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# People with alcohol dependence syndrome

## Perception of the causes

### Summary

**INTRODUCTION.** Alcohol Dependence Syndrome (ADS) and its consequences constitute a serious public health problem, representing a high social cost and compromising several areas of health of the person with ADS, with few nursing studies in this area.

**OBJECTIVE.** To describe the perception that people with ADS have about the cause(s) of the disease and reflect on the nursing interventions.

**METHODS.** Descriptive, cross-sectional and correlational study. Convenience sample consisting of 444 people with ADS. The sociodemographic, the clinical questionnaire and the last section of the Revised Illness Perception Questionnaire (IPQ-R), which assesses the causes of ADS, were used as instruments. We used exploratory and descriptive analysis.

**RESULTS.** Most of the people are male, with 45 years on average, married, unemployed and were diagnosed seven years ago on average. Participants believe that psychological aspects ( $M = 14.87$ ,  $SD = 3.24$ ) and personal aspects ( $M = 7.07$ ,  $SD = 1.85$ ) are the main causes of ADS.

**CONCLUSIONS.** Participants attributed the cause of ADS to external factors, which reduces personal responsibility, as well as confusing the causes and consequences. These results reinforce nursing importance to promote mental health literacy and maintaining abstinence.

**KEYWORDS:** ALCOHOLISM; CAUSALITY; NURSING CARE.

### Introduction

Alcohol consumption has “accompanied” all civilizations with the purpose and expectation of seeking “another mental state”, a stimulus of imaginative processes, facilitating the escape of experiences that cause pain, suffering or anguish.

Actually in Portugal, alcohol consumption is often associated with sports events, student parties and false beliefs, among other things. Alcoholic beverages are a legal drug and accepted by the community, which encourages consumption<sup>1,2</sup>. The behaviors adopted by the individual in relation to maintaining health and preventing diseases, depend on their individual beliefs about it. These beliefs, besides being part of the construction of their cognitive representation of the disease, will influence the strategies to deal with their pathology and with the treatment, as well as guide the evaluation of the

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results of the adopted behaviors<sup>3</sup>.

Alcohol is one of the most important determinants of health in the European Union, with consumption as the main risk factor for a higher incidence of diseases and higher mortality in developing countries and the third largest risk factor in developed countries. According to the WHO “Alcohol in the European Union” report, an average of 12.4 litres of alcohol a year, which is equal to three alcoholic drinks per day<sup>4</sup> is reported on average by the year 2009. In Portugal, in 2010, Portuguese people aged 15 years or more consumed an annual average of 12.9 litres of pure alcohol per year<sup>5-6</sup>.

It is known that there is an omission of the harmful effects of excessive alcohol consumption namely, contributing to family fragmentation, loss of productivity in study and work, and causes of numerous pathologies<sup>5</sup>. Throughout the study, The Global Burden of Disease proved that psychiatric disorders were responsible for 40% of years lived with disablement, highlighting alcoholism among its five main causes<sup>7</sup>. In addition, alcohol ranks fifth among all risk factors for morbidity and mortality, ranking above other

risk factors (e.g., obesity/being overweight, hyperglycaemia, salt intake or dyslipidaemia)<sup>8</sup>.

Alcohol Dependence Syndrome (ADS) is considered to be a chronic, multifactorial disease that is almost always detected at a late stage due to its insidious and prolonged course. In addition, it has physical, psychological, social, professional and family implications<sup>9-10</sup>.

### Explanatory theories of alcoholism

There is no single explanation for the aetiology of alcoholism. The greater or lesser probability will depend on the interaction between the different factors, be they biological, psychological or social. Several revisions of etiological factors point to a variety of determinants. These factors include genetic predisposition, cultural, family consumption patterns, alcohol learning history, and the individual's belief system with respect to alcohol, self-control, and other problems.

It started from a moral model, in which the alcoholic individual was considered as a person lacking or with diminishing moral character, weak and unable to resist alcohol, to arriving at a medical model, which supposes that the patient cannot control their behaviour voluntarily, thus removing any responsibility for the development of the problem, its modification and its relapse<sup>11</sup>. Seeing alcoholism as a disease, decreases its stigma, increasing the number of individuals seeking treatment<sup>12</sup>.

Regardless of cultural and environmental influences, the frequency of a genotype of alcoholism, in an individual context, could mark a predisposition through biological processes, later developing problems with alcohol<sup>12-13</sup>.

