหรือผิดเป็นการแสดงความคิดเห็นของท่านเท่านั้น ในการตอบสอบถามครั้งนี้ไม่มีการระบุของท่านหรืออ้างถึงตัวบุคคลได้ ขอให้ท่านตอบแบบสอบถามได้อย่างสบายใจ กรุณาตอบคำถามทุกข้อโดยใส่เครื่องหมาย √ ลงในช่อง [ ] หลังข้อความให้ตรงกับความเป็นเห็นของท่านมากที่สุด

ข้อ	ข้อความ	เห็นด้วยทั้งหมด	เห็นด้วยมาก	เห็นด้วยน้อย	เฉย ๆ	ไม่เห็นด้วยน้อย	ไม่เห็นด้วยมาก	ไม่เห็นด้วยทั้งหมด
1	มันเป็นเรื่องยากที่จะมีความสุข ยกเว้นฉันดูดี, เฉลียวฉลาด รวยและสร้างสรรค์							
2	ความสุขเป็นเรื่องของทัศนคติของฉันที่มีต่อตัวฉันเองมากกว่าความรู้สึกที่คนอื่นมีต่อตัวฉัน							
3	คนอื่นจะคิดถึงฉันน้อยลงถ้าฉันทำผิดพลาด							
4	ถ้าฉันไม่ทำดีตลอดเวลาคนเขาจะไม่เคารพฉัน							
5	การรับความเสี่ยงเพียงเล็กน้อยก็เป็นเรื่องโง่ได้เพราะเป็นการสูญเสียถึงขั้นหายนะได้							
6	มันเป็นไปได้ที่คนอื่นจะให้ความเคารพฉัน ทั้งที่ฉันไม่มีความสามารถพิเศษอะไรเลย							
7	ฉันไม่สามารถมีความสุข ยกเว้นว่าคนส่วนใหญ่ที่ฉันรู้จักจะชื่นชมฉัน							
8	การร้องขอความช่วยเหลือเป็นการบอกถึงความอ่อนแอ							
9	ถ้าฉันทำได้ไม่ดีเท่ากับคนอื่น ๆ ก็หมายความว่าฉันเป็นคนอ่อนแอ							
10	ถ้าฉันล้มเหลวเรื่องงาน ก็หมายความว่า ฉันเป็นบุคคลที่ล้มเหลว							
11	ถ้าฉันไม่สามารถทำอะไรบางอย่างได้ดีได้ ก็หมายความว่ามีประเด็นเพียงน้อยนิดเท่านั้นที่ฉันจะทำได้							
12	การทำผิดพลาดเป็นเรื่องยอมรับได้							

ข้อ	ข้อความ	เห็นด้วยทั้งหมด	เห็นด้วยมาก	เห็นด้วยน้อย	เฉย ๆ	ไม่เห็นด้วยน้อย	ไม่เห็นด้วยมาก	ไม่เห็นด้วยทั้งหมด
	เพราะฉันสามารถเรียนรู้จากมัน							
13	ถ้ามีบางคนไม่เห็นด้วยกับฉัน ก็อาจจะเป็นไปได้ว่าเขาไม่ชอบฉัน							
14	แม้ฉันล้มเหลวบางส่วน มันก็แย่พอๆกับล้มเหลวทั้งหมด							
15	ถ้าคนอื่นรู้ในสิ่งที่ฉันชอบจริงๆ เขาจะคิดถึงฉันน้อยลง							
16	ฉันไม่มีความหมายอะไรเลย ถ้าคนที่ฉันรักไม่รักฉัน							
17	คนเราสามารถมีความสุขจากกิจกรรมที่ทำได้โดยไม่ต้องคำนึงถึงผลของกิจกรรมจะอย่างไร							
18	คนเราควรจะมีโอกาสประสบความสำเร็จก่อนที่จะลงมือทำอะไรก็ตาม							
19	คุณค่าความเป็นคนของฉันขึ้นอยู่กับว่าคนอื่นจะคิดอย่างไรกับฉัน							
20	ถ้าฉันไม่ตั้งมาตรฐานสำหรับตัวฉันไว้สูงสุดฉันก็มีโอกาสเป็นคนชั้นสอง							
21	ถ้าฉันจะเป็นบุคคลที่มีคุณค่าโดดเด่นฉันจะต้องเก่งอย่างน้อยที่สุดในทางใดทางหนึ่ง							
22	คนที่มีความคิดที่ดีจะดีกว่าคนที่ไม่มี							
23	ฉันควรจะไม่สบายใจถ้าฉันทำผิดพลาด							
24	ความคิดเห็นของตัวฉันต่อตัวฉันเองมีความสำคัญมากกว่าความเห็นของคนอื่นที่มีต่อตัวฉันมากๆ							
25	เพื่อจะเป็นคนดี มีศีลธรรม มีคุณค่าฉันต้องช่วยทุกคนที่เขาต้องการ							
26	ถ้าฉันถามคำถามก็หมายความว่าฉันดูโง่							

