



Facilities of family adherence in treatment of chemical dependence: families' perception*


Ana Carolina Belmonte Assalin¹

 <https://orcid.org/0000-0002-7363-8924>


Sonia Regina Zerbetto²

 <https://orcid.org/0000-0002-2522-1948>


Bianca Oliveira Ruiz³

 <https://orcid.org/0000-0002-4464-8939>

Priscila Souza Cugler⁴

 <https://orcid.org/0000-0001-8807-970X>

Sarah Salvador Pereira^{2,5}

 <https://orcid.org/0000-0002-1151-6374>

Objective: to analyze family members' perception of the facilities of family adherence to the treatment of their chemically-dependent relative being cared for at the Psychosocial Care Center - alcohol and drugs. **Method:** qualitative study, conducted from April to September 2016, including 10 family members of drug users participating in family groups. A semi-structured interview was conducted and data were analyzed using the thematic content analysis technique. **Results:** families recognized that creating therapeutic alliances, hoping for their relatives' recovery and valuing their participatory roles in family treatment facilitate therapeutic adherence. **Conclusion:** the study contributes to health professionals' reflection regarding the possible strategic areas to care for families in order to help them with therapeutic adherence.

Descriptors: Treatment Adherence and Compliance; Family; Family Relations; Substance-Related Disorders; Mental Health.

* Supported by Fundação de Amparo à Pesquisa do Estado de São Paulo, Brazil, grant #15/11013-1.

¹ Irmandade da Santa Casa de Misericórdia de São Carlos, Unidade de Emergência, São Carlos, SP, Brazil.

² Universidade Federal de São Carlos, Departamento de Enfermagem, São Carlos, SP, Brazil.

³ Escola Técnica Estadual, Escola Técnica Estadual Paulino Botelho, São Carlos, SP, Brazil.

⁴ Secretaria Municipal de Saúde, Centro de Atenção Psicossocial Álcool e Drogas, São Carlos, SP, Brazil.

⁵ Scholarship holder at the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES), Brazil.

How to cite this article

Assalin ACB, Zerbetto SR, Ruiz BO, Cugler PS, Pereira SS. Facilities of family adherence in treatment of chemical dependence: families' perception. SMAD, Rev Eletrônica Saúde Mental Álcool Drog. 2021 Jan.- Mar.; 17(1):17-25. doi: <https://dx.doi.org/10.11606/issn.1806-6976.smad.2021.150251>

Facilidades de adesão familiar ao tratamento da dependência química: percepção dos familiares

Objetivo: analisar a percepção do membro familiar sobre as facilidades de adesão da família ao tratamento do dependente químico em acompanhamento no Centro de Atenção Psicossocial - álcool e drogas. **Método:** estudo qualitativo, realizado de abril a setembro de 2016, com 10 familiares de usuários de drogas, participantes de grupos de família. Realizou-se entrevista semiestruturada e os dados foram analisados pela técnica de análise de conteúdo temática. **Resultados:** as famílias reconheceram que criar alianças terapêuticas, ter esperança na recuperação de seu parente e valorizar seus papéis participativos no tratamento familiar facilitam a adesão terapêutica. **Conclusão:** o estudo contribui para a reflexão dos profissionais de saúde quanto às possíveis áreas estratégicas para o cuidado às famílias, de modo a ajudá-las na adesão terapêutica.

Descritores: Cooperação e Adesão ao Tratamento; Família; Relações Familiares; Transtornos Relacionados ao Uso de Substâncias; Saúde Mental.

Facilidade de adhesión familiar en el tratamiento de la dependencia química: percepción de los familiares

Objetivo: analizar una percepción del miembro familiar sobre las facilidades de adhesión de la familia, en el tratamiento del dependiente químico en el Centro de Atención Psicossocial de alcohol y drogas. **Método:** estudio cualitativo, realizado de abril a septiembre de 2016, con 10 familiares de usuarios de drogas, participantes de grupos de familia. Se realizó una entrevista semiestruturada y los datos fueron analizados por la técnica de análisis de contenido temático. **Resultados:** las familias reconocieron que crear alianzas terapêuticas, tener esperanza en la recuperación de su pariente y valorar sus papeles participativos en el tratamiento familiar facilitan la adhesión terapêutica. **Conclusión:** el estudio contribuye a la reflexión de los profesionales de la salud en cuanto a las posibles áreas estratégicas para el cuidado a las familias, para ayudarlas en la adhesión terapêutica.

Descriptorios: Cumplimiento y Adherencia al Tratamiento; Familia; Relaciones Familiares; Trastornos Relacionados con Sustancias; Salud Mental.

