
SELF-HELP GROUPS AS A MODALITY OF TREATMENT FOR ALCOHOL DEPENDENCE

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ABSTRACT: Self-help groups are becoming increasingly common as their members become organized in order to live and solve their own alcohol-related problems. This study aimed to identify, based on the experience of alcoholics, how a self-help group constitutes itself as a treatment alternative for alcohol dependence. A descriptive, qualitative study was conducted with 20 members of a self-help group. Data were collected through semi-structured interviews and analyzed according to the content analysis technique. Results show that supportive reception, exchange of experiences, and social reintegration favors participation in the group and, consequently, contributes to physical, mental and social wellbeing. There is a need to establish partnerships with self-help groups considering the importance of knowledge produced within these organizations, which can assist those requiring appropriate care.

DESCRIPTORS: Alcoholism. Social support. Self-help groups. Alcoholics anonymous.

GRUPO DE AUTOAJUDA COMO MODALIDADE DE TRATAMENTO PARA PESSOAS COM DEPENDÊNCIA DE ÁLCOOL¹

RESUMO: Grupos de autoajuda estão se tornando cada vez mais comuns, à medida que seus membros se organizam para conviver com o alcoolismo e resolver seus próprios problemas. Objetivou-se apreender da vivência de alcoolistas o modo como um grupo de autoajuda se constitui como modalidade de tratamento para pessoas com dependência de álcool. Estudo descritivo, qualitativo, realizado com 20 membros de um grupo de autoajuda. Os dados foram produzidos mediante entrevista semiestruturada e analisados conforme o método de análise de conteúdo. Resultados denotam que acolhimento, partilha de experiências e reinserção social, favorecem a participação no grupo e que, conseqüentemente, contribuem para o bem-estar físico, mental e social. Ressalta-se a necessidade de parcerias com grupos de autoajuda, tendo em vista a importância de conhecimentos produzidos nestas organizações, que podem ser colocados em favor daqueles que precisam do devido cuidado.

DESCRIPTORIOS: Alcoolismo. Apoio social. Grupos de autoajuda. Alcoólicos anônimos.

GRUPO ALCOHÓLICOS ANÓNIMOS COMO TRATAMIENTO PARA LAS PERSONAS CON DEPENDENCIA DEL ALCOHOL

RESUMÉN: Grupos de autoayuda se están convirtiendo cada vez más comunes, a medida que sus miembros se organizan con el fin de vivir y resolver sus propios problemas relacionados con el alcohol. Este estudio tuvo como objetivo aprender de la experiencia de manejo con los alcohólicos como un grupo de autoayuda se desarrolla como tratamiento para las personas con dependencia del alcohol. Estudio descriptivo, cualitativo con 20 miembros de un grupo de autoayuda. Los datos fueron recolectados a través de una entrevista semi-estructurada y analizados según el método de análisis de contenido. Los resultados muestran que la acogida del intercambio de experiencias y la reintegración social, promueven la participación en el grupo y contribuyen al bienestar físico, mental y social. Se hace hincapié en la necesidad de crear alianzas con grupos de auto-ayuda, en vista de la dependencia de los conocimientos producidos en estas organizaciones, que se puede colocar en la necesidad daqueles que a favor de la diligencia debida.

DESCRIPTORIOS: Alcoholismo. Apoyo social. Grupos de autoayuda. Alcoólicos anónimos.

INTRODUCTION

According to the World Health Organization (WHO), about 10% of the world population living in urban areas abuses of psychoactive substances, regardless of age, gender, educational level, or purchasing power. With the exception of variations without significant epidemiological repercussions, the same reality is observed in the Brazilian territory.¹

In response to the increasing use of drugs such as alcohol, different countries, including Brazil, have established policies with varying degrees of success. Choosing this path means to seek the best outcomes of historical experiences of other countries or peoples. The great social challenge lies in establishing a healthy and sustainable public policy capable of being effective in daily practice, connecting various social sectors (economic, legal, educational, health, cultural and others).

