Revista Brasileira de Enfermagem
REBEn

Psychiatric hospitalization of alcoholists from rural areas in a general hospital: expectations of families

Internação psiquiátrica no hospital geral de alcoolistas do meio rural: expectativas dos familiares

Hospitalización psiquiátrica en un hospital general de alcoholistas del medio rural: expectativas de los familiares

Andréa Noeremberg Guimarães[I]
ORCID: 0000-0001-5425-7627

Jacó Fernando Schneider[II]
ORCID: 0000-0002-0151-3612

Márcio Wagner Camatta[II]
ORCID: 0000-0002-4067-526X

Cíntia Nasi[II]
ORCID: 0000-0002-4322-3701

Lucimare Ferraz[I]
ORCID: 0000-0002-2487-8614

Leandro Barbosa de Pinho[II]
ORCID: 0000-0003-1434-3058

[I] *Universidade do Estado de Santa Catarina. Chapecó, Santa Catarina, Brazil.*
[II] *Universidade Federal do Rio Grande do Sul. Porto Alegre, Rio Grande do Sul, Brazil.*

How to cite this article:
Guimarães AN, Schneider JF, Camatta MW, Nasi C, Ferraz L, Pinho LB. Psychiatric hospitalization of alcoholists from rural areas in a general hospital: the expectations of families. Rev Bras Enferm. 2019;72(6):1442-9. doi: http://dx.doi.org/10.1590/0034-7167-2017-0710

Corresponding Author:
Andréa Noeremberg Guimarães
E-mail: andrea.guimaraes@udesc.br

Submission: 10-14-2017 **Approval:** 03-20-2019

ABSTRACT

Objective: to know the expectations of family members of alcoholics living in rural areas under treatment in a Psychiatric Hospitalization Unit. **Method:** qualitative research, through interviews with 15 relatives of alcoholics living in rural areas and hospitalized in a Psychiatric Unit. Information was interpreted in the light of Phenomenological Sociology. **Results:** two concrete categories emerged: Expectations that the family member quits using alcohol and Projects of family members for the alcoholic after discharge. Relatives expected the alcoholic to maintain abstinence and planned post-discharge care, which involved everything from welcoming them to projects with a prospect of control or even fear of not being able to care for the alcoholic. **Final considerations:** most participants have positive expectations regarding psychiatric hospitalization, but some relatives are not confident about caring for the alcoholic and mentioned alternatives such as hiring a caregiver or nursing homes.

Descriptors: Family; Alcoholism; Rural Population; Hospitals, General; Nursing.

RESUMO

Objetivo: Conhecer as expectativas de familiares de alcoolistas residentes no meio rural com tratamento em Unidade de Internação Psiquiátrica. **Método:** pesquisa qualitativa, mediante entrevista com 15 familiares de alcoolistas residentes no meio rural internados em uma Unidade Psiquiátrica. As informações foram interpretadas à luz da Sociologia Fenomenológica. **Resultados:** emergiram duas categorias concretas: Expectativas de que o familiar pare de fazer uso de álcool e Projetos do familiar do alcoolista após a alta hospitalar. Os familiares esperavam que o alcoolista mantivesse a abstinência e planejavam os cuidados após a alta, envolvendo desde o acolhimento em seus lares a projetos com perspectiva de controle ou de receio de não terem condições de cuidar do alcoolista. **Considerações finais:** a maioria dos participantes tem expectativas positivas em relação à internação psiquiátrica, mas há familiares que não se sentem seguros em cuidar do alcoolista e mencionaram alternativas como buscar outro cuidador e, até mesmo, asilos.

Descritores: Família; Alcoolismo; Zona Rural; Hospitais Gerais; Enfermagem.

RESUMEN

Objetivo: Conocer las expectativas de familiares de alcohólicos residentes en el medio rural con tratamiento en una Unidad de Hospitalización Psiquiátrica. **Método:** investigación cualitativa, mediante entrevista con 15 familiares de alcohólicos residentes en el medio rural hospitalizados en una Unidad Psiquiátrica. Las informaciones fueron interpretadas bajo la luz de la Sociología Fenomenológica. **Resultados:** dos categorías concretas han surgido: Expectativas de que el familiar deje de hacer uso de alcohol y Proyectos del familiar del alcohólico después del alta hospitalaria. Los familiares esperaban que el alcohólico mantuviera la abstinencia y planificara los cuidados después del alta, que envolvían desde la acogida en sus hogares hasta proyectos con perspectiva de control o de temor de no tener condiciones de cuidar del alcohólico. **Consideraciones finales:** la mayoría de los participantes tienen expectativas positivas con relación a la hospitalización psiquiátrica, pero hay familiares que no se sienten seguros en cuidar del alcohólico y mencionaron alternativas como buscar otro cuidador e, incluso, asilos.