Introduction

Families play an important role in the process of recovery and rehabilitation of their psychoactive-substance-dependent member, which requires them to adhere to treatment.

Although chemical dependency promotes intra-family imbalance⁽¹⁻²⁾, families can reorganize themselves and guarantee the development of their members through care, affection and assertive communication. This fact contributes to adherence to their relatives' treatment⁽³⁻⁴⁾ as well as to the prevention and resolution of problems related to the use of psychoactive substances by one or more of their members⁽⁴⁾.

Adherence is defined as a user's degree of commitment to participating, collaborating and following a care plan or therapeutic recommendations proposed by health professionals, but with the acknowledgment of his/her will and autonomy⁽⁵⁾. Thus, the person's active participation in the treatment, rather than his/her passivity and obedience (compliance) to recommendations, is assumed⁽⁵⁾.

From a behavioral perspective, the concept of adherence is related to the coping and learning process experienced by users and health professionals. Therefore, adhering to treatment is not limited only to following recommendations, but to the possibility of building or strengthening behavioral repertoires⁽⁶⁾.

The phenomenon of treatment adherence can be focused on users or on external factors⁽⁷⁾, such as, for example, the role played by the family, whether by encouraging the dependent member's participation in the treatment or by participating in it⁽⁸⁾. The greater the family members' participation in the therapeutic process, the better the user's and family's adherence to therapy^(4,9-10). Family members' engagement in therapy can be facilitated when they are motivated to help their chemically-dependent relatives⁽¹¹⁾.

An integrative review that analyzes the domestic scientific production on the family's role in caring for relatives who use psychoactive substances (PASs) points out difficulties in including families in the treatment, which are justified by family conflicts, physical and emotional overload and the lack of interventions by family health services⁽⁴⁾.

However, most studies have placed greater emphasis on the issue of users' adherence to treatment than on the family's⁽¹²⁻¹³⁾. They address factors that facilitate such adherence^(8,12) and involve users' length of stay on treatment⁽¹²⁾, their motivational processes⁽⁸⁾, the importance of establishing bonds⁽¹³⁾ and the therapeutic alliance between users and health professionals⁽¹³⁻¹⁴⁾.

It is noticed that, in relation to the therapeutic process of chemically-dependent individuals, few studies address family adherence to the treatment of their dependent relatives⁽¹⁵⁾.

Thus, the research question is: What are the auxiliary factors recognized by families for their adherence to the treatment of their chemically-dependent relatives?

Therefore, this study is justified by its relevance, as it will support health professionals in the configuration of extended care for dependent family members undergoing treatment as well as for their families, helping them in the process of inclusion and permanence on treatment.

The objective of this study is to analyze family members' perception of the facilities of family adherence to the chemically-dependent person's treatment at the Psychosocial Care Center - alcohol and other drugs.

Method

Qualitative study conducted from November/2015 to October/2016 at a Psychosocial Care Center - Alcohol and Drugs (CAPS ad) in São Paulo state, Brazil, with six families. Intentional sampling was used, and the sample comprised ten family members of drug users. The inclusion criteria adopted were: being a family member aged 18 years or over, regardless of gender, motivated or not by the treatment of his/her sick relative and being a frequent and assiduous participant in Family Groups for at least three months. Such period of time was based on scientific evidence that affirms the dependent person's behavior of therapeutic adherence after three months of treatment⁽¹²⁾. Thus, it is believed that families can remain for the same period as they acknowledge treatment adherence by their chemically-dependent relative.

The exclusion criteria were: family members who were intoxicated by the use of psychoactive substances.

Family recruitment consisted of indications by the health professionals working at the abovementioned service and by the fifteen families in the groups. Eight agreed to participate in the study; however, when they were contacted by phone, only six confirmed their participation.

The semi-structured interviews, conducted at home and at CAPS ad, were audio recorded and lasted from 45 minutes to two and a half hours. This process consisted in characterizing the participants in terms of personal identification data, age group, degree of kinship with the dependent person, family configuration and length of stay in the family group. The guiding questions addressed the importance of families' participation and permanence on treatment and their motivations.

To analyze the data, the thematic content analysis technique was used⁽¹⁶⁾. In the first analysis, the transcribed interviews were read and organized. In the next phase, referred to as exploration, the collected material was read, line by line, which indicated phrases that addressed families' participation in the treatment, their reasons for staying on treatment, as well as their role in therapy. After decomposing the set of messages, the meaning units

were apprehended and selected through excerpts taken from the interview statements, according to themes⁽¹⁶⁾. The themes were grouped by similar and different meanings, and the reports identified in each interview. Then, the illustrative statements of the meaning units were aggregated, alphanumerically coded and nominated with the purpose of designing the first empirical categories (categorization moment)⁽¹⁶⁾.