ข้อที่	ข้อความ	เห็นด้วยทั้งหมด	เห็นด้วยมาก	เห็นด้วยน้อย	เฉย ๆ	ไม่เห็นด้วยน้อย	ไม่เห็นด้วยมาก	ไม่เห็นด้วยทั้งหมด
27	มันเป็นสิ่งที่น่ากลัว ถ้าไม่ได้รับการยอมรับจากคนที่มีความสำคัญต่อเรา							
28	ถ้าคุณไม่มีคนให้พึ่งพิง คุณก็ควรจะเศร้า							
29	ฉันสามารถบรรลุเป้าหมายที่สำคัญได้โดยไม่ต้องผลักดันตนเอง							
30	มันเป็นไปได้ที่คนคนหนึ่งอาจจะถูกดูถูกแต่ก็ไม่ได้รับรู้สึกทุกข์ร้อนอะไรเลย							
31	ฉันไม่สามารถไว้ใจคนอื่นๆเพราะพวกเขาอาจจะโหดร้ายกับฉัน							
32	ถ้าคนอื่น ๆ ไม่ชอบคุณ คุณก็ไม่สามารถมีความสุขได้							
33	ดีที่สุดคือการยอมไม่เอาผลประโยชน์ของคุณเพื่อเป็นการเอาใจคนอื่น							
34	ความสุขของฉันขึ้นอยู่กับคนอื่นมากกว่าที่จะขึ้นกับตัวฉันเอง							
35	ฉันไม่เห็นจำเป็นจะต้องได้รับการการยอมรับจากผู้อื่นเพียงเพื่อจะทำให้ฉันมีความสุข							
36	ถ้าฉันหลีกเลี่ยงปัญหา แนวโน้มของปัญหาก็คือจะผ่านไป							
37	ฉันสามารถมีความสุขได้แม้ว่าฉันจะพลาดในสิ่งดีๆหลายสิ่งในชีวิต							
38	สิ่งที่คนอื่นๆคิดเกี่ยวกับตัวฉันเป็นสิ่งมีความสำคัญมากๆ							
39	การอยู่ตามลำพังจะนำไปสู่การไม่มีความสุข							
40	ฉันสามารถพบกับความสุขได้แม้จะไม่เป็นที่รักของคนอื่น							

ส่วนที่ 5 แบบสอบถามแบบสอบถามความคิด

คำชี้แจงให้ท่านแบบประเมินความคิดที่เกิดขึ้นในสถานการณ์ทางสังคมและความสำเร็จของท่าน โดยจะยกตัวอย่างให้ท่านประเมินความคิดว่ามีความถี่ที่เกิดขึ้นของความคิดบ่อยเพียงใด โดยทำเครื่องหมายวงกลมรอบหมายเลขเดียวเท่านั้น

1.สมศรีกำลังดื่มกาแฟกับสมชายแฟนของเธอ สมชายเงียบสงบและสมศรีจึงถามว่ามีอะไรผิดปกติเหรอ สมชายตอบว่า “ฉันโอเค ปกติดี” สมศรีไม่เชื่อว่าสมชายปกติเธอเริ่มคิดว่าเขาไม่มีความสุขที่มีเธอ ให้ท่านประเมินความคิดเหมือนสมศรีบ่อยครั้งแค่ไหน

1 2 3 4 5 6 7

ไม่เคย ตลอดเวลา บางครั้ง

2.บุญมาได้ทำงานโครงการเป็นเวลาหลายสัปดาห์ที่ผ่านมา ในที่สุดเขาก็สามารถทำผลิตภัณฑ์ให้เจ้านายของเขา เมื่อผ่านไปสองสามวันบุญมาเริ่มกังวลว่าเจ้านายของเขาคงจะคิดว่าเขาเป็นคนไร้ความสามารถ ให้ท่านประเมินว่ามีความคิดเหมือนบุญมาบ่อยครั้งแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