Descriptores: Familia; Alcoholismo; Medio rural; Hospitales Generales; Enfermería.

INTRODUCTION

According to the World Health Organization (WHO), roughly 3.3 million deaths are related to the harmful use of alcohol each year[1]. A study evaluating the burden of such disease and the injury caused by 67 risk factors worldwide estimated that the number of alcohol-related deaths and the decrease in life expectations have increased in recent decades. In 1990, alcohol ranked eighth on the list of leading causes of death and disability in the world, and in 2010 it ranked fifth[2].

Alcohol dependence is a serious public health problem in most countries, including Brazil, and affects people from both urban and rural areas. Alcoholism, besides being a risk factor for the development of several noncommunicable diseases, such as cancer, mental disorders and cardiovascular diseases, is associated with numerous social, labor and economic damage[3]. This problem does not affect only dependents, but also their relatives, who end up presenting an objective and subjective overload when living with the alcoholic person. Changes in the routine of the household cause financial impacts to the family members who take on obligations that were of the alcoholic, causing sleep loss, irritability, anguish, depressed mood, among other harm[4].

In current public mental health policies in Brazil, the paradigm that currently operates with psychiatric reform emphasizes the provision of psychosocial care in a service network and in a given territory[5]. In this context, among the services designed to treat individuals with needs arising from the problematic use of alcohol and other drugs, there are wards specialized in general hospitals.

Given that alcoholism is a disease that affects the whole family, during the period of psychiatric hospitalization in the general hospital, the care given by the interdisciplinary team, especially by Nursing professionals, must be extended to the family, so that they feel cared for and strengthened to assist throughout the recovery process of the alcoholic. In addition, this process of caring for individuals and their families must be continuous, occurring after hospitalization, articulating the services of the network with territorial practices that contribute to improving the living conditions and the provision of health care[5].

Thus, under the perspective of psychosocial care, Nursing features in the context of paradigmatic transition, based on the recognition of the holistic, ecological and human complexity of human beings and their relationships, with a view to overcoming the biomedical model, converging with the subjectivity of others. The theoretical framework of Alfred Schütz's Phenomenological Sociology can help in the understanding of the phenomena of this nature, since nurses guide their health care actions in a face-to-face relationship, which makes them comprehend the motivations of individuals from the perspective of their daily lives[6].

According to Phenomenological Sociology, motivations refer to the way how human actions can be interpreted, and they are distinguished in *reasons for* and *reasons why*. The *reasons for* are related to the future, because they involve expectations, that is, the objectives to be reached with a determined action, which was designed by an individual; and the *reasons for* refer to their previous experiences, which determine their ways of acting[7].

For Nursing professionals, understanding the reasons of the individuals involved in the care process helps design a therapeutic plan, considering the human and social dimensions of individuals, fulfill their needs and seek to establish an intersubjective relationship that facilitates the interaction and approximation of professionals to the world lived by users[8].

Brazil still lacks studies on the reasons of family members of alcoholic inhabitants in rural areas, especially regarding their psychiatric treatment in a general hospital. It is understood that research on the matter is relevant, since giving voice to these relatives and understanding their expectations as to the treatment of alcoholics can help professionals working in the area of Mental Health to reflect on their practices and propose actions for prevention, promotion and rehabilitation that meet the real needs of this population. In addition, it will stimulate reflection on the organization of mental health services in rural areas.

OBJECTIVE

To understand the expectations of family members of alcoholics living in rural areas under treatment in a Psychiatric Hospitalization Unit.

METHOD

Ethical aspects

All ethical requirements for research involving human beings were respected, in accordance with Resolution 466/2012 by the Brazilian National Health Board (CNS). The research project was approved by the Research Ethics Committee of the *Universidade do Estado de Santa Catarina* (UDESC).

Participants signed the Free and Informed Consent Term and the authorization document for voice recording. To ensure their anonymity, each participant was identified by the letter "F", followed by an ordinal number and the level of kinship with the alcoholic.

Type of study

This is a qualitative study, with Alfred Schütz's Phenomenological Sociology approach. This framework has as a cornerstone the works by Max Weber and Edmund Husserl and seeks to understand human action in the social environment[7,9].

The use of Phenomenological Sociology in studies within Nursing and Mental Health in health services allows unveiling social phenomena. It is proposed to understand subjects as beings in the world, which are made of knowledge, biography, subjectivity, singularity, individuality and motivations. The relational attitude of familiarity and recognition of the subjectivity of others are operational bases of this referential that favor the implementation of mental health care initiatives, based on social needs[10].