The stage for the treatment of results involved the inference and interpretation phases. Each category was described, and the synthesis-text was produced, expressing the thematic meanings. The interpretation process consisted in aggregating the information obtained, unveiling its manifest or underlying content⁽¹⁶⁾, based on the grounds of adherence concepts, as well as on the literature concerning the subject.

The statements were identified by letters: "F" (Family), followed by kinship initials ("M"-Mother, "Fa"-Father, "B"-Brother and "S"-Sister, "G"-Grandmother and "W"-Wife), and sequenced by numbers corresponding to the order of the interviews conducted.

The study complied with the ethical aspects of Resolution no. 466/2012 by the National Health Council and was approved by the Ethics Committee for Research Involving Human Beings, according to report no. 1.114.587 dated 07/14/2015.

Results

In Figure 1, families were characterized according to the degree of kinship with the dependent person, age, length of follow-up in the group and the interviewed relative's age.

Family/ Data	Participating family member and age	Length of group participation	Dependent relative and age
Family 1 (F1)	Mother (M1) - 61 years old	6 years	Son (U1) - 32 years old
	Mother (M2) - 51 years old		
	Father (Fa2) - 52 years old		
Family 2 (F2)	Sister (S2) - 24 years old	5 months	Daughter (U2) - 17 years old
	Brother (B2) - 22 years old		
Family 3 (F3)	Mother (M3) - 53 years old	5 years	Son (U3) - 31 years old
Family 4 (F4)	Grandmother (G4) - 71 years old	6 years	Daughter (Ua4) - 32 years old
			Grandson (Uo4) - 15 years old
Family 5 (F5)	Wife (W5) - 59 years old	2 years	Husband (U5) - 53 years old
Family 6 (F6)	Mother (M6) - 56 years old	1 year	Son (U6) - 40 years old
	Father (Fa6) - 61 years old		

Figure 1 - Characterization of ten family members. São Paulo, Brazil, 2016

In Figure 1, family members were characterized as to their degree of kinship with the dependent person and age, length of follow-up in the group and age of the family member interviewed. As for the families' characterization, three of them had a nuclear configuration (father, mother and children); one was a single-parent family (mother and children); one was a reconstituted family (children, mother and a new partner, who was not the child's biological father); and one was a two-member family (grandmother and grandson, with the sporadic presence of the mother). The family members' ages ranged from 22 to 71 years old, with a mean of 51 years old. Of the interviewees, four were females, in the roles of mothers, grandmother, wife and sister of the dependent persons. As to the interview, males participated in only two families, in the condition of users' fathers or brothers.

Three categories were created: Creation of the therapeutic alliance, Families' positive expectations in relation to users' recovery and Perception of the importance of the family role in treatment continuity.

Creation of the therapeutic alliance

The family groups and the relationship between CAPS ad health workers and family members consisted of therapeutic alliances that favored family members' adherence to treatment. The family group strengthened and promoted learning by enabling the exchange of experiences and reflection among families.

A lot of help [from the family group] [...] it strengthens us, it really does. We see stories, each one is different [...] that [family group] gives us such strength so we can become stronger, survive and to learn how to fight, I can't even explain. (F1M1)

The exchange of experiences represented a moment when families felt embraced. The group provided consolation and support to the participants, who realized that they were not alone in the fight against the use of psychoactive substances by their relatives.

We [family] do not feel alone, we have other people's experiences, as we also share our experiences with other people. So, there is this statement that we are not alone, that the family group has really helped us. (F2Fa2)

Learning enabled reflection on how to act in the face of critical situations, to make self-assessments of one's behavior and conducts. Previously, the participants felt lost in relation to their actions, without knowing how to deal with the situation and their relatives.

When I arrived here [CAPS ad], I was inexperienced, I had not been through these things in life, I did not know where to step, where to run, who to turn to or what to do. Trying to help and not knowing how. Not today, today, I am learning everything little by little, where to step, where I go, how to do it, with whom to

speak, with whom to act, with my head held up high. So, it was a great learning experience. (F1M1)

The group was a continuous source of knowledge about symptoms, withdrawal signs and users' behavior, which motivated and encouraged the family to stay on treatment.