3. วันชัยเรียนอยู่มหาวิทยาลัย ชั้นปี 1เขาสอบได้คะแนนวิชาชีววิทยา 70 คะแนน เขากังวลทันทีว่าเขาคงจะได้เกรดน้อยตลอดหลักสูตร และการเข้าเรียนแพทย์ต่อคงจะเป็นเรื่องยาก ให้ท่านประเมินว่ามีความคิดเหมือนวันชัยบ่อยครั้งแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

4.แฟนของสุมาลีได้คุยเกี่ยวกับความสัมพันธ์ระหว่างเขากับเธอ แฟนของสุมาลีบอกว่า อยากมีเวลาอยู่กับเพื่อนมากกว่านี้ คำสะท้อนความรู้สึกนี้ทำให้สุมาลีได้คาดเดาว่า นี้สิ่งนี้จะเป็นเหตุผลที่ทำให้เขาและแฟนต้องห่างกันและสุดท้ายก็จะเลิกกัน ท่านประเมินความคิดเหมือนสุมาลีบ่อยครั้งแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

5.พรชัยสอบได้เกรด B+ พรชัยรู้สึกผิดหวังเพราะเขาไม่ได้เกรด A พรชัยมีแนวโน้มที่จะมองการประสบความสำเร็จจากการสอบว่า ฉันจะต้องได้คะแนนดีเลิศ ถ้าไม่ได้ก็หมายความ ว่าฉันล้มเหลว ให้ท่านประเมินว่ามีความคิดเหมือนพรชัยบ่อยครั้งแค่ไหน

11. สุรีวรรณได้ยินแฟนใหม่ของเธอคุยกับเพื่อนที่ชื่อ อลงกรณ์พูดว่า “ดีมาก ทุกอย่างดำเนินไปด้วยดี . สุรีวรรณเป็นผู้หญิงที่ฉลาด และสนุกสนานเวลาที่อยู่ด้วย แล้วเราก็มีอะไรหลายๆอย่างที่คล้ายๆกัน แต่เธอมีข้อเสียเล็กน้อย แต่ก็โอเคนะ” ถึงแม้ว่าอลงกรณ์จะบอกข้อดีของเธอมากมาย แต่สุรีวรรณยังคงนึกเห็นแต่ความเห็นที่เป็นข้อเสีย และมันทำให้เธอรู้สึกแย่ จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนสุรีวรรณบ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

12. .สมพงษ์กำลังเรียนชั้นมัธยมปลาย สมพงษ์ได้รับคำแนะนำจากอาจารย์หลังจากส่งเรียงความ อาจารย์บอกว่า “สมพงษ์คุณสามารถแสดงความคิดเห็นได้อย่างดีเยี่ยม ผมรู้สึกสนุกที่ได้อ่านงานของคุณ อย่างไรก็ตาม คุณควรพยายามใช้คำเชื่อมจากประโยคหนึ่งไปยังประโยคหนึ่งให้มากขึ้น” แม้จะมีข้อเท็จจริงว่าสมพงษ์ทำงานได้ดี แต่สมพงษ์ยังคงคิดว่า คือ คำตำหนิ และเขารู้สึกว่าตัวเองแย่ จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนสมพงษ์บ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

13. แฟนของฉวีวรรณเพิ่งหักอกจากเธอ และฉวีวรรณจึงคิดกับตัวเองว่า ฉันคงไม่สามารถที่จะมีความสัมพันธ์ที่มั่นคงกับใครได้อีกแล้ว รู้สึกแย่ จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนฉวีวรรณบ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

14. วิทวัส สอบบทเรียนย่อยในวิชาคณิตศาสตร์ไม่ผ่าน ทำให้วิทวัสคิดกับตัวเองว่า เทอมนี้เขาอาจจะสอบวิชาคณิตศาสตร์ไม่ผ่านทำให้รู้สึกแย่ จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนวิทวัสบ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

15. บริษัทของสุรัตน์ยังไม่ได้รับการว่าจ้างทำโครงการสำคัญ ถึงแม้ว่าทุกๆคนกำลังทำงานอย่างหนักอยู่ ซึ่งสุรัตน์คิดว่า มันเป็นความผิดของเขาแน่ๆ จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนสุรัตน์บ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย ตลอดเวลา บางครั้ง