The Policy of Integral Care Provided to Users of Alcohol and Other Drugs was implemented in 2004 in agreement with the principles of current mental health policy –recommended and implemented by the Brazilian Ministry of Health – and regulated and supported by Federal Law 10216, enacted in 2001. This ministerial strategy considers the need to structure and strengthen a healthcare network focused on community care associated with both the health service and social networks, to emphasize the rehabilitation and social reintegration of its users. It also emphasizes that psychosocial care provided to drug users should be based on a support network organized by the Psychosocial Care Centers (CAPS), which should connect and cooperate with other health services in accordance with the principles of the Psychiatric Reform.¹

Even though self-help groups directed to chemical dependents are not considered in current public policies as a formal device in the healthcare network, since these were not created by the State, they represent one way the civil society participate in this care network. These support groups are organizations that provide an environment that encourages social interaction through group activities or individual relationships with the specific purpose to rehabilitate or support people with related health problems. These groups are an important source of support for people with problems related to the abusive consumption of alcohol. People with such problems also receive support in other environments (workplaces and churches, among others) that do not involve interaction with health workers. Hence, profes-

sionals can encourage these people to participate in self-help groups and also ask for professional help when needed.²

Alcoholics Anonymous (AA) stand out among these groups as an organization of self-labeled alcoholics who meet regularly and voluntarily to reinforce their abstinence from alcohol consumption. It emerged in the United States in 1935 and spread throughout the world, receiving alcoholics who share their experiences with a group. Its financial resources derive exclusively from the contributions of its members.³

Despite more than 150 studies addressing the efficacy of self-help groups since 1980, including the yet-to-be-concluded 'Project Match', there are no conclusive data about the efficacy of AA. Still, it is believed that a movement that attracts million of dependents around the world and continues to diversify and grow after 70 years of existence might have something to contribute to the treatment of psychoactive substance dependence.⁴ Participation in these groups has been described as an important tool in the promotion of well being and differentiated care, considered a way to identify and understand health, and deal with disease, facilitating the socialization of ideas.

Given the previous discussion and acknowledging the relevance of AA in enabling individuals to cope with alcohol dependence, this study was conducted to grasp, from the experience of alcoholics, the way the self-help group is constituted as a modality of alcoholism treatment.

Considering that social support to alcoholics consists of an effective intervention, health workers can act to connect health services providing care to psychoactive users and dependents (CAPS, day-hospitals, outpatient clinics, beds in general hospitals) to support organizations such as self-help groups, strengthening communitarian actions and decision-making. The connection between technical and folk knowledge, and the mobilization of institutional and communitarian resources, in this context makes it possible to understand the problem and devise problem-solving strategies through empowering individuals to improve or regain control over their health.

METHOD

This descriptive study with qualitative approach was developed in an AA group located in Fortaleza, CE, Brazil. A total of 20 alcoholics, older than 18 years old, affiliated with the group

for at least one year and regularly attending the meetings, and who also were in the physical and emotional condition necessary to answer the questionnaire, voluntarily consented to participate in the study. The respondents were intentionally chosen through quota sampling, that is, those who met the inclusion criteria were approached. To ensure confidentiality of information, each respondent was identified according to the order of interview. Hence, "11" was the first who consented to participate in the study and so on.

A semi-structured script was used. It contained guiding questions addressing: history concerning alcohol consumption and the trajectory of treatment up to the point the individuals engaged in the self-help group; meaning of the group; motivation to seek the group and experience it; and influence of the group on the alcoholic's lifestyle. Information collected during the interviews was recorded with the participants' authorization. Recorded content was transcribed verbatim.

Three chronological axes that compose content analysis were used.⁵ Information was grouped into the following categories: a) alcohol consumption and trajectory of treatment: history of the AA participants, experiences of alcoholics in self-help groups and repercussions on their lifestyles; and b) health services providing care to alcohol users and dependents and the remaining support organizations: mapping based on the AA's inter-sector actions.

The results were not based on a specific theoretical framework but on literature addressing related themes, found in the following databases: Virtual Health Library, MEDLINE and SciELO. The following descriptors in health sciences were used: alcoholism, social support, self-help groups, and alcoholic anonymous.

The study complied with the ethical recommendations of Resolution 196/96, Brazilian Council of Health, that regulates research involving human subjects.⁶ It was also approved by the Ethics Research Committee at the Federal University of Ceará (Process n° 198/08).

RESULTS AND DISCUSSION

The use of alcohol and the trajectory of treatment: the history of AA participants

The participants had different characteristics concerning aspects related to the use of alcohol

and experiences concerning the adverse consequences to their health, with a negative impact on various aspects of life: personal, family, social and economic.