These models contributed to the emergence of new approaches. The psychoanalytical perspective presupposes that individuals who did not successfully pass the oral phase develop alcohol consumption habits due to the constant need for oral satisfaction, while the behavioural approaches are essentially based on the model of operant conditioning resulting from the learning principles.

Behavioural approaches to alcoholism are based primarily on the operant conditioning model derived from the learning principles, based on data analogous to that of animals<sup>14</sup>. The behavioural approach postulates that all behaviour is learned and that human beings would be particularly shaped and determined by their socio-cultural environment. According to the Social Learning Theory, addictive behaviours represent a category of "bad habits", which can be analysed and modified in the same way as other habits. This model aims to study the determinants of addictive habits, including antecedents, beliefs, expectations, family history and previous learning experiences, as well as to know the consequences and effects of negative or positive reinforcements<sup>13-15</sup>.

The cognitive approach, associated with cognitive-behavioural therapies, is based on the metaphor of conditioning and cognitive restructuring therapy, with the primary goal of modifying maladaptive beliefs and increasing control over thoughts and behaviours<sup>13,15</sup>. Finally, the systemic approach considers the role of the family. In this perspective, dependence is a symptom of the family and not only of the addict<sup>15-16</sup>.

### Dependence syndrome

Dependence is, in fact, accompanied by problems of physical health, relationships with others, and social and economic behaviour<sup>2</sup>. Physical health problems include noncommunicable diseases (e.g., neoplasms, cardiovascular, respiratory or hepatic diseases) and communicable diseases (e.g. HIV/

AIDS, tuberculosis and pneumonia acquired in the community). In addition, perinatal mortality, low birth weight and fetal alcohol syndrome have increased. Concerning the problems of relationships and social and economic behaviour, we face homicide, domestic violence and unemployment. The relevance of these public health problems led to the integration of the approach to the person with excessive consumption of alcohol in the referral/articulation network in the scope of addictive behaviours and dependencies<sup>8,17</sup>.

In fact, these comorbidities are very common among people with ADS<sup>18</sup>. The ADS person often uses alcohol as a self-medication to deal with everyday problems and to facilitate the escape of experiences that cause pain, suffering or distress<sup>2,19</sup>. This means that alcohol use can either be the cause of a problem (e.g., being dismissed from work) or, in turn, the consequence of dealing with it.

The treatment of ADS involves interventions at various levels, be they psychotherapeutic, such as group therapies, self-help groups (AA, Al-Anon), or psychopharmacological<sup>15</sup>. The beliefs that the individual has about the causes of the disease, as well as their interpretation, mediate behavioural responses and may or may not lead them to search for health services<sup>20-21</sup>. In the psychotherapeutic follow-up, the motivation is worked out and reflected in the causes that led to ADS.

### Research questions

The knowledge of the perception of people with ADS on the cause(s) of their illness is fundamental for nursing work on motivation, and to establish objectives, strategies of treatment and maintain abstinence<sup>12,15</sup>.

In this context, since ADS has such an obvious impact on personal and family functioning, leading to endless challenges and/or changes,

with implications on functioning, well-being and Quality of Life, we are faced with the following questions:

- What is the perception of the causes for people with ADS?
- What are the relationships between the causes and the sociodemographic and clinical characteristics?

### Objectives

Since alcoholism is a common situation in our country and given the lack of research that studies the perception of the causes of ADS and the way people with alcohol dependence perceive these causes, we intend, with this study, to contribute to the development of research in this area. The following objectives were laid out for this study:

- To describe the perception that people with ADS have about the cause(s) of the disease;
- To analyse the relationship between the causes and the sociodemographic and clinical characteristics.

The nurse is one of the main players that integrates the multi professional team in the approach of the caring for people with ADS and their families. One of the objectives of the nursing intervention is to offer the possibility of recovery, aiming to reach the maximum of well-being. From the analysis of the objectives onwards, it was intended to reflect the nursing interventions.

### Methods

In order to achieve the objectives, we opted for a descriptive study, cross-sectional and correlational study.

### Participants

The sample consisted of 444 people with ADS who had been diagnosed for at least one year. A convenience sample was made of all those meeting the previously defined inclusion criteria. The sample was selected from different sub-regions of the Country (North, Centre and Lisbon and Vale do Tejo). To that end, we selected five institutions at a national level, with alcoholology services and self-help groups for people with alcoholism (Alcoholics Anonymous).