I learned to deal with the situation, knowing when [the user] will relapse or not. (F3M3)

The groups made it possible to reflect on the exposed cases, to compare others' experiences to one's own reality and to exercise empathy.

[The family group] Helps me to see things that I couldn't see [...] experiencing other people's problems, putting myself in their shoes, seeing what was wrong, what I'm doing wrong, trying to fix it. (F2M2)

The relationship between health professionals and family members was focused on informational support and qualified listening.

But it helps me with any questions I have, I can say anything, can't I? About my little problem, and [name of health professional], in this case, he will help me to solve it and also to listen, of course, I am not perfect. If I'm wrong, if I'm right, you know? In some attitudes that I take about him [sick relative]. So, that's why I want to stay here [family group]. (F4G1)

Families' positive expectations in relation to users' recovery

The families' positive expectation that their relative will again be as he/she was before chemical dependency and will return to previous routines and lifestyle habits favors family members' treatment adherence. Such facts depend on Divine support and on finding formal work.

[...] so, one day, God [...] [user's name] will again be what he was [...]. (F1M1)

If he [user] gets a job, works, has an income, I think he will improve [...] then, he will again be that person he used to be, you know? (F5W1)

For family members, recovery is achieved with the absence of relapses.

I pray to God that he [user] will never relapse. (F1M1)

Hope for users' improvement depends on their first hospitalization in chemical-dependency specialized clinics, with perspectives of social living, reestablishment of family bonds and search for happiness.

The first time she was hospitalized, my hope was that it would be the first time she [user] would really go to a specialized clinic for

chemically-dependent people, you know? With professionals and such. So, I found that hope that she would have recovered by the time she left it. (F5G1); The hope to see the other person well and willing to get through this problem, to return to normal life, to fit in with what is considered the standards of society and live well. To be happy again, to have a good family bond [...]. (F2B2)

Perception of the importance of the family role in treatment continuity

The families recognized their singular role in the recovery of their relatives undergoing treatment and in therapeutic adherence by offering support to the user. The struggle and not desisting from the family member helped him/her to be persistent in the treatment continuum.

And I will continue to fight [...] And I won't give up. It's no use, I've already told them [her other children]: 'it's no use, your brother needs help and while his mother is [alive], his mother will stand by him'. (F1M1)

Family support was also understood as not abandoning the sick family member, but as bringing him/her closer to family life and dialoguing with him/her while providing emotional support and creating or resuming healthy family rituals. This strategy encouraged the permanence of the chemically-dependent member and the family on treatment.

I think we have to be by the person's side and not abandon him because it is really difficult even when you stand by him, if you abandon him, it will be worse. [...] talk, ask if everything is fine, don't abandon him, invite him to come and spend the weekend at home, to lunch, to dinner when you are at home [...] Because the help you can give, it is emotional, it is not financial; so it's by talking, understanding [...]. (F3M3)

Another family support strategy consisted in monitoring the moments of intense desire to use the drug (craving) and following the dependent person's daily routine to prevent relapse.

Talking, I'm always hinting: 'Oh, watch out, you're going to relapse; you watch it to see if he is relapsing'. [...] I am in control like, I mean, I talk to him [sick relative] a lot; I call him during the day to see if he is well, I call him at night to see if he is well [...] so I've learned from my son's attitudes, when he is about to a relapse. (F3M3)

Family unity and the treatment of its members can show the family's commitment and involvement to continue treatment.

So, if the family is not together, it there's no point in her [user's] going to the clinic. It doesn't even make sense to start any kind of treatment. And the importance that we give to the treatment, we are also part of this, there is no way to think: '[user's name] is recovering and we are not part of this?'. It's just one thing, it

doesn't make sense for her to be there [in the health service] and for us not to be treated here. There's no way to separate it, you know? There is no way to say what the family will do for her to improve it. It's everybody being treated. (F2S2)

The families' obligation to care for their sick relatives was related to their interactional modes, according to marital, patriarchal or maternal commitment. At other times, the families' lack of courage to abandon their relatives made it possible to resort to other resources to protect them.

I've wanted to separate a thousand times, I didn't want it anymore, but he has nowhere to go. If I split up, he'll stay on the street [...] I know that if I split up, if I don't help him, then [the sick husband] will hit rock bottom, there will be no way, so that's what motivates me to help, and also there's no way out. (F5W1)

We [the user's father and mother] have decided this: "We have two paths to follow - Either we would separate him and put him in his own room [user] or we would put him out on the street". It's as I said in the family group: 'I don't have the courage to put a child on the street'. [...] and separating the room, that was when he helped his father to separate the room. [...] He is very violent [...] if he is violent in the street, they will kill him. That's why I won't put him out on the street, because I know he won't last long. (F6M6).