Most respondents started using alcohol during adolescence, while for some, alcohol consumption began in childhood or adulthood. Seventeen individuals reported that the abusive use of alcohol started in adulthood and the other three participants reported that abusive alcohol use started in adolescence. The most recent period of abstinence from alcohol was significant from the age of 40 years old (17 participants); it also occurred during older age for some. In regard to the frequency alcohol was consumed before joining AA, 15 participants reported daily use; four reported only on weekends; and one participant reported irregular use.

All the participants were abstinent and the length of sobriety ranged from seven months to 24 years. Length of abstinence was related to the time of participation in AA for 16 individuals. The fact they perceived abstinence to be the solution for alcoholism and for associated problems may have influenced their acceptance of the twelve-step program proposed by the group, the goal of which is sobriety.

Delay in seeking help, hesitation and difficulty in acknowledging alcoholism was observed among the participants. Late acknowledgement occurred as the frequency of use increased along with the manifestation of the consequences of abuse in various spheres of life. One of the factors that contributed to such a fact was a lack of sensitivity on the part of health workers who, at some point in life, were in contact with these individuals. The following reports illustrate these findings:

[...] I started at the age of 13 and stopped at the age of 33... I started slowly, drinking in a few places and ended up drinking in virtually every corner. Everybody would say that drinking was ok, a manish thing to do, that beating and aggressiveness were manish. So, I never thought I had a problem [...] (E20).

[...] I've been to an emergency room once only to take glucose, but I've never been treated for alcoholism. I've been to an emergency room because I had a hangover, with so much agony, it felt like I'd die, so I went there and took glucose and left one, two hours later [...] (E11).

Believing that the problem is not severe enough to merit treatment (denial) is one of the barriers most frequently mentioned by alcohol dependents and users hidden from health ser-

VICES. Deeming that the treatment is not relevant to promoting lifestyle changes is another claim frequently observed when users opt to deal with the problem by themselves. Fear of stigma seems to be another relevant factor impeding these individuals from seeking treatment, especially among women.⁷

These individuals have a tendency to deny the abusive consumption of alcohol to avoid being labeled as alcoholics, due to the term's underlying moralistic nature, an important factor leading individuals to minimize their real consumption of alcohol.⁸ This remarkable tendency to deny the problem of alcoholism puts the lives of these individuals at risk. Some problems may emerge over the history of alcohol consumption with increased frequency of consumption, such as cancer, heart disease, accidents and suicide. The incidence of these events and diseases varies due to factors such as permissiveness, availability of the drug, access, type and volume of alcohol intake. Another problem related to drug consumption is the social disability that harms interpersonal, affective, family, professional and academic relationships. Social disability occurs due to psychological changes caused by the drug, as well as due to the dependence itself.⁹

Other barriers reported in the literature hindering individuals from seeking health services that provide treatment for chemical dependence include: the perception that treatment is inefficient; not acknowledging oneself as dependent because the substances are not used daily or are not injected; feeling isolated due to the perception that nobody else has similar problems; difficulties sharing problems; lack of awareness concerning treatment sites; fear of losing a job or upsetting family; perception of being unable to adapt to the treatment rules or modalities of treatment, especially those with a religious connotation; fear of relapse and consequent embarrassment; unwillingness to give up the pleasure the drug provides; men may become afraid of not corresponding to the socially expected male role; fear of being forced to abstain and of the HIV test; unwillingness to interrupt low-level drug trafficking; belief that the family might not provide support; not wanting to "waste time"; women may fear reprisals on the part of partners who are also users. More "practical" barriers may emerge after users decide to undergo treatment: health insurance does not cover the treatment; waiting lists; not being able to abstain while waiting for a spot

(a requirement of services that do not detoxify); bureaucracy; not having someone to take care of the children; women do not want to be cared for by men or with male patients; fear, on the part of users, of clinicians and facilities (perceived as having sadistic characteristics); and a detachment between clinician and patient.⁷

Some authors report a lack of specialized services in Brazil that care for alcoholics, as well as a lack of specialized education to qualify health workers, of modalities of treatment, and techniques and interventions directed to this specific population, which would favor the early detection of the problem and implementation of treatment.¹⁰ Most of the institutions specialized in the treatment of chemical dependence are non-governmental organizations, which shows the reduced role of the State in health policies. Most of these are non-profit organizations, such as AA and Narcotics Anonymous (NA), the ones that stand out in quantitative terms.¹¹