Inclusion criteria in the sample:

- Clinical diagnosis of alcohol dependence for at least 1 year.
- Age equal to or above 18 years.
- Know how to read and write.
- Do not present neurological or cognitive alterations that impede the completion of the questionnaire.

### Variables

Our study describes the behaviour and mutual influence of several variables, which is why we chose to define them as main and secondary variables.

- Main variables: Causes of the disease: Generic risk factors; Psychological aspects; Personal Aspects and Heredity/Work overload.
- Secondary variables: Sociodemographic: age, sex, literacy, marital status and employment/professional status; Clinics: duration of alcohol dependence, number of hospitalizations, number of relapses and duration of abstinence.

### Material

The sociodemographic, the clinical questionnaire and the last section of the Revised Illness Perception Questionnaire (IPQ-R)<sup>3</sup>, which assesses the causes of ADS, were used as instruments. This subscale is made up of 18 items

using a Likert scale. It presents an open question, where the person is asked to identify three causes that he considers the most important, classifying them in order of importance. We used exploratory and descriptive analysis.

- Sociodemographic questionnaire – This questionnaire was developed with the purpose of making a sociodemographic characterization of people with ADS through the collection of personal data, such as age, sex, years of schooling, employment/professional status, marital status.

- Clinical questionnaire – We collected data on the clinical characteristics of ADS: age at which they began consuming alcoholic beverages, time of diagnosis of alcoholism, number of hospitalizations, absenteeism, and duration and number of relapses.

- Revised Illness Perception Questionnaire (IPQ-R) - Subscale Causes - In our study, the causes of the ADS evaluated by the last section of the IPQ-R in the Portuguese version, developed by Figueiras and Alves<sup>3</sup>, were analysed. The subscale Causes (Likert-type scale) consists of 18 items and evaluates the beliefs that respondents have about the cause or causes of their disease. Items are not added because each represents a belief in a specific causal attribution. It is suggested, when the sample is constituted by 85 or more cases, to perform a factorial analysis of the main components (PCA) to obtain groups of causal attributions. This subscale also presents an open question, where the patient is asked to identify the three causes that he considers the most important, classifying them in order of importance.

In this way, the PCA was performed, with a criterion of selection of personal or specific values (eigenvalue) above 1 and with varimax rotation (table 1).

From the accomplishment of the PCA of the subscale causes of the disease, four factors explain 52.85% of the total variance, which were deno-

**EXPLORATORY FACTORIAL LOAD OF ITEMS, OWN OR SPECIFIC VALUES (EIGENVALUE), VARIANCE AND CRONBACH'S ALPHA COEFFICIENT OF EACH FACTOR**

1

| Items                                    | Factors |       |      |       | h <sup>2</sup> |
|--|---------|-------|------|-------|----------------|
|  | 1       | 2     | 3    | 4     |                |
| <b>Generic risk factors (α = 0.85)</b>   |         |       |      |       |                |
| 3. Smoking                               | 0.54    |       |      |       | 0.36           |
| 4. Being overweight                      | 0.59    |       |      |       | 0.43           |
| 5. Being unfortunate or having bad luck  | 0.58    | 0.30  |      |       | 0.49           |
| 6. Type of nutrition                     | 0.70    |       |      |       | 0.56           |
| 7. Environmental pollution               | 0.75    |       |      |       | 0.59           |
| 10. Little medical care in the past      | 0.45    |       |      |       | 0.30           |
| 11. Accident or injury                   | 0.69    |       |      |       | 0.50           |
| 13. Ageing                               | 0.71    |       |      |       | 0.54           |
| 14. A microbe or a virus                 | 0.71    |       |      |       | 0.53           |
| 16. Alteration in the body's defences    | 0.71    |       |      |       | 0.52           |
| <b>Psychological aspects (α = 0.67)</b>  |         |       |      |       |                |
| 1. Stress or concern                     |         | 0.67  |      |       | 0.47           |
| 8. Emotional state                       |         | 0.64  | 0.41 |       | 0.57           |
| 15. Mental Attitude                      |         | 0.65  | 0.34 |       | 0.55           |
| 17. Family Problems or Concerns          |         | 0.69  |      |       | 0.57           |
| <b>Personal aspects (α = 0.56)</b>       |         |       |      |       |                |
| 9. Personal behaviour                    |         | 0.42  | 0.69 |       | 0.65           |
| 12. Personality (way of being)           |         |       | 0.82 |       | 0.70           |
| <b>Heredity/Work overload (α = 0.10)</b> |         |       |      |       |                |
| 2. Heredity                              |         | 0.35  |      | -0.57 | 0.54           |
| 18. Work overload                        |         |       |      | 0.74  | 0.66           |
| Personal or Specific Values (Eigenvalue) | 4.42    | 2.40  | 1.60 | 1.09  |                |
| Variance (Total = 52.85%)                | 24.5%   | 13.3% | 8.9% | 6.1%  |                |