Discussion

In the first category, the study participants recognized the family group as a space for empowerment, learning and motivation to continue the treatment of their own families and their dependent members. Thus, creating a therapeutic alliance among family members and between family members and the CAPS ad team favors adherence.

The data corroborated studies on the exchange of experiences lived by family members in similar group situations, which helped them to feel embraced, as if belonging to the group, as well as strengthened and motivated to assist other family members in adhering to treatment^(13,17-18). Such opportunities in a therapeutic group make it possible for them to establish new friendship bonds⁽¹⁹⁾ and hope for the recovery of their chemically-dependent relatives^(13,18).

Such exchange of experiences, despite the singularities of each family, promotes reflections, mutual help and encourages the search for unique and different meanings in this trajectory of taking care of oneself and taking care of the other. The feeling expressed by the families participating in this study of not being alone in the therapeutic trajectory and of being able to share their experiences made it possible for them to feel relieved and belonging to the group. In addition, they acknowledged that their problems were simple and easy to face in view

of those expressed by other members, according to studies^(3,13,17).

These data corroborate the literature^(3,13,17) by indicating that the family group means embracement, support and a source of listening^(3,13,17,19), as well as provides families with a base and comfort, thus facilitating their involvement in the treatment⁽²⁰⁾.

The process of sharing potentialities, difficulties and challenges among families triggers a social and therapeutic network, in which its participants interact with one another, identify with one another construct and reconstruct their lives.

The family members' reports confirmed studies that point to the family group as a learning space, since it is a source of information and guidance^(3,13,17) as well as allows for change in family behavior^(3,19). Information obtained by participants concerning chemical dependence (symptoms and withdrawal signs) and users' attitudes enabled learning and the management of relapse situations, thus corroborating the literature^(13,17,19). However, the health service must be careful not to turn families simply into guidance recipients only, but rather develop therapeutic projects aimed at them⁽⁴⁾.

The findings in this study highlighted that the group provides tools and strengthens family members to live with and care for their dependent relative on a daily basis, according to the literature^(3,13,18). Thus, the group constitutes a continuous source of knowledge that motivates and encourages families to engage and remain in adherence to treatment.

In the group space, families can reflect, perform self-assessments, discover or rediscover abilities that help them face and solve problems in their daily lives, with the support of sharing their relatives' stories.

A study involving the relatives of children and adolescents with mental suffering who participate in an operative group points out that such group enables them to reflect and internalize knowledge to solve problems⁽²⁰⁾.

The group enables the process of self-reflection and self-knowledge⁽²⁰⁾, thus empowering family members so that they can identify with situations arising from other people's experiences. However, such experiences reverberate in the collective and provide a review of family members' knowledge, beliefs, feelings, emotions, attitudes and behaviors.

The reports corroborate a study emphasizing that the therapeutic alliance between the health team and users and/or family members is associated with better treatment adherence⁽²¹⁾. An investigative study on the reasons for the therapeutic engagement of youngsters and families who experience the first psychotic episode pointed out the importance of the therapeutic relationship with the health team. The engagement of both groups represents the result of the professionals' communicational and

informational process⁽²¹⁾ concerning chemical dependency, their support and their optimistic postures regarding users' recovery⁽²¹⁾.

In the second category, families' adherence to the treatment of their dependent members is driven by their positive expectations regarding their relative's recovery.

A study on relatives of drug-dependent persons showed that 83% of them had recovery and cure expectations for their family members⁽²²⁾, thus corroborating the findings in the present investigation that users will return to old life habits through Divine power and labor.

In fact, there is a study that highlights drug users' expectations to return to old lifestyle habits through work and study⁽²³⁾. In the recovery process of chemically-dependent individuals, work can play an important role in reorganizing and re-establishing their daily routine, by recovering their self-esteem, recognizing them as citizens with rights and re-including them socially. However, it can be a source of stress, acting as a risk factor for people with difficulties competing in this environment⁽²⁴⁾.

It is understood that the recovery process requires time and investment from families, users, the health team and the government. Such investment spans cultural, social, economic, legal, technical, scientific and political dimensions. There is a need for public-health and labor policies that would enable the inclusion of such users in a new job market, thus breaking society's stigma and prejudice.

In our findings, the families reinforced the view that recovery is based on cure, abstinence from drugs and relapse prevention, thus corroborating a study that relates such perception to the biological or disease model⁽⁴⁾.