Methodological procedures

Research setting

Research was carried out in a Psychiatric Hospitalization Unit of a general hospital, located in the Western region of the state of Santa Catarina, Brazil. This unit serves people with mental

disorders and/or needs arising from the use of alcohol and other drugs, with a serious clinical picture, and serves as a reference for about 50 municipalities in the Western region of Santa Catarina. Inpatient hospitalizations are performed through the Brazilian Unified Health System (SUS – *Sistema Único de Saúde*), with a maximum programmed length of up to 30 days.

Data source

A total of fifteen family members of alcoholics from rural areas hospitalized for treatment participated in the study. The definition of the number of participants was based on Gaskell[11], who establishes a maximum limit between 15 and 25 interviews, which is necessary for the interpretation of qualitative research. The number of family members interviewed was defined due to the possible repetition of data and the absence of new information, enough to achieve the study objective[12].

Inclusion criteria to participate in research were: being 18 or older, living daily with the alcoholic, being considered as family by the user, self-declaring to be resident in the rural area, and accompanying the alcoholic in family visits during hospitalization. The exclusion criterion to participate in research was not having verbalization conditions.

Data collection and organization

Information was collected from August 2015 to July 2016, based on a semi-structured interview, guided by a script composed of identification data and by the open question: What do you expect from the treatment of your family member?

Family members were invited to participate in research at the time of the visits. Interviews took place in a reserved room inside the hospital, according to the availability of interviewees. They were recorded on a digital recorder and had an average duration of 40 minutes and were later transcribed in full.

Data analysis

For the analysis of information, the following adapted steps[13] were used: 1) Reading each speech without any attempt to interpret what is expressed; 2) Re-reading each of the statements and identifying those that present meanings considering the objective of the study; 3) Using a reflexive posture before the significant affirmations from speeches, describing the motivations of participants, grouping fragments of lines that contain similar or significant expressions or phrases; 4) Building concrete categories, being: *Expectations that the family member quits using alcohol* and *Alcoholist's familiar projects after discharge*; and 5) Understanding the motivations of family members of alcohol users who live in rural areas, based on Alfred Schütz's Phenomenological Sociology and the production of knowledge in the field, in order to contextualize the essence of the phenomenon studied.

RESULTS

According to Schütz, all individuals who are in the social world position themselves in life in a specific way, called the *biographical situation*. For contextualization of the profile of family members of alcoholics living in rural areas, interviewed in this study, the synthesis of some characteristics of biographical situations was performed.

Of the 15 participants in the study, 8 were male. Their ages ranged from 25 to 73 years old. Most attended the 4th grade of elementary school. They all lived in rural areas of small municipalities in the state of Santa Catarina. Most family members (10), although retired, worked with activities related to agriculture and livestock. Regarding the monthly family income, one interviewee could not inform it, and the others answered that it was between R$800.00 and R$5,000.00. In relation to the level of kinship with the alcoholic, 1 son-in-law, 2 children, 1 daughter, 1 grandfather, 4 mothers, 2 sisters and 4 siblings participated in the study.

The following topics presented are the two concrete categories that emerged from the convergences in participants' speeches.

Expectations that the family member quits using alcohol

The relatives revealed their expectations, that is, their *reasons for*, and expressed hope that, with the treatment in the Psychiatric Inpatient Unit, the alcoholic does not use alcohol anymore. The expectation regarding abstinence showed the concern with the hospitalized relative, both with his/her health and labor aspects, demonstrating the affection felt:

> *I hope he quits drinking alcohol because he has a lot of liver problems, if he wants to live, he must stop using it.* [...] *I hope he lives with us for the rest of his life.* [...] *I hope he quits because I want him to live because he has suffered all his life with these drinks, so I want he lives life, enjoys the time he is alive.* (F1-Son-in-law)

> *Work again, it's what we wanted for him.* (F2 - Sister)

> *I hope he moves forward, drink no more, put his head in order. Because if he comes back and start drinking, he'll leave and die.* (F6 - Sister)

> *I hope he gets better, gets out of here and goes travel. He even abandoned his job,* [...] *his boss put another person on his truck to work.* (F7 - Mother)

> *I hope he changes; that he gets better. I hope it works out. Imagine, he's young, he should care for his life; the way he was, he could have had a stroke.* (F12 - Mother)

> *I hope he recovers and quits drinking, because he's always sick. If it stops it will improve a lot his situation.* (F14 - Son)

> *I hope he becomes better, lives better. He already has problems, he has even cancer.* (F15 - Brother)

Family members also have the expectation that, after hospital discharge and the consequent abstinence of the alcoholic, they can maintain a good family and social relationship, generating well-being for themselves and for other relatives.