16.. กมลชัยเป็นเพื่อนสนิทของประสิทธ์ กมลชัยกำลังอยู่ในอาการอารมณ์ที่ไม่ดี เขาจึงไม่ติดต่อใคร ประสิทธ์ คิดว่าตัวเองเป็นคนที่ทำให้กมลชัยรู้สึกแย่ กมลชัยจึงแสดงออกแบบนั้น จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนประสิทธ์บ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

17. สุรชัยรู้สึกหัวเสียที่ได้คะแนนสอบ 85 คะแนน สุรชัยคิดว่าเขาควรจะได้90 คะแนน แล้วเขาก็คิดกับตัวเองบ่อยๆจนมีความคิดมากมายในหัว (เช่น เขารู้สึกว่า เขาไม่ควรเล่นฟุตบอล หรือ เขาควรจะจัดการบางอย่าง เขา เชื่อว่า เขาต้องทำตัวให้สนุกสนาน และน่าสนใจเวลาที่เข้าสังคม) จากตัวอย่างท่านคิดว่าท่านเคยคิดเหมือนสุรชัยบ่อยแค่ไหน

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

18.นารีเชื่อว่า เขาต้องทำตัวให้สนุกสนาน และน่าสนใจ เวลาเข้าสังคม ท่านคิดว่าท่านเคยคิดแบบอรุณศรีบ่อยเพียงใด

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

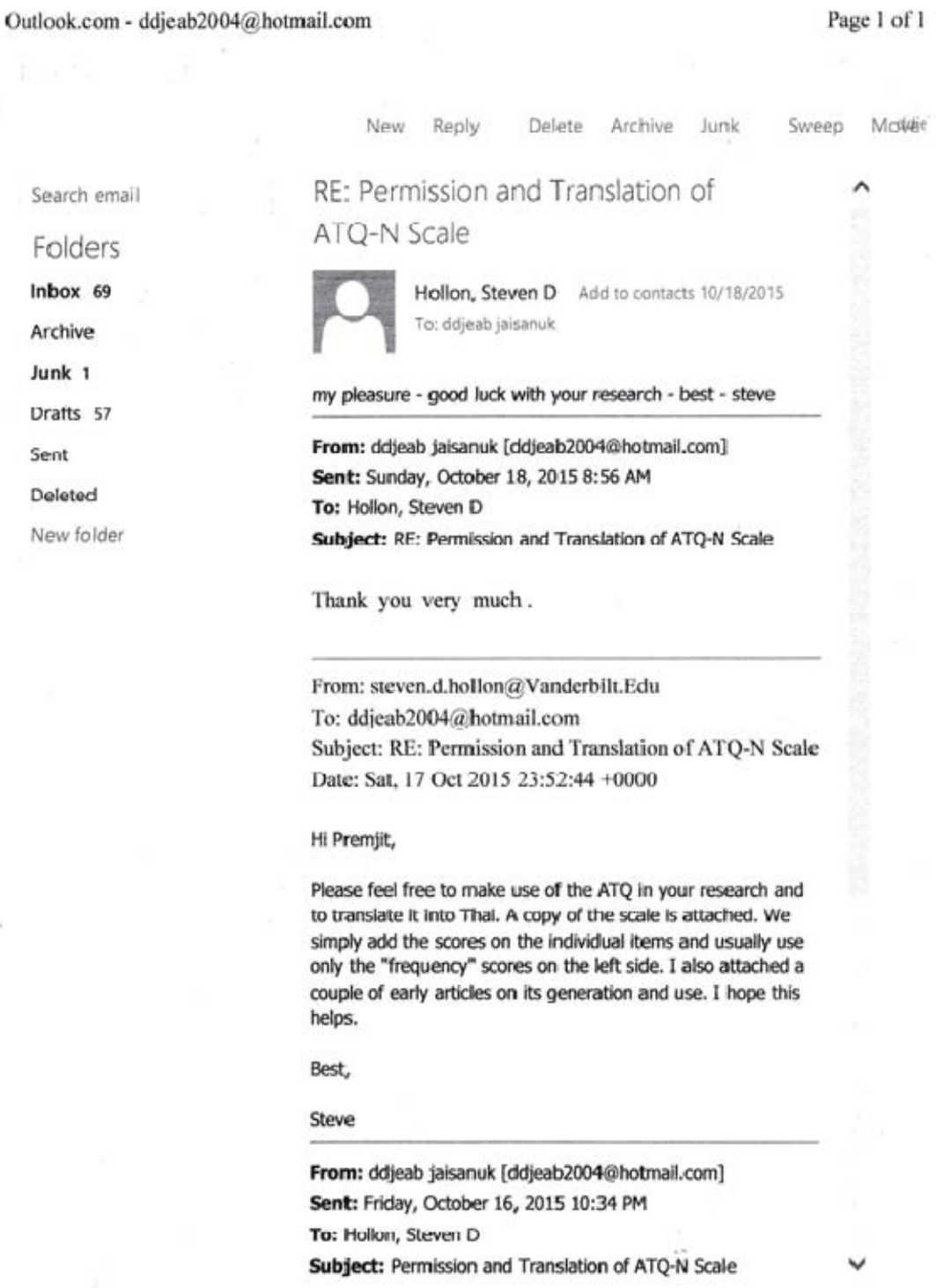
19. ชิดชนกทำงานในบริษัทอสังหาริมทรัพย์ เจ้านายของเธอบอกชิดชนกว่า ชิดชนกเป็นนักขายที่มหัศจรรย์มาก แต่ในความคิดของชิดชนก ชิดชนกคิดว่าเธอไม่ได้ประสบความสำเร็จ แต่ที่มันเกิดขึ้น เพราะเธอโชคดีมากกว่า ท่านคิดว่าท่านเคยคิดแบบชิดชนกบ่อยเพียงใด