A family participating in this study hoped that the first hospitalization in therapeutic communities or specialized clinics could cure the dependent relative, which corroborates the literature⁽⁴⁾. Probably because it was this family's first hospitalization experience, such belief and hypothesis were more intense. Indeed, the family believed that hospitalization was the first and only solution for cure, thus becoming an immediate resource⁽⁴⁾. However, the current Brazilian mental-health policy has invested in therapeutic monitoring in open community-based services, based on the strategic Harm Reduction policy⁽⁴⁾. This policy proposes care-provision actions that allow subjects to relate to substances in a way that is less harmful to their health, without necessarily reducing or ceasing use. However, hope promotes motivating forces for families to persist in treating their relatives⁽²⁵⁾.

The findings in the latter category confirmed studies which point out that families play a role in supporting treatment⁽²¹⁻²²⁾ by not desisting from helping their dependent relatives⁽⁴⁾. Struggle and persistence permeated these families' trajectories, assisting them in therapeutic adherence.

Despite the difficulties faced by the families participating in this study, they mobilized themselves to emotionally support their relatives, bringing them closer to family life and recovering healthy daily family rituals and routines. The family context can be configured as a protective factor in users' lives⁽²⁶⁾. Another study on the facilitating forces in families with a member showing a mental disorder highlights the importance of including daily pleasurable practices with their members; in addition to stimulating and encouraging the family in the process of assertive communication and adherence to routines⁽²⁷⁾.

For the interviewees, another important role played by families was to monitor the chemically-dependent person's behavior in relation to relapse. This is one of the factors that most affects drug users' families⁽²⁷⁾. Despite the importance of this act, attention is needed to the process of intense emotional involvement by family members, which is referred to as codependency. In the care-provision process, there is obsessive concern and dedication from family members towards the chemically-dependent person, in the tendency to control his/her behavior, thus forgetting to take care of themselves⁽²⁾.

However, the findings in this study highlighted that the family's unity showed commitment to treatment. They all add forces so that the final objective is successfully achieved, that is, the relative's and the family's recovery, reorganization and better family life. However, for this to occur, everyone must participate in the therapeutic process. Thus, families⁽³⁻⁴⁾ and their relatives⁽⁴⁾ adherence to treatment involves a degree of involvement and participation in care provision by both parties.

Such degree of family involvement can be related to the feeling of being obliged to take care of one's relative, as found in this study. The literature points out that this feeling represents an intrinsic need to the human condition, in which an individual undertakes to take care of another as an ethical ideal, encompassing acts, behaviors and attitudes, with the purpose of promoting the well-being and recovery of the person being cared for⁽²⁸⁾. However, codependency can trigger feelings of guilt in family members and/or emotional dependence between family members and drug users⁽²⁾, requiring constant dedication to care provision. Family members may feel ethically and morally responsible for the care of their relatives for fear of being negatively judged by society.

Conclusion

The present study concluded⁽²⁵⁾ that the families acknowledged that creating therapeutic alliances, having hope in their relatives' recovery and valuing their participatory roles in family treatment facilitate their therapeutic adherence.

The limitations to this study are related to the participation of only two families that had more than one

member in the interview, which provides a more collective view of families rather than an individual one. However, the results in this study contribute to the reflection by health professionals regarding the possible strategic areas in the care for families so as to help them in therapeutic adherence.