> *I'm confident, I hope it works out.* [...] *If he could do it, he'd give many people some rest.* [...] *He may change.* (F8 - Grandfather)

> *I hope he leaves here and stops drinking. My wife also hopes he gets better, because otherwise, she says she will not be able to handle it.* (F9 - Brother)

> *I hope he recovers, because it is not easy to deal with a person who drinks and when you get older it gets more expensive.* (F11 - Mother)

> *I think it's going to work now, enough of that suffering. I don't want him to drink anymore. Because of his family, dear family.* (F15 - Brother)

It can be noticed in the speeches that the support factors of relatives to their expectations regarding the treatment of the alcohol user were faith and religiosity. Besides that, some people mentioned the prospect of "healing" of the alcoholic, demonstrating their ignorance towards alcoholism as a chronic disease.

> *I have faith that he puts up without alcohol.* (F1- Son-in-law)

> *It would be good if he could get out of here healed.* (F2 - Sister)

> *I hope he does not drink again, that he will be my perfect son again.* [...] *If he isn't healed, I don't know* [...]. (F4 - Mother)

> *If it gets better, what happiness it'll be for us! Because there are some who say it (the treatment) doesn't work sometimes, but I have faith that it does.* [...] *I have faith that he will get better just like the others, just like his brother and father.* (F7 - Mother)

> *I hope God will give him strength to quit it,* [...].*I have faith that God will bless him because here the treatment is good.* (F11 - Mother)

Projects of the family member for the alcoholic after discharge

During the interviews, when referring to the future, research participants revealed projects to be carried out after the discharge of the alcoholic. Some spoke about the reception for the alcoholic in their homes:

> *He's a poor guy, if we do not welcome him back home, he'll end up dying on the streets.* [...] *I told him that I don't want anything, I'll give him clean clothes, food, whatever he needs for him to live the rest of his life.* [...] *If we don't help him, he'll resume drinking, and that will be the end of this man, he'd die for not having someone caring for him. And it really makes me suffer when I see someone in pain, and you have the means to help and don't do it.* (F1-Son-in-law)

> *We're going to change her house a bit. In my opinion, I'd remove that house from there, bring it closer to mine; but since she doesn't want me to do it, I can't do that. She can stop by, we can visit her, she can go to my brother's, it's all near.* (F13 - Daughter)

Some relatives, however, have shown some uncertainty regarding the improvement of the clinical picture and the maintenance of abstinence from alcohol. Although they did not mention the interest in receiving the alcoholic in their own home after discharge, they did not intend to abandon the alcoholic family member, because they wanted to provide care, seeking alternatives such as hiring a caregiver or a nursing home. The projects manifested were translated into fear of not being able to constantly care for the alcoholic.

> *Who will care for him, who will give him the medications? Because he won't accept them and if he doesn't take them it will get worse. We will have to see what to do because we don't have anyone to take care of him, we have our obligations. When we bring him home, how do we deal with him?* [...] *We were thinking of building a small house for him near his father's.* (F2 - Sister)

> *There's got to be somebody to give the medications. Because the first time, after two weeks, he was conscious, very calm, and he took the pills and said, 'I don't want any more, "m going to drink'. I said, 'Oh, he's going to give in again.' And that's what happened. You can't do it alone. There's got to be somebody there for you.* (F3 - Brother)

> *He has his house there,* [...] *he can get a job in the city. If it works out with his wife, if they want to go back living together, he lives in the house and works in the city. It's what I had thought because together here it won't work. Because he and his father never got along very well at work, and then they would argue.* [...] *My husband does not want to work with him either. He said he can live in his own house, but working together with his father, he doesn't want to.* (F4 - Mother)

> *I have already talked to my brothers, if he doesn't get better, we'll have to find a way out because I have to work* [...] *if he doesn't get better, we'll search a nursing home.* [...] *And we must help him, there's no way we're leaving him alone, he is not insignificant* [...] *we'll see what to do or maybe pay someone who stays there with him. Leaving him, that we won't do.* (F10 - Son)

Among research participants, some revealed projects that included planned care for a control perspective:

> *We'll keep him at home because if he goes out* [...] *we can't handle it. Just like hospitalizing him here, he's being monitored. So, he'll stay home with us. He must attend meetings on Wednesdays in the church here, he must attend everything.* [...] *He promised, otherwise* [...] *we will hospitalize him again.* [...] *We have plans for him, if he resumes drinking, he goes straight* [...] *because we have no conditions anymore.* (F12 - Mother)

> *We'll supervise, help him.* [...] *Now we are not going to let him walk free like back then, only accompanied by his wife, that's how it'll be.* (F15 - Brother)

DISCUSSION

In the concrete category *Expectations that the family member quit using alcohol*, the statements given by participants about what they expected regarding the treatment of their relative reflected, from the point of view of Phenomenological Sociology, their *reasons for*, because they dealt with what they intended with their care and participation in the treatment process of the alcoholic.