In contrast, other studies highlight that the main network working among people with chemical dependence is the CAPS for users of alcohol and others drugs (CAPSad). Based on this assumption, there is a pressing need to qualify these professionals and change the teaching models of different disciplines so that different types of knowledge and practice are in complete accord and professionals acquire a broader view concerning the community role and, more importantly, provide care in accordance to the new care model established by the Psychiatric Reform. CAPSad, as the main operating network for these individuals, literally excluded from a dignified social life, requires interventions that focus on the need for these individuals to establish and keep lasting and healthy bonds. Additionally, the social network in which these individuals are inserted, needs to be supported in order to change its vulnerable structure, undermined as it is by the consequences of the dependence process on psychoactive substances.¹²

Only after they experience repercussions in their lives, will the individuals acknowledge the disease and awaken to the need to change their lifestyle: [...] *I realized that I needed help at the moment I was kicked out of home. The police arrested me once because I wanted to set a fire in the house with my children inside. That day I was aggressive, mad [...]* (E15).

The findings reveal the need for the individuals to change behaviors and how it favored their search for health services and support groups.

The search was not always directed for alcoholism treatment, but to treat its consequences. Additionally, the help available did not always meet the individual's needs, which led to abandonment of the treatment attempt.

[...] once I spent 15 days drinking nonstop, so I was committed to a psychiatric facility, I remained hospitalized 15 days; it didn't help because... they only treated the physical part, there wasn't like a change for me to keep living. So I left the hospital and went back to drinking. Then, after I left it, they took me to macumba*, to Spiritualism. But it didn't work [...] (E18).

[...] I used to go to a public hospital whenever something happened as a consequence of my drinking. I spent one month hospitalized; a good doctor was taking care of me, promised I'd not drink anymore. On the same day I left, on the same night, I was so drunk that I wasn't able to turn on my bedroom light. I don't disbelieve in psychology or psychiatrics, but this disease is so severe it has no cure. They do what they can. Nowadays I go to AA, I managed to stop drinking here [...] (E2).

Examining the history of therapeutic modalities available to alcoholics, we observed that, as a rule, since the 1970s, the treatment was restricted to psychiatric confinement. Such a procedure, instead of improving the condition, aggravated it even more. Since then, the recommendation is that the treatment has to be adequate to the individual's needs.¹³

A considerable portion of drug users has never undergone drug dependence treatment in the health services. Their first choice is usually religion because it is free of cost, immediately and easily accessible. The few dependents seeking professional help emphasize the need to find public services in the area and a delay in scheduling consultations and potential therapies.¹⁴

The experience of alcoholics in the self-help group and repercussions on lifestyle

Treatment is seen as the possibility to improve a pathology, whether it affects the physical, psychological or social health. Based on this assumption, we noticed that the self-help group is a modality of treatment for alcoholism, based on the reports of the informants emphasizing that attending AA meetings promoted acceptance, respect, social reintegration, the exchange of experiences, the possibility of expressing their feelings, and achieving abstinence.

Supportive reception and the availability the group manifests in relation to its members when in need were mentioned. The following excerpt shows that health services do not always provide a supportive reception when sought as an alternative for treatment:

[...] it was good at the AA. I felt like quitting but didn't know how; I accepted it on the same day I went there, for the first time. I readily identified myself with the reports of other members. Nobody discriminates against you here. If you go to a health service, to a church, everybody looks at you, stares. Here, nobody cares about your clothes, money and they even help me [...] (E15).

Supportive reception is a technological arrangement that seeks to ensure access for individuals and attentively listen to them, solve problems and/or refer them to other services, if necessary. It consists of opening the services for demand and being accountable for certain problems in a given area. When people feel supported, they seek responsive services with a problem-solving capacity beyond their geographical boundaries. Providing supportive reception within the health sector, enables social reintegration through clinical care that includes attentive listening and the recovery of citizenship.¹³

Supportive reception enables the humanization of interactions between health professionals and the users of services. The meeting of these two subjects enables the establishment of a relationship that includes attentive listening and accountability, based on bonding and commitment that guide intervention projects.

In addition to providing supportive reception, the informants report the group helps them to become aware of themselves as social beings, which favors living together and social interaction, inclusion in groups of friends with positive attitudes in relation to the use of alcohol and sharing experiences. Emphasis on such elements during participation in the AA may be related to the experience prior to social exclusion.

The interviewees also highlight that abstinence, achieved with participation in the group's meetings, reflected on their health, family, economic situation, work, and also on their spirituality, as the following report shows:

[...] I've practiced the program the way it is suggested so I keep myself sober. I have no desire to drink.