1 2 3 4 5 6 7

ไม่เคย บางครั้ง ตลอดเวลา

20. กนกพรกำลังจะไปออกเดทครั้งแรก เพื่อนๆบอกว่าเขาดูดีแล้ว แต่ในความคิดของกนกพรที่เพื่อนพูดแบบนั้นเพราะต้องการให้กนกวรณรู้สึกดี ท่านคิดว่าท่านเคยคิดแบบกนกพรบ่อยเพียงใด

APPENDIX B



Outlook.com - ddjeab2004@hotmail.com Page 1 of 1

New Reply Delete Archive Junk Sweep Move

Search email

Folders

Inbox 69

Archive

Junk 1

Drafts 57

Sent

Deleted

New folder

RE: Permission and Translation of ATQ-N Scale

Hollon, Steven D Add to contacts 10/18/2015

To: ddjeab jaisanuk

my pleasure - good luck with your research - best - steve

From: ddjeab jaisanuk [ddjeab2004@hotmail.com]
Sent: Sunday, October 18, 2015 8:56 AM
To: Hollon, Steven D
Subject: RE: Permission and Translation of ATQ-N Scale

Thank you very much .

From: steven.d.hollon@Vanderbilt.Edu
To: ddjeab2004@hotmail.com
Subject: RE: Permission and Translation of ATQ-N Scale
Date: Sat, 17 Oct 2015 23:52:44 +0000

Hi Premjit,

Please feel free to make use of the ATQ in your research and to translate it into Thai. A copy of the scale is attached. We simply add the scores on the individual items and usually use only the "frequency" scores on the left side. I also attached a couple of early articles on its generation and use. I hope this helps.

Best,

Steve

From: ddjeab jaisanuk [ddjeab2004@hotmail.com]
Sent: Friday, October 16, 2015 10:34 PM
To: Hollon, Steven D
Subject: Permission and Translation of ATQ-N Scale

Search email

Folders

Inbox 145

Archive

Junk 14

Drafts 88

Sent

Deleted

New folder

RE: Translated in Thai language scale for cognitive distortion,.

GP Permissions Add to contacts 20/10/2015

To: Ddjeab Jaisanuk

Premjit Dear,

We Can Grant permission for You to use the scale in your Research, Guilford but does not provide PDFs of the Material. You must either Purchase a Copy of the Article or Find Access to it via a Library Resource.

One-time non-Exclusive World rights in all Languages for Print and Electronic formats are granted for your requested use of the Selections Below in your Master's Research for. Mahidol University in Thailand .

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Best,
Angela.

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Archive

Junk 1

Drafts 57

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New folder

Re: CDS (help me please .)

Dr. Roger Covin (ottawapsychologist@gmail.com) Add to contacts 10/14

To: ddjeab jaisanuk

1 attachment (401.3 KB) Outlook.com Active View

THE TYPES OF THI...