Note: Orthogonal rotation by the varimax method (with Kaiser Normalization); items with a factorial load greater than 0.30. The items corresponding to each subscale are shown in bold.

minated as *generic risk factors*; *psychological aspects*; *personal aspects and heredity/work overload* (table 1). The overall Cronbach Alpha coefficient of the disease cause subscale presented a value of 0.84.

### Ethical procedures and data collection

Ethical standards have been respected in accordance with the Helsinki Declaration. The Project was approved by the Ethics Committee of the Portuguese Catholic University, Lisbon.

After selecting the places for the collection of data, we contacted, by letter, the various entities with alcoholic services and self-help groups in order to request proper authorization for the study, and the project was sent to the respective Administrative Board and those in charge of self-help groups. They gave a favourable opinion on the implementation of this study. Finally, authorization was required to use the IPQ-R scale in the study. From each person in the sample, after clarifying the objectives of the study and the data collection process, and confidentiality, informed consent and voluntary participation were requested, in accordance with the principle of autonomy.

Participants were also assured of the confidentiality of all information collected. Data was collected over a period of six months in 2010. Appropriate authorizations were requested from the institutions and author of the scale.

At the beginning of the questionnaires, a set of instructions for completing the questionnaire was prepared, followed by the initial questions on sociodemographic and clinical data and the selected material (subscale causes of IPQ-R) was attached. Subsequently, we tested its application on 15 people with ADS. Participants voiced a good understanding of the questionnaire, with no doubts. The questionnaire response time ranged from 15 to 20 minutes.

The indication of the individuals with ADS for this study was made by the doctors, nurses and social workers of the alcoholology services, as well as by the members responsible for the self-help groups.

### Analysis and processing of data

The questionnaires were analysed using the Statistical Program for Social Sciences SPSS-version 23.0<sup>22</sup>. The methodology used, for each scale being studied, was similar to the one used by the authors. In the statistical treatment of the data, statistical inference techniques were used in addition to the descriptive and exploratory analysis of the data<sup>23</sup>.

For the interpretation of the intensity of the relationship between variables, we considered the criterion suggested by Marôco<sup>23</sup>, namely: Poor correlation ( $r < 0.25$ ); Moderate correlation ( $r \geq 0.25$  and  $r < 0.5$ ); Strong correlation ( $r \geq 0.5$  and  $r < 0.75$ ) and very strong correlation ( $r \geq 0.75$ ).

The results of the present study are considered statistically significant at a significance level of 5% or 1%<sup>23</sup>, i.e., for  $p < 0.05$  or  $p < 0.01$ . The results will be presented through tables, if they are considered significant or essential to the interpretative analysis.

**DISTRIBUTION OF SAMPLES ACCORDING TO AGE OF ONSET OF ALCOHOL CONSUMPTION, DIAGNOSIS PERIOD, DURATION OF WITHDRAWAL, NUMBER OF HOSPITALIZATIONS AND RELAPSES**

**2**

| Clinical variables                         | range   | M     | SD   |
|--|---------|-------|------|
| Age at which they started drinking (years) | 4-55    | 17.86 | 8.11 |
| Period of diagnosis (years)                | 1-38    | 7.73  | 7.17 |
| Number of hospitalizations                 | 0-21    | 2.01  | 2.46 |
| Number of relapses                         | 1-2     | 1.69  | 0.46 |
| Duration of abstinence (years)             | 0.02-43 | 2.79  | 5.96 |