References

1. Bortolon CB, Signor L, Moreira TC, Figueiró LR, Benchaya MC, Machado CA et al. Family functioning and health issues associated with codependency in families of drug users. *Ciênc Saúde Coletiva*. [Internet]. 2016;21(1):1001-7. [cited Oct 28, 2018]. Available from: <http://www.scielo.br/pdf/csc/v21n1/1413-8123-csc-21-01-0101.pdf>.
2. Costa B, Marcon SS, Paiano M, Sales CA, Maftum MA, Waidman MAP. Feelings and codependent behavior in the family of illicit drugs users. *Acta Sci Anim Sci*. [Internet]. 2017;39(2):175-81. [cited Oct 28, 2018]. Available from: <http://www.redalyc.org/articulo.oa?id=307252895007>
3. Nascimento LTR, Souza J, Gaino LV. Relationship between drug dependence and alcohol users receiving treatment in a community health center specializing in alcohol treatment. *Texto Contexto Enferm*. 2015;24(3):834-41. doi: <http://dx.doi.org/10.1590/0104-07072015003610013>.
4. Belotti M, Fraga HL, Belotti L. Família e atenção psicossocial: o cuidado à pessoa que faz uso abusivo de álcool e outras drogas. *Cad Bras Ter Ocup*. 2017;25(3):617-25. doi: <http://dx.doi.org/10.4322/2526-8910.ctoAR0988>.
5. Chakrabarti S. What's in a name? Compliance, adherence and concordance in chronic psychiatric disorders. *Wld J Psychiatry*. [Internet]. 2014;4(2):30-6. [cited Oct 28, 2018]. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4087153/pdf/WJP-4-30.pdf>.
6. Moraes ABA, Rolim GS, Costa AL Jr. O processo de adesão numa perspectiva analítico comportamental. *Rev Bras Ter Comport Cogn*. [Internet]. 2009;11(2):329-45. [Acesso 4 jan 2018]. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1517-55452009000200009&lng=pt.
7. Leite SN, Vasconcellos MPC. Adesão à terapêutica medicamentosa: elementos para a discussão de conceitos e pressupostos adotados na literatura. *Ciênc Saúde Coletiva*. [Internet]. 2003;8(3):775-82. doi: <http://dx.doi.org/10.1590/S1413-81232003000300011>.
8. Scaduto AA, Barbieri V. O discurso sobre a adesão de adolescentes ao tratamento da dependência química em uma instituição de saúde pública. *Ciênc Saúde Coletiva*. [Internet]. 2009;14(2):605-14. doi: <http://dx.doi.org/10.1590/S1413-81232009000200029>.
9. Alvarez SQ, Gomes GC, Oliveira AMN, Xavier DM. Grupo de apoio/suporte como estratégia de cuidado: importância para familiares de usuários de drogas. *Rev Gaúch Enferm*. [Internet]. 2012;33(2):102-8. doi: <http://dx.doi.org/10.1590/S1983-14472012000200015>.
10. Paz AZ FM, Colossi PM. Aspectos da dinâmica da família com dependência química. *Estud Psicol*. [Internet]. 2013;18(4):551-8. [Acesso 2 jan 2016]. Disponível em: <http://www.scielo.br/pdf/epsic/v18n4/a02v18n4.pdf>.
11. Maciel LD, Zerbetto SR, Filizola CLA, Dupas G, Ferreira NMLA. Consequências e dificuldades da dependência química no âmbito familiar: uma revisão de literatura. *Rev APS*. [Internet]. 2013;16(2):187-96. [Acesso 28 out 2018]. Disponível em: <https://aps.ufjf.emnuvens.com.br/aps/article/view/1809/721>.
12. Monteiro CFS, Fé LCM, Moreira MAC, Albuquerque IEM, Silva MG, Passamani MC. Perfil sociodemográfico e adesão ao tratamento de dependentes de álcool em CAPS-ad do Piauí. *Esc Anna Nery*. 2011; 15(1):90-5. doi: <http://dx.doi.org/10.1590/S1414-81452011000100013>.
13. Vasters GP, Pillon SC. Drugs use by adolescents and their perceptions about specialized treatment adherence and dropout. *Rev. Latino-Am. Enfermagem*. 2011; 19(2): 317-24. doi: <http://dx.doi.org/10.1590/S0104-11692011000200013>.
14. Ribeiro DVA, Turato ER, Azevedo RCS, Campos CJG. Views on treatment adherence among psychoactive substance-dependent women in the outpatient setting: a qualitative study. *Trends Psychiatry Psychother*. 2012;34(4):192-206. doi: <http://dx.doi.org/10.1590/S2237-60892012000400005>
15. Seleguim MR, Oliveira MLF. Influence of the family environment on individuals Who use crack. *Acta Paul Enferm*. [Internet]. 2013;26(3):263-8. doi: <http://dx.doi.org/10.1590/S0103-21002013000300010>
16. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14th ed. São Paulo: Hucitec; 2014.
17. Gomes RJ, Martos CC, Cavalari MCA, Rossetto AA. Atendimento grupal: trabalhando a codependência. *Colloquium Humanarum*. [Internet]. 2012; 9(n.esp): 508-16. [Acesso 2 jan 2016]. Disponível em: <http://www.unoeste.br/site/enepe/2012/suplementos/area/Humanarum/Ci%C3%A4ncias%20Humanas/Psicologia/ATENDIMENTO%20GRUPAL%20TRABALHANDO%20A%20CO-DEPEND%C3%8ANCIA.pdf>
18. Alves RD, Morais TTM, Rocha SP, Rocha NNV, Duarte SR, Sampaio FFF. Grupos de familiares em CAPS ad: acolhendo e reduzindo tensões. *Sanare, Rev Políticas Públicas*. [Internet]. 2015; 14(1):81-6. [Acesso 2 jan 2016]. Disponível em: <https://sanare.emnuvens.com.br/sanare/article/view/613/330>
19. Duarte MLC, Viana KR, Olschowsky A. Crack users' evaluation regarding family groups in the psychosocial care center. *Cogitare Enferm*. [Internet]. 2015;20(1): 81-8. [Acesso 4 jan 2018]. Disponível em: <http://dx.doi.org/10.5380/ce.v20i1.37597>