* Term usually used in Brazil to designate any ritual or religion of African origin.

My daughter doesn't tremble anymore. I got here 11 kg thinner. Recovery is not only physical but also spiritual. I don't drink or use drugs anymore [...] (E4).

Associative networks contribute to empower popular sectors of society, albeit occasionally, through focused projects and treatment provided to those socially excluded. However, social problems are severe and require urgent response.¹⁵

The individuals highlight the contribution of AA as a place where its members can express themselves, given an opportunity to listen and to verbalize:

[...] sometimes my mind is crazy, I feel so annoyed, so I came to AA. You listen to someone give vent to their feelings or you go and freely express yourself, then you leave there as a sheet of paper. Everything bad passes by the ear. Nowadays, I no longer feel like drinking [...] (E17).

Note in the testimonies the well being the individuals feel due to the opportunity to express their feelings: anguish, fear, gains and losses. The load of mental suffering that involves the context of alcoholism is considerable and consumes great energy from those affected by it. Obtaining affective and emotional support during this process can be essential to being able to achieve positive and effective responses. AA has provided both an environment of traditional expression, face-to-face meetings, and a virtual environment, where people share experiences through the internet.

The advances in informatics and telecommunications favored access to an increasingly larger number of people to distant health services. Phone-based services providing information, guidance and counseling concerning health have enabled the exchange of clinical information between health workers and patients. These services complement face-to-face interventions and self-help besides being useful as strategy to prevent relapses and drug use.¹⁶

Currently, the Brazilian population has available a National Service of Information and Guidance on the Prevention to the Misuse of Drugs, the VIVAVOZ. It was conceived by the National Antidrug Department (SENAD) and the Federal University of Health Sciences Foundation in Porto Alegre (UFCSPA). This service provides, through a phone number (0800-510-0015) counseling that is reactive, free of cost and anonymous for the population in general. It is specialized in providing drug-related information and guidance in appropriate language deprived of prejudice. In addition

to VIVAVOZ, other phone-based services in Brazil include: Toxicological Information Centers in Rio Grande do Sul (CIT/RS), the Information Service on Psychoactive Substances (SISP), Stop Smoking Dial from the National Cancer Institute (INCA), the National Information Service on Teratogenic Agents (SIAT), Medication Information Center (CIMS), and Toxicological Information and Care Centers (CEATOX). Each of these services use teleservice strategies in addition to providing information. VIVAVOZ provides scientific information on drugs and also brief motivational interventions for users.¹⁶

In regard to the repercussions of group participation on lifestyle, the interviewees reported that after entering the group they acquired a perception they were regaining control over their lives, a feeling of physical and mental wellbeing and social reintegration. Some respondents, however, reported elements considered to be negative that emerged after they became engaged in the group: co-dependence on family members and the problematic situation of living with an alcoholic relative. The alcoholic's family is considered to be an important source of social support, but some family members, when directly experiencing the abusive consumption of alcohol on the part of one of the family members, may also experience difficulties dealing with the problem and also require support.

Co-dependence interferes in a person's life, especially in one's mental health and way of dealing with the chemical addiction. Manifestation of co-dependence includes suffering, emotional pain, and physical and psychological illness, that are reflected in multiple responses. Additionally, some feelings that emerge from this co-dependence experience are frequently observed, such as discontent, uncertainty, anxiety, sadness, hopelessness, and loss.¹⁷

The interactions of a health worker with an individual are also indirect interactions with the individual's family because it is a dynamic system and the inability of one member may affect the other family members. Only when the family is included in the rehabilitation process, can the family system adapt to change by one of its members. When the professional focuses on this dimension of human contact, s/he can, in addition to the biopsychosocial aspect, identify bottlenecks in family life through health educational actions and home visits.¹⁸

Health services providing care to users and the alcohol-dependent and the other support organizations: mapping based on the AA's inter-sector actions

The reports reveal the social support services the participants sought to connect with: self-help groups (Ministry of Sobriety, NA, Al-Anon, Nar-Anon); educational institutions (schools and universities); health services (primary health care units, CAPS, and hospitals, among others), religious institutions, and the community in general.

Among the actions that move toward inter-sector cooperation, other actions implemented in areas close to the group included: distribution of informative material (business cards, flyers, or posters), lectures, meetings open to the public, and informal conversations. Such actions mainly aimed to promote awareness of the group as an alternative of treatment for alcoholism.