**VARIATION OF RESULTS, MINIMUM, MAXIMUM, AVERAGE, AVERAGE SCORE AND MEAN SCORE OF THE SUBSCALE CAUSES OF IPQ-R**

**3**

| Causes of IPQ-R            | Number of items | Min./Max. | M     | SD   | Average score (M / Number of items) |
|----------------------------|-----------------|-----------|-------|------|-------------------------------------|
| Generic risk factors       | 9               | 9-45      | 24.75 | 8.14 | 2.75                                |
| Psychological aspects      | 4               | 4-20      | 14.87 | 3.24 | 3.72                                |
| Personal aspects           | 2               | 2-10      | 7.07  | 1.85 | 3.54                                |
| Heredity and Work overload | 2               | 2-10      | 5.82  | 1.88 | 2.91                                |

Note: Measurement range (Likert) ranges from 1 to 5.

**Results**

The sample consisted of 81.5% (n = 362) of men. In relation to their marital situation, the majority were married or living together, with 42.3% (n = 188), 27.9% were single (n = 124), and 25.9% divorced (n = 115). Concerning the employment/professional situation, the majority are unemployed (41.9%, n = 186), although there are a significant number of workers (39.4%, n = 175), 13.3% (n = 59) were retired, 4.1% (n = 18) reported another situation and 0.7% (n = 3) were students.

The average age was 45 years (SD = 9.29 and range 21-69). As for the number of years of schooling being on average 7.6 years (full years) (SD = 3.67 and range 0-19), the four participants without schooling knew how to read and write.

Table 2 shows the distribution of the sample according to age of onset of alcohol consumption, diagnosis period, duration of abstinence, number of hospitalizations and relapses.

With the sample of people with ADS, on average, the age at which alcohol consumption started was around 17.86 years and the diagnosis period of ADS is around 7.73 years. Regarding the number of hospitalizations, this varies between no hospitalization and 21 admissions and an approximate average of two relapses. However, the years of abstinence are on average about three and two years (table 2).

Most of the people are male, married, unemployed, diagnosed seven years ago on average, and the average age is 45 years. Participants believe that *psychological aspects* (M = 14.87, SD = 3.24) and *personal aspects* (M = 7.07, SD = 1.85) are the main causes of ADS. As causal factors of the first order, the importance attached to the emotional state (low self-esteem, anxiety, feeling of emptiness and demotivation) was evident, followed by family problems, stress or concerns and influence of companies and environments (table 3). Some studies have reported this similarity<sup>2,18</sup>.

With regard to causal attributions, people with ADS rarely agree with generic risk factors (fate or bad luck, type of diet, smoking, among others), with greater agreement on *personal aspects* (behaviour and personality), and *psychological aspects*, believing that stress or worry, their emotional state, family problems and their mental attitude are the possible causes of their alcohol dependence (table 3).

The results of the open question, posed to our participants, where they were asked to rank three causes that they considered as a priority in the onset of alcohol dependence, showed the importance given to emotional state, such as low self-esteem, anxiety, feeling of emptiness and lack of motivation, followed by family problems or worries, stress or concern resulting from personal experiences and the influence of companies and environments.

Secondary factors include emotional state (the negative way a person feels), stress or worry, family problems or concerns, and the effect of alcohol (e.g., disinhibition, well-being). In the third option of causal assignments, one maintains one's emotional state, one's family problems, one's daily stresses or concerns, and finally one's mental attitude.

The Mann-Whitney test was used to compare the perception of the causes between the sexes, where statistically significant differences were detected with respect to the *psychological aspects* (U = 8637.00, p = 0.006), and it was verified that the women presented higher values (Md = 17.00) than men (Md = 16.00), that is, more believe that the cause of ADS is due to psychological aspects.

From the analysis of table 04, it was concluded that, statistically significant differences were detected, between the subscale *psychological aspects*, the marital situation and the labour/professional situation.