The *reasons for,* involve motivations directed towards results. When actors project their actions, they are aware of these reasons, since they incite them[7]. Relatives, in expressing their perceptions

about the *reasons for*, referred to the recovery, sobriety and reinsertion of the alcohol user in family and social dynamics.

Given that they deal with the experience of social actors - in this case the relative - who lives in the ongoing process of his/her activity, the *reasons for* are considered essentially subjective, being revealed to another individual only if he/she asks what the meaning that the actor attributes to his/her action. The actor committed to his/her action, included as part of the continuous process of designing, defines and interprets the meaning of his/her action in terms of *reasons for*. For him/her, the reason means what he/she really has in mind and gives meaning to the action performed, and this is always the *reason for*, the intention to achieve a state of things, to reach a preconceived end. In this way, the subjective aspect of the *reasons for* refers to the relationship that maintains the action with the actor's consciousness. Consequently, it has nothing to do with ideas of introspection, psychological conditions or private attitudes[7].

In the speeches given by relatives, their expectations are associated with the feelings of faith, confidence and hope in the treatment of the alcoholic. The term "faith" means something that makes you believe in someone or something else. It manifests itself as a support that seeks to overcome difficulties at some point in life. Trust is a synonym of faith. This is an important feeling for family members who live with alcoholics, and it need must be worked with professionals who work in the perspective of mental health. It is not easy, however, to put it into practice. According to the meaning of the word, when you trust someone, you expect something good to happen. Despite that, it is no uncommon for families to face disappointments due to the individual's dependence on alcohol, leading to personal conflicts that weaken the bond between users and their families[14].

In this perspective, in the context of a chronic health condition, such as alcoholism, the family must be included in care[15]. When thinking about the role professionals play on the Psychosocial Care Network (*Rede de Atenção Psicossocial* - RAPS), based on the Phenomenological Sociology, the *biographical situation* and the motivations of the family members who contribute to their strengthening are paramount to face the challenges triggered by the alcoholic's dependence.

The concept by Schütz of *biographical situation* permeates human production of life, since it represents the consolidation of previous experiences of individuals and their possessions, making each biography unique, in the midst of the world shared by all. According to this conceptualization, it is relevant for Nursing to encourage the active listening of the family member of the alcoholic in health care, which can contribute to implement a therapy focused on the user's situation and their situation. Thus, health actions based on the needs of each person are instituted, consistent with their biographical situation[10].

In this regard, a good example was presented in a study carried out at a Psychosocial Care Center for Alcohol and Other Drugs (CAPS AD - *Centro de Atenção Psicossocial para Álcool e outras Drogas*) in the state of Minas Gerais, which concluded that the proposal to give freedom for alcohol users' relatives to talk, discuss and being heard motivated them to attend the service. This led relatives to assume co-participation in the treatment of alcoholics, improving its functioning and a family adjustment[16].

Although Brazil has a universal and public health system, one of its challenges is to carry out its initiatives throughout the domestic territory, in places of limited access, where infrastructure conditions hinder the availability of services. This is the case of rural communities[17].

In terms of Primary Care, there are 332,289 Community Health Agents (CHA) and 48,410 Family Health Strategy (FHS) teams across the country. These figures do not reach the established coverage ceiling, which is 492,854 ACS and 96,981 ESF teams[18]. These gaps reflect the proportion of households and inhabitants registered in Family Health Units, which are 50.6% and 53.3%, respectively, in urban areas; and 70.9% and 72.3%, in rural areas[19]. When it comes to the Family Health Support Center (*Núcleo de Apoio à Saúde da Família* - NASF), there are 5,067 teams in Brazil. This deficit is directly related to the 48,571 ESF teams not yet implemented, resulting in a percentage of 32% of municipalities (1,798) without NASF coverage in the country[18].

Many are the challenges to consolidate Primary Care and, undoubtedly, the improvement in coverage is critical. However, further steps are still needed to improve management, integration with the health services network, financing, resolving and quality of care, which are essential aspects for ensuring equitable and comprehensive care[19].

Administrative rule 3.088/2011 established the RAPS within the scope of SUS, with the purpose of creating, expanding and articulating places of health care for people with mental disorders and problems resulting from alcohol and other drugs[20]. The RAPS, and especially the CAPS, have increased throughout Brazil; however, the reality of mental health care in rural areas remains a problem. Thus, inhabitants of rural communities have problems accessing these services, whose organizational dynamics do not facilitate their participation in RAPS[16].

In the concrete category *Projects of family members for the alcoholic after discharge*, some research participants expressed mixed feelings as for the alcoholic in post-discharge, revealing the desire for approximation, reception and, at the same time, distancing from his/her life at home; however, there were no abandonment feelings. The uncertainty of maintaining abstinence from alcohol was possibly rooted in the history of relapses and psychiatric hospitalizations, considering that during the interviews most family members commented the alcoholic had already undergone other hospitalizations.