The excerpt below shows some examples of inter-sector actions: [...] *medical professionals, religious people come to talk in these meetings. We go to the healthcare units to spread the word; we go to the hospital to hang posters; we talk to the social worker; we give books; we also distribute leaflets. In the field of justice, we go to the 11th district and talk to the sheriff, transmit the message, invite him to participate, to talk to the inmates, with the families about AA, and hang AA posters with his permission. We ask him to refer people to us. And we also talk person-to-person in the community. We distribute flyers and business cards. The cards are different depending on the approach. There are cards for professionals, for alcoholics, and people in general. We disseminate information and things happen [...]* (E6).

The efforts of the participants to establish inter-sector connection and cooperation were remarkable. Nonetheless, there was no single initiative to connect the group to the health sector as a strategy of intervention in the studied context. The Ministry of Health acknowledges that many health workers have difficulty relating to self-help groups due to various reasons: the groups are not based on theories or lines of work; have certain spiritual/religious content that diverges from some theoretical approaches; and there is scarce data evaluating the efficiency of these groups, among other reasons.⁴

We note that the number of devices providing care to users was expanded; in general though, such services still function under poor conditions and with professionals that lack qualification. The

service provided is often insufficient and the quality is questionable. Hence, a considerable number of Brazilians experiencing alcoholism resort to AA and other non-governmental organizations as a treatment option.¹⁹

The current and recent policy concerning the delivery of integral care to users of alcohol and drugs does not put an emphasis on abstinence but on reducing consumption. It may have cultural implications and the need to aggregate a change of paradigms and care models. At the same time, the easy access to self-help groups, their pragmatism, and the fact that their practical actions are focused on the present moment, coupled with a real possibility of achieving abstinence, may lead people to seek these groups as an alternative to treatment.

CAPS should play the role of building and strengthening support networks, connecting the resources existing in the community: social, health, legal, labor, unions, schools, businesses, and community groups, among others. CAPS needs the support of these other devices and related sectors, to address complex demands concerning the re-integration of those excluded from society due to mental suffering.¹

Some researchers reinforce the importance of CAPSad to connect with the various elements existing in social support networks of users of alcohol and other drugs. One of the studies focused on the social networks of users undergoing treatment in CAPSad, aiming to reflect on the quality and situation of bonds established with people and places significant for the studied subjects. CAPSad and its multidisciplinary staff were present as elements of the five mapped social networks. The bonds established with the users and these two components were considered to be from strong to moderate, but all the participants identified CAPSad as a supporter. Other support devices, in addition to CAPSad, were identified: users association, AA groups and religious institutions.²⁰

We note that the power of institutional support function is associated with the possibility of intercession, connection and cooperation, and production of care networks where discussion and analysis concerning what has been produced daily by the mental health collective is possible. Such interference should result in a policy to establish connections and cooperation among CAPS, mental health and health services, and all sectors of society.

FINAL CONSIDERATIONS

The individuals were, over the health-disease continuum, slow in seeking treatment for alcoholism due to the fact they did not acknowledge the problem, among other reasons. Before affiliating to AA, the participants reported the search for help from religious institutions, health services, and other self-help groups to treating the consequences of alcoholism.

The acceptance and supportive reception provided by the AA group helps the individuals to identify themselves with the twelve-step program provided by the group, whose purpose is to achieve abstinence. Testimonies concerning the experience within the self-help group help the individuals to identify improvements in terms of physical, psychological and social health, which makes the group an alternative treatment for alcoholism. This group enables the individuals to express themselves, including concerning adversities that may emerge in the experience with alcoholism.

Data indicate civil society has participated in the care network directed to users and those dependent on alcohol and other drugs in Brazil, not only through the establishment of non-governmental organizations like AA, but also because it has established connections with other devices in the support network. There was no report or emphasis on health services as being efficient support devices in the treatment of alcoholism, a fact that may have led users to first contact AA.

Based on this context, we also reflect upon the need for health workers to become more committed to coping with chemical dependence, to a more decisive practice of strengthening and evaluating policies and practices capable of perceiving and caring for this complex condition, as a public health problem that requires inter-sector actions. Given such complexity, this participation requires some basic conditions, among them: problem-solving capacity at the various levels of healthcare delivery, especially at the primary healthcare level; technical competence, ethics, and policies to implement problem-solving strategies; acknowledgement of the importance of other types of knowledge and modalities of treatment; and the establishment of partnerships as a strategy to provide care and promote social reintegration.

