

Perceptions of Primary Health Care Professionals towards Alcoholic Patients: an Exploratory Study in a Brazilian Municipality*

Percepciones de profesionales de atención primaria en salud sobre pacientes alcohólicos: un estudio exploratorio en una municipalidad brasileña

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ABSTRACT

The objectives of the present research were to explore perceptions of Primary Health Care professionals towards alcoholic patients and to verify possible differences in the perceptions of male and female alcoholism. Participants read and responded to three case vignettes describing a male alcoholic, a female alcoholic and a male diabetic. Data were analyzed with repeated measures MANOVA and univariate F follow-up tests. Results showed that the alcoholic was objectified as an “atypical and difficult” patient towards whom there were negative attitudes and stigma-related socio-cognitive elements. Female alcoholism was possibly perceived as more difficult to explain than male alcoholism. The discussion highlights the importance of social representations and social identities in the continued training of health personnel.

Keywords

alcoholism; attitude; primary health care; social representation; social stigma

RESUMEN

Los objetivos de la presente investigación fueron la exploración de las percepciones de profesionales de atención primaria en salud sobre los pacientes alcohólicos y la verificación de posibles diferencias en las percepciones del alcoholismo masculino y femenino. Los participantes respondieron a tres viñetas que describían un paciente alcohólico, una paciente alcohólica y un paciente diabético. Los datos fueron analizados con MANOVA de medidas repetidas y con test univariados. El alcohólico fue objetivado como paciente “atípico y difícil” asociado a actitudes negativas y a elementos sociocognitivos de estigma. El alcoholismo femenino fue posiblemente percibido como más difícil de explicar que el alcoholismo masculino. La discusión destaca la importancia de las representaciones y identidades sociales para la formación continuada de profesionales de salud.

Palabras clave

alcoholismo; actitud; atención primaria en salud; representación social; estigma social

The Brazilian health system is based on the principles of universality, comprehensiveness and decentralization. The Family Health Strategy is the organizing axis of public Primary Health Care (PHC). Family Health Teams are responsible for providing longitudinal care to specific communities, after identifying all its families. The teams are mainly composed by physicians, nurses and community health workers. They work in Family Health Centers, which are the most important facilities of Brazilian PHC (Ministério da Saúde, 2006).

Public health policies and services in Brazil, as in other Latin-American countries, must face specific challenges related to social inequalities, poverty and violence deeply-rooted in those countries' history and culture. Researchers and professionals must seek a broad conceptualization of the health-sickness process, adopting a psychosocial regard. Interactions with patients must be understood as "social encounters" determined by cultural and historical factors. From this perspective, health care can lead to patient empowerment, democratic participation and social change in urban and in rural areas (Arrivillaga-Quintero, 2009; Escorel, Giovannella, Mendonça, & Senna, 2007; Pick, Rodríguez, & Leenen, 2011).

The broad understanding of the health-sickness process leads to the goals of changing life styles and improving the quality of life. These goals are particularly important for chronic conditions such as "alcoholism". In Brazil, as in many other countries, alcohol misuse can be described as a major public health problem, associated with great economic and social losses (Laranjeira, Pinsky, Zaleski, & Caetano, 2007; World Health Organization, 2004). Brazilian public policies give PHC an important role in providing constant care to problematic users of alcohol and other drugs. These policies are based on the principles of harm reduction, early identification and brief intervention (Ministério da Saúde, 2004).

The mental health care delivery to alcohol abuse and dependence is scarce worldwide (Kohn, Saxena, Levav, & Saraceno, 2004). In Primary Care, researchers have observed professionals' lack of training and lack of knowledge about counseling

guidelines (Lock, Kaner, Lamont, & Bond, 2002). Professionals investigated by Johansson, Bendtsen, and Akerlind (2005) feared that approaching the topic would harm their relationship with patients, as alcohol consumption was seen as a "delicate" subject.

In Brazil, few studies have investigated perceptions of Family Health Teams (PHC professionals) towards the topic. The first research to approach this issue (as claimed by the authors) showed that PHC professionals perceived the dependence of alcohol and other drugs through a moral model, implying the belief of high personal responsibility of the drug dependent over the addiction and the social rejection not only of the symptoms but of the whole person (Ronzani, Higgins-Biddle, & Furtado, 2009).

The research reported here aimed at exploring perceptions of Brazilian Family Health professionals towards alcoholic patients. In this study, professionals were asked to evaluate brief case vignettes in which patients were described as noncompliant.

The perception of treatment noncompliance is not restricted to its technical definition. Health professionals view noncompliance to be a social deviation related to health system abuse and rebel behavior. Noncompliant patients are often seen as deserving punishment and not deserving health care (Fineman, 1991).

To explore this perception dimension, the present research asked professionals to compare a non-compliant alcoholic patient to another non-compliant patient with another "chronic disease", i. e. diabetes. Diabetes is one of the main targets of Brazilian PHC policies and of professionals' practice (Escorel et al., 2007). The diabetic patient represents a typical PHC patient, a reference point to which the alcoholic can be compared (Ronzani et al., 2009, used the hypertensive patient in one of their research instruments for similar purpose).

The present research also aimed at exploring possible differences in the perception of male and female alcoholism. Traditional representations depict alcohol consumption as an act of virility. Female alcoholism is often seen as shocking and unnatural, once it would oppose shared ideals of

femininity such as beauty, chastity, reproductive capacity, ability to take care of the family and the home. In men, alcoholism is represented as a “cause” of psychological and psychiatric problems. Conversely, in women, alcoholism tends to be seen as a “consequence” of problems of that nature. These well-established beliefs reinforce gender roles and stereotypes, being present in common sense and in medical discourse (Gaussot, 2005).