Schütz's theorizing about social action and the project refers to the question of volition (desire and will) and determination of human conduct. The term "action" refers to human conduct as an ongoing process conceived beforehand by the actor, i.e., a conduct based on a preconceived project. The action can be manifest or latent, and after it is performed, it is called an act[7].

Every action manifested is at the same time projected and endowed with purpose. It originates in the consciousness of the actor. Designing an action consists in predicting the future conduct by the imagination; however, it is not the process of action in progress, but the act that is imagined as performed that constitutes the starting point for any projection. The actor, who in this case are family members, must visualize the state of things to be accomplished by their future action before defining the specific steps of such future action that will result in this state

of things. They pose themselves imaginatively in a future time, when this action has already taken place. Only then they will be able to reconstruct, in their imagination, each of the steps that will have to be taken to produce this future act. Therefore, using the terminology by Schütz, the project does not predict future action, but the future act[7].

In this line of reasoning, the orientation to the family on the recovery stage of the alcoholic is important to create action projects aimed at the social and family reintegration after discharge. Given that the recovery process is slow and gradual, much general and family support is needed[15].

It is important to highlight that the temporal structure has significant consequences for any action project. According to Schütz, it always refers to the collection of knowledge that actors have at hand when designing the project. They carry their horizon of empty anticipations, the assumption that the proposed act will occur just like all the typically similar past acts they know at the time of project design. Such knowledge is a purely subjective element, and for this reason, actors, insofar as they live in their projection and acting, feel exclusively motivated by the act designed in the way *for*[7].

Schütz adds that in designing an action, the realization of the actors' plans involves many intermediaries. Of course, not all projects will be effective, and generally those that are performed are not made in the pure form in which they were designed. Everyday life is characterized by both disappointment and success; even if it is intuitive, it is known that what is imagined will not be identical to what will later reflect the act performed. The very notion of pure imagination is ambiguous, for what one imagines is a complex and changing ego, whose knowledge of the world and of others is fragmented as knowledge of oneself[7].

In the case of family members of alcohol users, knowledge at hand they have at the time of designing the project differs from knowledge at hand they will have after performing the act designed. In this new moment, family members will have aged, and if nothing else has changed, at least the experiences they had while carrying out their projects changed their biographical circumstances and expanded their experience collections[9].

It is common for family members to suffer from a sense of inability for not finding a solution, even when showing dedication and love. Without the guidance of professionals working in the Health Network, such feelings interfere in a negative way in the recovery of the alcoholic, because it is common to experience anger, frustration, distrust and, in the end, they discredit the recovery process, which generates demotivation and treatment by the alcoholic[21].

Families often tend to isolate the alcoholic, and when this happens nursing professionals must warn of the need to support this person to prevent future relapses. Relatives need to understand that relapse is a phase of alcoholism and, if it occurs, its motivation may be even related to the family environment[22]. Studies with alcoholics identified that interpersonal relationships and social and cultural aspects are among the causes, both for the use of psychoactive substances and for the search for treatment[23].

It should be noted that controlling care is present in the action plans of relatives of alcoholics, to be developed after hospital discharge, as the speeches by F12 and F15 illustrate. Nursing professionals are of utmost importance in orienting alcohol users' families to discuss other possibilities of care approaches foreseen in health policy, such as in the perspective of harm reduction. This policy seeks to understand the user's relationship with alcohol and then intervene with him/her and not on his/her behalf. This is done by focusing on a logic of reducing social and health damages and caring for one's health in the act of consuming drugs, and not on the drug and its control for users.

From the perspective of Phenomenological Sociology, human beings find, in their daily lives, at any moment, a collection of knowledge at their disposal, which serves as a code of interpretations of their past and present experiences, and determines their anticipation of the things to come. This collection of knowledge is socially acquired, from the sharing of the social world with others[9]. The social world, in turn, is the space in which one acts, interacts and interprets the lived environment, transforming it and being transformed. It refers to social relations, context and culture as determinants for the constitution of beings in the world they live in[10]. The social world is interpreted in terms of *typification* of social actors, their patterns for courses of action, motives and objectives, or the sociocultural products that generated their actions[9].

By following this train of thought of Schütz, Nursing, in providing a comprehensive and overlapping care to social reality, must consider previous experiences of alcohol users and their families constituents of the biographical situation of each one, the singular meanings of their motivations and the typical of the action.

Health care professionals must permanently seek training to serve this public. The demands arising from the universe of alcohol dependence are coated with complexities and setbacks, and the time factor must be considered in the evaluation of more effective results. It is thus essential that professionals working with relatives of alcoholics believe in the possibility of change and that starting over is part of a continuous process in users' search for changing and rescuing autonomy. It should be borne in mind that the treatment of alcoholism is a long process and is permeated by ups and downs[24].