20. Albuquerque MCS, Nascimento YCML, Brêda MZ, Luca LCG. Mudanças percebidas por familiares de crianças/adolescentes em sofrimento mental que participam de grupos operativos. *Rev Eletr Enferm.* 2014;16(3):652-61. doi: <https://doi.org/10.5216/ree.v16i3.21777>
21. Stewart KD. Factors contributing to engagement during the initial stages of treatment for psychosis. *Qual Health Res.* 2012;23(3):336-47. doi: <http://journals.sagepub.com/doi/10.1177/1049732312468337>.
22. Xavier MF, Rodrigues PHJ, Silva MCR. A percepção da família no tratamento e suporte de dependentes químicos. *Encontro, Rev Psicol.* [Internet]. 2014;17(26):99-110. [Acesso 4 jan 2016]. Disponível em: <http://www.pgsskroton.com.br/seer/index.php/renc/article/view/2419/2319>.
23. Gomes RR, Ribeiro MC, Matias EC, Brêda MZ, Mângia EF. Motivation and expectations in treatment search for abusive use and addiction of crack, alcohol and other drugs. *Rev Ter Ocup Univ São Paulo.* 2015;26(3):326-35. doi: <http://dx.doi.org/10.11606/issn.2238-6149.v26i3p326-335>.
24. Silva AC, Weber F, Adan A, Hidalgo MPL. O papel do trabalho no processo saúde-doença em dependentes de crack. *Arq Ciênc Saúde.* 2015;22(1):48-52. doi: <https://doi.org/10.17696/2318-3691.22.1.2015.26>
25. Zauszniewski JA, Bekhet AB, Suresky MJ. Indicators of resilience in family members of adults with serious mental illness. *Psychiatr Clin North Am.* 2015;38(1):131-46. doi: <http://dx.doi.org/10.1016/j.psc.2014.11.009>
26. Marcon SR, Sene JO, Oliveira JRT. Contexto familiar e uso de drogas entre adolescentes em tratamento. *SMAD, Rev Eletrônica Saúde Mental Álcool Drog.* [Internet]. 2015;11(3):122-8. [Acesso 20 ago 2018]. Disponível em: http://pepsic.bvsalud.org/pdf/smad/v11n3/pt_02.pdf
27. Bishop M, Greeff AP. Resilience in families in which a member has been diagnosed with schizophrenia. *J Psychiatr Ment Health Nurs.* [Internet]. 2015;22(7):463-71. [cited Jan 4 2018]. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/jpm.12230/epdf>
28. Waldow VR, Borges RF. Caring and humanization: relationships and meanings. *Acta Paul Enferm.* [Internet]. 2011;24(3):414-8. doi: <http://dx.doi.org/10.1590/S0103-21002011000300017>.

Author's Contribution

Study concept and design: Ana Carolina Belmonte Assalin, Sonia Regina Zerbetto. Obtaining data: Ana Carolina Belmonte Assalin, Sonia Regina Zerbetto, Bianca Oliveira Ruiz. Data analysis and interpretation: Ana Carolina Belmonte Assalin, Sonia Regina Zerbetto. Drafting the manuscript: Ana Carolina Belmonte Assalin, Sonia Regina Zerbetto. Critical review of the manuscript as to its relevant intellectual content: Ana Carolina Belmonte Assalin, Sonia Regina Zerbetto, Bianca Oliveira Ruiz, Priscila Souza, Sarah Salvador Pereira.

All authors approved the final version of the text.

Conflict of interest: the authors have declared that there is no conflict of interest.


Received: Sep 11th 2018

Accepted: Ago 24th 2020

Corresponding Author:

Sonia Regina Zerbetto

E-mail: szerbetto@hotmail.com

 <https://orcid.org/0000-0002-2522-1948>

Copyright © 2021 SMAD, Rev. Eletrônica Saúde Mental Álcool Drog.
This is an Open Access article distributed under the terms of the Creative Commons (CC BY-NC).

This license lets others remix, tweak, and build upon your work non-commercially, and although their new works must also acknowledge you and be non-commercial, they don't have to license their derivative works on the same terms.