It has been found that married

## RESULTS OF THE KRUSKAL-WALLIS TEST, FOR COMPARISON OF THE SUBSCALE CAUSES OF IPQ-R AMONGST THE CATEGORIES OF MARITAL STATUS AND EMPLOYMENT/PROFESSIONAL STATUS

4

| Causes - Psychological Aspects           |                                 | n   | Md    | Min./Max. | $\chi^2$ | g.l. | p     |
|--|---------------------------------|-----|-------|-----------|----------|------|-------|
| <b>Marital status</b>                    | Married/non-marital partnership | 162 | 15.00 | 4-20      | 9.80     | 3    | 0.02  |
|  | Single                          | 115 | 16.00 | 4-20      |          |      |       |
|  | Divorced/separated              | 108 | 16.00 | 5-20      |          |      |       |
|  | Widower                         | 6   | 16.00 | 12-18     |          |      |       |
|  | Total                           | 391 |       |           |          |      |       |
| <b>Employment/professional situation</b> | Employed                        | 153 | 15.00 | 4-20      | 19.45    | 4    | 0.001 |
|  | Student                         | 3   | 13.00 | 16-19     |          |      |       |
|  | Unemployed                      | 168 | 16.00 | 7-20      |          |      |       |
|  | Retired                         | 52  | 15.00 | 4-18      |          |      |       |
|  | Other                           | 17  | 14.00 | 8-18      |          |      |       |
|  | Total                           | 393 |       |           |          |      |       |

## PEARSON'S CORRELATION BETWEEN SUBSCALES OF IPQ-R CAUSES AND AGE, YEARS OF SCHOOLING

5

| Causes                | Age     | Years of schooling |
|-----------------------|---------|--------------------|
| Generic risk          |         | -0.38**            |
| Psychological aspects | -0.17** | 0.12*              |
| Personal aspects      |         | 0.16**             |

Note: \*p &lt; 0.05; \*\*p &lt; 0.01

people believe less that the cause of their illness is related to the *psychological aspects* compared to the other groups. However, in relation to the categories of the employment/professional situation, the unemployed people believe mainly that the *psychological aspects* are the cause of the ADS (table 4).

The correlation (Pearson) between causal subscales and age, years of schooling, duration of alcohol dependency, number of hospitalizations due to alcohol dependence and relapses were also studied. Only statistically significant differences in age and schooling were detected (table 5).

The results of table 5 indicate that the older people with ADS agree less with the *psychological aspects* as a cause of the disease. On the other hand, more educated people with ADS agree more with the *psychological* and *personal aspects* as causal factors of the disease and disagree with the *generic risk factors*.

## Discussion

After presenting the results obtained, we proceeded to their discussion and respective critical appraisal, based on the objectives proposed for this study. We will take as main guidelines the main variables (causes of the disease) and their relationship with sociodemographic and clinical variables.

People with ADS attach a high belief to *psychological aspects* (such as stress or worry, emotional state, family problems, and mental attitude) as possible causes of alcohol dependence. Several studies have reported on the similarity between chronic and familial diseases<sup>20,24</sup>.

Regarding the causes of the disease attributed by the respondents, it is interesting to note that the emotional state (psychological aspect) was the most remembered in the three orders of answers. This fact demonstrates the difficulty for the subjects to understand the disease, seeking explanations

about the causes that do not always correspond with reality<sup>24</sup>. This distorted perception can be generated, since people suffering with ADS can often be blamed for their illness.

The maintenance of the use of alcoholic beverages is often related to the relief of anxiety and to the negative perception of the biological response to its interruption (withdrawal syndrome). At the same time, during the period of alcohol abuse, feelings of guilt may arise, which perpetuates anxiety, as well as consumption as a strategy to reduce it<sup>25-26</sup>.

People with ADS who are unmarried, divorced, widowed and unemployed believe that the cause of their illness is more related to the *psychological aspects*. It seems to us that these people live the ADS with fear, worry, anxiety and depression. Do they feel more alone and without family and/or social support?

According to Nunes & Jóluskin<sup>27</sup>, the occupation of the person in employment activities is associated with a slight reduction in heavier consumption. It is concluded, therefore, that the absence of a job occupation leads to the consumption of alcoholic beverages, in order to have company or to not think about the problem of unemployment. The following questions may, however, be raised: Was the drink the cause of

unemployment or was the condition of the unemployed that led to excessive consumption of alcoholic beverages?

It is therefore essential to help people with ADS better understand what alcohol dependence is and what the different stages of the disease are, so that the care provided is effective. However, it should be taken into account that this understanding can be influenced by individual beliefs, based on lived experiences, often confusing causes and consequences. Thus, as long as the person with ADS finds “excuses” to continue drinking, they will not be able to truly address the problem. It should be noted that the perception of the disease will change throughout the course of someone’s life, which affects other types of beliefs, which contribute to explaining the variation of behaviour related to health<sup>21,28</sup>.