Download as zip Save to OneDrive

Hi Premjit, I do not own the scale - the journal that originally published it technically owns it. I have attached it here for your use (you may want to email the editor of the journal to get permission to translate it). You score it by adding all the items. Subscales can be calulated by adding the interpersonal and work/school scales separtately,

Take care,

Roger

On Oct 13, 2015 8:09 PM, "ddjeab jaisanuk" <ddjeab2004@hotmail.com> wrote:

Greetings!

Dear Mr. Roger Covin, I'm writing you to seek your permission for using the scale (cognitive distortion scale, CDS) that you have used for measuring cognitive errors . I am Masters student at Mahidol University in Thailand, taking my degree in Addiction Studies. For my research, I am interested to see the prevalence of cognitive distortion due to use of methamphetamine among young adults. I would be highly obliged if you could send me the scale and its scoring. I will have to get it translated in Thai language and then administer among clients of methamphetamine. Kindly allow me to use the scale. I would be truly grateful. Have a nice day.

Reagrds,

Premjit Chailungkar

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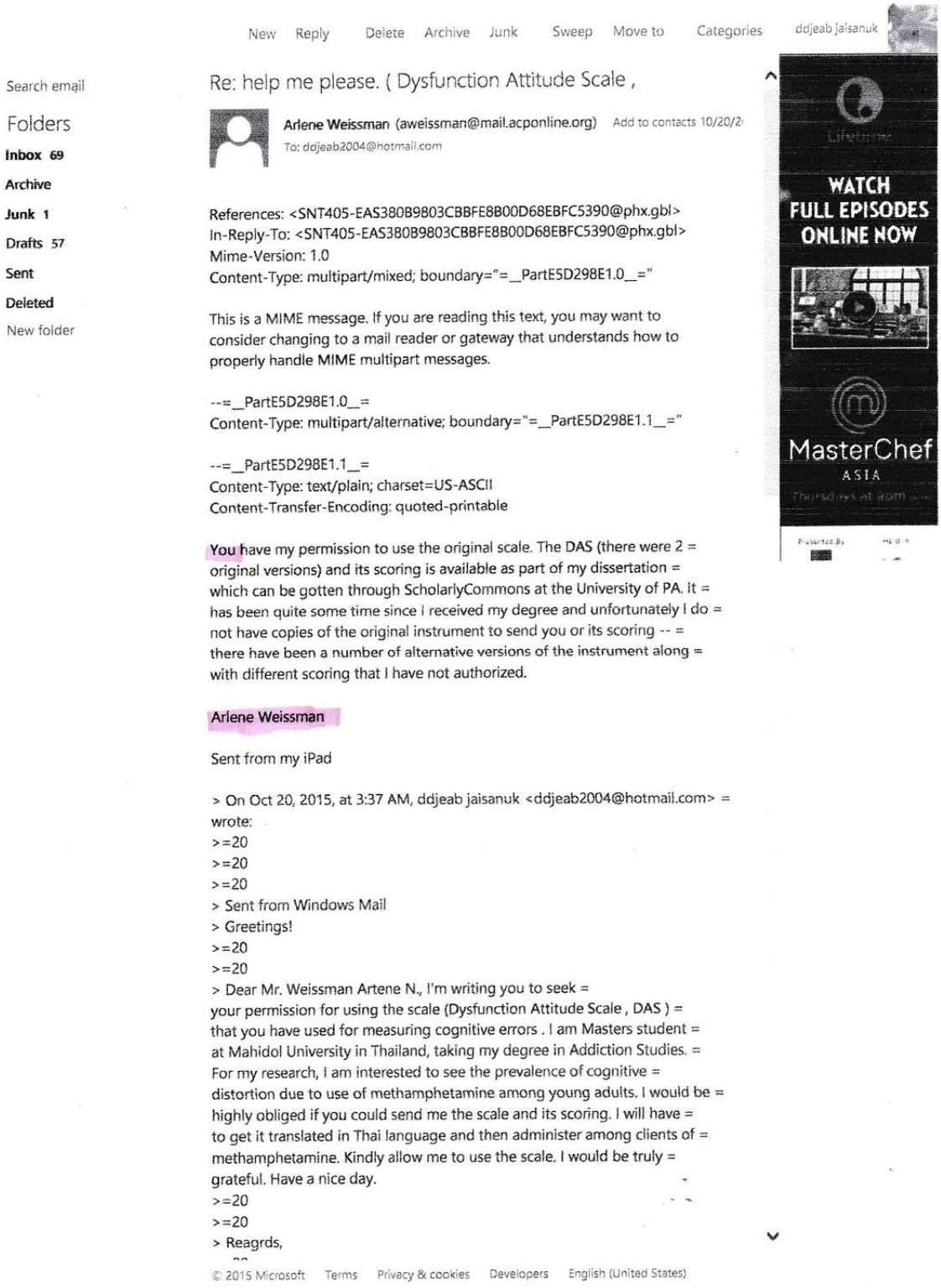