Finally, the services offered by the Networks of Support to families are still insufficient, fragmented, and do not offer efficient service for their diverse needs. Therefore, an emphasis on public policy proposals is needed, so they work with families and support users, not only during treatment, but also preparing all those involved to deal with relapses during recovery, if so needed[21].

Study limitations

The study limitation was the fact that interviews occurred in a single contact with relatives, during the visiting hours in the Psychiatric Hospitalization Unit. Nonetheless, when analyzing the speeches given by participants, no fragilities of information were observed, considering that the empirical material collected allowed a comprehensive reading with the theoretical framework. Finally, it is suggested that further studies of this nature contact participants in a recurrent and timely manner, giving the opportunity to reflect more deeply on the phenomenon under study.

Contributions to the Nursing field

The speeches given by research participants allowed the reflection on the Nursing activity among families living in a context of

alcoholism in rural areas, based on Phenomenological Sociology, which refers to care based on a face to face relationship. In such, professionals seek to understand the motivations of individuals. Seen that, it is expected that this study will strengthen the understanding of the importance of caring for this population, favoring practices that are aligned with the effectiveness of the Psychosocial Care Network.

FINAL CONSIDERATIONS

Research allowed knowing the expectations of relatives in relation to the treatment of the alcoholic in a rural area. Regarding the *reasons for,* family members expected the alcoholic to maintain abstinence to achieve a good health condition and resume their work activities, in addition to improving their family and social relationships. These *reasons for* are based on faith and religiosity, and some family members believe in healing, ignoring the chronicity of this disease. In this aspect, the importance of Nursing support-education is mentioned before the information needs of families of alcohol dependents.

As for the plans for care after hospitalization, there are possibilities that range from welcoming the alcoholic in their homes to structuring/providing a space near the rural property in which this person can live and work, from a perspective of control of relapses. Among research participants, there are relatives who do not feel able to care for the alcoholic after discharge. Despite this, they did not show abandonment behaviors and mentioned alternatives such as seeking caregivers and nursing homes.

It is observed that relatives of alcoholics in rural areas under psychiatric hospitalization in the general hospital have, in most cases, expectations of a biographical situation of rehabilitation after hospital discharge. To that end, they recognize that welcoming and direct and indirect care are paramount for this outcome. Nursing professionals who work in hospital institutions must listen attentively to the needs of each family, providing support and education to confront and manage adverse situations that they may face.

Moreover, it is important to highlight that these families live in rural areas, where Primary Health Care services are hampered by the distance between properties and the scarce number of services and health professionals. Despite the difficulty in serving families who live in rural areas, health professionals should be alert to cases of alcoholism in the community, seeking to understand this phenomenon and provide individual and collective care.

FUNDING

This study was carried out with the support of the Coordination for the Improvement of Higher Education Personnel - Brazil (CAPES - *Coordenação de Aperfeiçoamento de Pessoal de Nível Superior*) - Financing Code 001.

REFERENCES

1. World Health Organization-HO. Global status report on alcohol and health 2014 [Internet]. Geneva: WHO; 2014 [cited 2017 Jul 15]. Available from: https://www.who.int/substance_abuse/publications/alcohol_2014/en/
2. Lim SS, Vos T, Flaxman AD, Danaei G, Shibuya K, Adair-Rohani H, et al. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380(9859):2224-60. doi: 10.1016/S0140-6736(12)61766-8
3. Sujiv A, Chinnakali P, Balajee K, Lakshminarayanan S, Kumar SG, Roy G. Alcohol use and alcohol use disorder among male outpatients in a primary care setting in rural Puducherry. Ind Psychiatry J. 2015;24(2):135-9. doi: 10.4103/0972-6748.181711
4. Vaishnavi R, Karthik MS, Balakrishnan R, Sathianathan R. Caregiver Burden in Alcohol Dependence Syndrome. J Addict. 2017;2017:8934712. doi: 10.1155/2017/8934712.
5. Yasui S, Luzio CA, Amarante P. From manicomial logic to territorial logic: impasses and challenges of psychosocial care. J Health Psychol. 2016;21(3):400-8. doi: 10.1177/1359105316628754.
6. Salvador PTCO, Santos VEP, Tourinho FSV, Enders BC. Comprehensive approach of nursing: possibility of interpretation based on Alfred Schütz. Rev Pesqui Cuid Fundam (Online). 2014;6(1):183-93. doi: 10.9789/2175-5361.2014.v6i1.183-193.
7. Schütz A. El problema de la realidad social: escritos I. 3ª. ed. Buenos Aires: Amorrortu; 2015.
8. Freitas RJM, Moura NA, Monteiro ARM. Violence against children/adolescents in psychic suffering and nursing care: reflections of social phenomenology. Rev Gaucha Enferm. 2016; 37(1):e52887. doi: http://dx.doi.org/10.1590/1983-1447.2016.01.52887
9. Schütz A. Sobre fenomenologia e relações sociais. Petrópolis: Vozes; 2012.
10. Schneider JF, Nasi C, Camatta MW, Oliveira GC, Mello RM, Guimarães AN. The schutzian reference: contributions to the field of nursing and mental health. J Nurs UFPE. 2017;11(Suppl-12):5439-47. doi: 10.5205/1981-8963-v11i12a22321p5439-5447-2017
11. Gaskell G. Pesquisa qualitativa com texto, imagem e som: um manual prático. 13ª ed. Petrópolis: Vozes; 2015.
12. Minayo MCS. Amostragem e saturação em pesquisa qualitativa: consensos e controvérsias. Rev Pesqui Qualit[Internet]. 2017 [cited 2017 Jul 15];5(7):01-12. Available from: https://editora.sepq.org.br/index.php/rpq/article/view/82/59
13. Jesus MCP, Capalbo C, Merighi MAB, Oliveira DM, Tocantins FR, Rodrigues BMRD, et al. The social phenomenology of Alfred Schütz and its contribution for the nursing. Rev Esc Enferm USP. 2013;47(3):728-33. doi: 10.1590/S0080-623420130000300030
14. Ferreira Filha MO, Sá ANP, Rocha IA, Silva VCL, Souto CMRM, Dias MD. Alcoolismo no contexto familiar: estratégias de enfrentamento das