It should also be pointed out that people with ADS with more schooling also do not believe in generic risk factors as the cause of the disease. Higher schooling has also been associated with a greater capacity to seek appropriate help and articulate what resources they need<sup>29</sup>. Participants with more schooling probably feel more need for treatment, which influences therapeutic adherence. So when the person is not aware of their problem and has no intention of changing their behaviour (even if the people around them are aware of the problem), then they do not feel the need to seek help either.

It seems that people with ADS often confuse causes and consequences, thus making it essential to discuss the causes that lead to ADS, to establish strategies and objectives that contribute to effective treatment and, of course, to maintaining abstinence.

Nurses occupy a privileged position because, in their essence of care, they contribute to the empowerment of the person with alcohol dependency and their family members, to efficiently manage the disease. As each health behaviour is supported by a varied set of beliefs and feelings, susceptible to change, it is important that the nurse can identify them and then intervene in partnership with the client/family, and promote a more positive and healthy adaptation behaviours. For planning the nursing intervention, it is necessary that the person with ADS and the family be aware of the need for help and the goals outlined. In addition, family involvement in treatment is essential.

In relation to educational valence, it is intended to provide relevant information, i.e. to promote knowledge about the disease, namely on signs and symptoms, early signs of relapse, causes, consequences, possibilities of control (staff and treatment), prognosis and community resources. When considering the dynamic and variable nature of empowerment [30], and assuming that a person is able to learn to use skills to influence life events, even in less beneficial situations, these intervention strategies play a key role in understanding problems and in support of decision-making.

It is important to consider some limitations of this study, such as the use of convenience sampling and it is a cross-sectional study, the evaluation of the various variables was performed only once, and it was not possible to capture the influence of certain vital events on the perception of each participant. The perception of disease is a dynamic entity with variations over time<sup>3</sup>. In this sense, we considered it important to carry out prospective and longitudinal studies in order to investigate the perception of the causes of ADS at other times of the disease, such as at the beginning and at the end of treatment.

## Conclusion

ADS has become one of the most complex public health problems because of the slow and sometimes silent progression of the disease. It affects ev-

eryone indifferently and has implications for the physical, social and psychological dimensions, both for individuals and for their families.

It becomes increasingly relevant to assess people’s perceptions about ADS because it provides information about what they think about their health status. In this way, more effective intervention strategies can be developed. In addition, several studies show that health professionals should be aware not only of physical and/or psychological aspects, but also of people’s subjective perceptions, which may interfere with their behaviour in seeking help.

The results of this investigation allowed it to be concluded that:

- The sample (people with ADS) had an average age of about 45 years and with a low level of schooling (measured in years of schooling). Most participants were either married or in a non-marital relationship and were male and no longer in employment.
- In clinical terms, the average diagnosis period, according to the person with ASD, was eight years, but for the family, it was fourteen years. The beginning of the consumption of alcoholic beverages occurred around the age of 18.
- Participants believed above all that the aetiology of the disease (causal attributions) was due to psychological aspects (e.g., stress or concerns, family problems), or rather external factors, which reduces responsibility confusion of the causes and consequences).
- Understanding the causes of ADS, as well as some sociodemographic and clinical characteristics, should be taken into account in the design of intervention strategies in nursing.

In the treatment of ADS, psychotherapeutic follow-up is essential, where motivation is worked out and reflected on the causes that led to ADS.

We emphasize the relationship of therapeutic help, which plays a major role in identifying beliefs, motivations, difficulties and support that



can turn threats into challenges and encourage adaption behaviours. On the other hand, we emphasize the importance of nursing's contribution to the promotion of mental health literacy and the maintenance of abstinence.

The ADS is responsible for physical, psychological and social suffering, both for the person with the disease and for the family. Thus, our research suggestions are related to the development of knowledge about ADS on the one hand (in the person with ADS and their relatives) and their intervening variables in the processes of perception of the disease; on the other hand, they intend to know the efficiency of health interventions, with the purpose of improving Quality of Life.

We suggest some future work, such as the replication of the present study in a broader context, longitudinal studies and quasi-experimental studies, where the effectiveness of a set of specific interventions and the development of an investigation aimed at the planning of an intervention program for the person with ADS/family dyad.

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