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Drafts 57

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Re: help me please. (Dysfunction Attitude Scale ,

Arlene Weissman (aweissman@mail.acponline.org) Add to contacts 10/20/2

To: ddjeab2004@hotmail.com

References: <SNT405-EAS380B9803CBBFE8B00D68EBFC5390@phx.gbl>
In-Reply-To: <SNT405-EAS380B9803CBBFE8B00D68EBFC5390@phx.gbl>
Mime-Version: 1.0
Content-Type: multipart/mixed; boundary="=__PartE5D298E1.0__="

This is a MIME message. If you are reading this text, you may want to consider changing to a mail reader or gateway that understands how to properly handle MIME multipart messages.

--=__PartE5D298E1.0__=
Content-Type: multipart/alternative; boundary="=__PartE5D298E1.1__="

--=__PartE5D298E1.1__=
Content-Type: text/plain; charset=US-ASCII
Content-Transfer-Encoding: quoted-printable

You have my permission to use the original scale. The DAS (there were 2 = original versions) and its scoring is available as part of my dissertation = which can be gotten through ScholarlyCommons at the University of PA. It = has been quite some time since I received my degree and unfortunately I do = not have copies of the original instrument to send you or its scoring -- = there have been a number of alternative versions of the instrument along = with different scoring that I have not authorized.

Arlene Weissman

Sent from my iPad

> On Oct 20, 2015, at 3:37 AM, ddjeab jaisanuk <ddjeab2004@hotmail.com> = wrote:
>=20
>=20
>=20
> Sent from Windows Mail
> Greetings!
>=20
>=20
> Dear Mr. Weissman Artene N., I'm writing you to seek = your permission for using the scale (Dysfunction Attitude Scale , DAS) = that you have used for measuring cognitive errors . I am Masters student = at Mahidol University in Thailand, taking my degree in Addiction Studies. = For my research, I am interested to see the prevalence of cognitive = distortion due to use of methamphetamine among young adults. I would be = highly obliged if you could send me the scale and its scoring. I will have = to get it translated in Thai language and then administer among clients of = methamphetamine. Kindly allow me to use the scale. I would be truly = grateful. Have a nice day.
>=20
>=20
> Reagrds,

Certificate of MU-SSIRB Approval

★★★★★★★★★★★★

Certificate of Approval No.:	2015/405.0401
MU-SSIRB No.:	2015/472 (B2)
Title of Project:	PATTERN OF COGNITIVE DISTORTION IN METHAMGHETAMINE YOUNG ADULT
Principal Investigator:	MRS. PRAMJIT CHAILANGKAR
Name of Institution:	ASEAN Institute for Health Development, Mahidol University
Approval includes:	1) MU-SSIRB Submission form version received date 4 January 2016
	2) Participant Information sheet version date 4 January 2016
	3) Informed Consent Form version date 6 November 2015
	4) Questionnaire version date 4 January 2016

The Committee for Research Ethics (Social Sciences) is in full compliance with International Guidelines of Human Research Protection such as Declaration of Helsinki, The Belmont Report, CIOMS Guidelines and the International Conference on Harmonization in Good Clinical Practice (ICH-GCP)

Date of Approval: January 4, 2016
Date of Expiration: January 3, 2017

Chairman

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(Assoc.Prof.Dr.Wariya Chinwanno)
Dean of Faculty of Social Sciences and Humanities

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Phuttamonthon 4 Rd., Salaya, Phuttamonthon District, Nakhon Pathom 73170. Tel.(662) 441 9180 Fax.(662) 441 9181
Website: www.mu-ssirb.com ; e-mail: mussirb310@gmail.com

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EMPLOYMENT ADDRESS	Thunyaruk Hospital khonkaen 775 M.19 T. Sira A.Moung Khonkaen 40000 043-345391 ,087 -2384477