idosas usuárias da terapia comunitária. Rev Rene [Internet]. 2012 [cited 2017 Jul 15];13(1):26-35. Available from: http://www.periodicos.ufc.br/rene/article/view/3762/2979

15. Horta ALM, Daspett C, Egito JHT, Macedo RMS. Experience and coping strategies in relatives of addicts. Rev Bras Enferm. 2016;69(6):962-8. doi: http://dx.doi.org/10.1590/0034-7167-2015-0044
16. 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: 10.1590/0104-07072015003610013
17. Silva VHF, Dimenstein M, Leite JF. O cuidado em saúde mental em zonas rurais. Mental [Internet]. 2013 [cited 2017 Jul 15];10(19):267-85. Available from: http://pepsic.bvsalud.org/pdf/mental/v10n19/a08v10n19.pdf
18. Macedo JP, Dimenstein M, Leite J, Dantas C. Condições de vida, pobreza e consumo de álcool em assentamentos rurais: desafios para atuação e formação profissional. Pesqui Prát Psicossoc [Internet]. 2016 [cited 2017 Jul 15];11(3):552-69. Available from: http://pepsic.bvsalud.org/pdf/ppp/v11n3/03.pdf.
19. Malta DC, Santos MAS, Stopa SR, Vieira JEB, Melo EA, Reis AAC. Family Health Strategy Coverage in Brazil, according to the National Health Survey, 2013. Cienc Saúde Colet. 2016;21(2):327-38. doi: 10.1590/1413-81232015212.23602015
20. Ministério da Saúde (BR). Portaria n. 3088, de 23 de dezembro de 2011. Institui a Rede de Atenção Psicossocial para pessoas com sofrimento ou transtorno mental, incluindo aquelas com necessidades decorrentes do uso de crack, álcool e outras drogas, no âmbito do Sistema Único de Saúde (SUS) [Internet]. Brasília; 2011 [cited 2017 Jul 15]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2013/prt3088_23_12_2011_rep.html
21. Santos JE, Muniz MS, Alves RR, Bernardino AV. A inserção da família na recuperação do usuário de álcool. Rev Flu Exten Univ [Internet]. 2016 [cited 2017 Jul 15];6(1/2):41-4. Available from: http://editora.universidadedevassouras.edu.br/index.php/RFEU/article/view/631
22. Soares JR, Farias SNP, Donato M, Mauro MYC, Araujo EFS, Ghelman LG. Relevance of family role in the prevention of alcoholism relapse. Rev Enferm UERJ [Internet]. 2014 [cited 2017 July 15];22(3):341-6. Available from: http://www.e-publicacoes.uerj.br/index.php/enfermagemuerj/article/ view/13691/10483
23. Marques ALM, Mângia EF. Itinerários terapêuticos de sujeitos com problemáticas decorrentes do uso prejudicial de álcool. Interface (Botucatu). 2013;17(45):433-44. doi: 10.1590/S1414-32832013000200015
24. Braun LM, Dellazzana-Zanon LL, Halpern SC. A família do usuário de drogas no CAPS: um relato de experiência. Rev SPAGESP [Internet]. 2014 [cited 2017 Jul 15];15(2):122-40. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1677-29702014000200010