REFERENCES

1. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. A política do Ministério da Saúde para
- atenção integral a usuários de álcool e outras drogas. Brasília (DF): Ministério da Saúde; 2004.
2. Lima HP, Braga VAB, Carvalho LV, Morais ACO. Significados do feminino no discurso de alcoolistas e a interface com a saúde mental. *Texto Contexto Enferm.* 2010 Jul-Set; 19(3):496-503.
3. Alcoólicos Anônimos. Os doze passos e as doze tradições. São Paulo (SP): Junta de serviços gerais de Alcoólicos Anônimos no Brasil; 2005.
4. John EB, Labonia Filho W. Grupos de ajuda-mútua no tratamento de pessoas dependentes de substâncias. In: Pechansky F. Encaminhamento de pessoas dependentes de substâncias psicoativas, organizador. Brasília (DF): Secretaria Nacional de Políticas sobre Drogas; 2009. p. 21-7.
5. Bardin L. Análise de conteúdo. Lisboa (PT): Edições 70; 2009.
6. Ministério da Saúde (BR), Conselho Nacional de Saúde, Comissão Nacional de Ética em Pesquisa. Resolução N° 196 de 10 de outubro de 1996: diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos. Brasília (DF): MS; 1996.
7. Fontanella BJB, Turato ER. Barreiras na relação clínico paciente em dependentes de substâncias psicoativas procurando tratamento. *Rev Saúde Pública.* 2002 Ago; 36(4):439-78.
8. Oliveira ER, Luis MAV. Distúrbios relacionados ao álcool em um setor de urgências psiquiátricas. *Cad Saúde Pública.* 1996 Out; 12(2):171-9.
9. Marques VMG. O viver da família do alcoolista [monografia]. Sobral (CE): Universidade Estadual Vale do Acaraú; 2006.
10. Elbreder MF, Laranjeira R, Siqueira MM, Barbosa DA. Perfil de mulheres usuárias de álcool em ambulatório especializado em dependência química. *J Bras Psiquiatr.* 2008 Jan; 1: 9-15.
11. Garcia MLT, Siqueira MM. Instituições especializadas em dependência química no estado do Espírito Santo. *J Bras Psiquiatr.* 2005 Jul-Set; 54(3):192-6.
12. Souza J, Kantorski LP, Mielke FB. Vínculos e redes sociais de indivíduos dependentes de substâncias psicoativas sob tratamento em CAPS AD. *SMAD Rev Eletrônica Saúde Mental Álcool Drog.* 2006 Fev; 2(1):1-17.
13. Siqueira MM, Garcia MLT, Souza RS. O impacto das faltas às consultas em um programa de dependentes de álcool. *J Bras Psiquiatr.* 2005 Abr-Jun; 54(2):114-9.
14. Sanchez ZM, Nappo SA. A religiosidade, a espiritualidade e o consumo de drogas. *Rev Psiq Clín.* 2007; 34(1):73-81.
15. Gohn MG. Empoderamento e participação da comunidade em políticas sociais. *Saude Soc.* 2004 Mai-Ago; 13(2):20-31.
16. Souza MF, Kohlrausch ER, Mazoni CG, Moreira TC, Fernandes SD, Mesquita DC, Ferigolo M, Barros HMT. Perfil dos usuários do serviço de

- teleatendimento sobre drogas de abuso VIVAVOZ. Rev Psiquiatr Rio Gd Sul. 2008 Jul; 30(3):182-91.
17. Moraes LMP. Atenção de enfermagem ao familiar do dependente químico: grupo como estratégia do cuidar [tese]. Fortaleza (CE): Universidade Federal do Ceará. Programa de Pós-Graduação em Enfermagem; 2008.
18. Fornazier ML, Siqueira MM. Consulta de enfermagem a pacientes alcoolistas em um programa de assistência ao alcoolismo. J Bras Psiquiatr. 2006 Ago; 55(4):280-7.
19. Laranjeira R. Desassistência ao dependente químico. Eco & Ação: Ecologia e Responsabilidade [online]. 2007 [acesso 2011 Jul 17]; Disponível em: http://www.sindhosp.com.br/website/exibe_txt.asp?conteudo_txt=445&tit=artigos
20. Souza J; Kantorski LP. A rede social de indivíduos sob tratamento em um CAPS ad: o ecomapa como recurso. Rev Esc Enferm USP. 2009 Jun, 43(2):373-83.