The objectives of the present research were: a) to explore perceptions of graduated Family Health professionals towards alcoholic patients, considering the following dimensions: patient noncompliance, perception of capacity of care, attitude, attribution of causes, attribution of stigma; b) to verify possible differences in professionals’ perception of male alcoholism and female alcoholism; c) to evaluate possible effects of participants’ gender and profession (physicians *versus* non-physicians) on investigated variables; d) to analyze the data through a socio-psychological perspective to gain insight into the implementation of professionals’ continued training and of health care strategies.

Based on previous literature, two main hypotheses were considered: judgments towards the alcoholic patient would be more negative than those made towards the diabetic patient, even if both were presented as noncompliant (hypothesis 1); the female alcoholic would be submitted to more negative judgments than the male alcoholic (hypothesis 2).

Theoretical Background

A general definition of attitude was considered as “evaluative disposition”: a positive or negative evaluation of an object associated with affective and cognitive responses as well as to behavioral tendencies (Neiva & Mauro, 2011).

Stigma was defined as an individual or group attribute that is deeply discredited or discreditable, i. e., an attribute associated with a stereotype implying strong social reprobation. The stigmatized person and the ensemble of his/her characteristics tend to be neglected, shadowed by the central role of the stigma. The stigmatized trait defines the

person, who is often perceived as “less worthy” or “less human”. Stigma engenders fear of biologic or “symbolic” contagion (Goffman, 1963/1986). Stigmatization is composed of multiple elements: individual or group traits are identified, labeled and related to negative stereotypes; identity distinctions are established by stigmatizers between “us and them”; stigmatized individuals or groups are discriminated, which leads to various types of social disadvantages. These processes occur in a context where the stigmatizers exercise institutionalized power (Link & Phelan, 2001).

Negative social judgments can be related to “naïve” theories about causal attributions which are constantly formulated in daily life. Social judgments can operate according to a “sin or sickness” model, based on the perceptions of the “possibility of controlling the causes” and “personal responsibility”. In general, the perception of causes judged to be non-controllable and of persons judged to be non-responsible for their undesired actions or conditions engenders sympathy and help-related behaviors. Conversely, the perception of causes judged to be controllable and of persons judged to be responsible for their undesired actions or conditions leads to anger, social distance, punishment and aggressive behavior (Weiner, 1993).

The theory of social representations (TSR) provided a framework to analyse some socio-psychological implications of the results. In the TSR perspective, the studied perceptions can be described not only as individual features but as psychosocial processes. They are collectively constructed in the form of social representations, having effects on the formation of social identities. Health care practices are not only based on technical-scientific knowledge. They are social practices immersed in social beliefs (Morin & Apostolidis, 2002; Moscovici, 2007).

Method

Participants

A hundred and twenty graduated Family Health professionals participated in this research. All pro-

professionals worked in the same municipality, with approximately 330 thousand inhabitants, located in southeastern Brazil. In Family Health Centers, the number of graduated health professionals comprised by 428 people. The research sample represented 28% of these professionals. The sample was intentionally defined, because access to professionals was difficult (the researcher has contacted professionals in their work places, in 16 different Family Health Centers, and has administered questionnaires in individual encounters to professionals who could grant part of their work time). None of the invited professionals refused to participate. All Family Health Centers were located in low socio-economic status (low SES) urban areas.

Nurses ($n = 38$), physicians ($n = 34$), dentists ($n = 16$) and pharmacists ($n = 11$), “traditional actors” of health care, composed 82.5% of the sample. The other participants were psychologists ($n = 10$), social assistants ($n = 9$) and sport educators ($n = 2$). The majority of the professionals were female (75%). The mean age was 36.4 years ($SD = 9.12$). The mean work experience in PHC was 7.16 years ($SD = 0.61$).

Instruments and Procedures

Following National Health Council guidelines (CNS 196/96), the research project has been analyzed and approved by a Human Research Ethics Committee from a Federal University (research process number FR-263177). Questionnaires were administered after obtaining informed consent. Socio-demographic data were gathered with a specific questionnaire.

The main questionnaire was formulated for this research and included three case vignettes. The participants evaluated each case vignette using Likert-type agreement scales with five levels. Before reading the questionnaire, the participants answered two training items. Only options 1 and 5 were labeled, respectively *strongly disagree* and *strongly agree*. Options 2 to 4 were presented to participants as intermediate levels of agreement.

The case vignettes (hereafter “cases”) were presented in separate sheets one at the time. The cases referred to fictitious patients, Roberto, Solange and Antonio (common Brazilian names). All patients were described as having low SES, three kids and

TABLE 1
Investigated Perception Dimensions and Corresponding Items

Dimensions	Items
Perception of capacity of care	1. I feel prepared to take care of [name of the patient], having him/her as my patient
	2. I think that the Family Health Center in which I work can efficiently handle this case
	3. I think that the Family Health Center can change [name of the patient]’s behavior towards the orientations given by health professionals
Attitude	4. If [name of the patient] were not my patient and were a well-known and competent professional, I would accept to hire him/her to work as my housekeeper
	5. If [name of the patient] were not my patient and were a well-known and competent professional, I would trust him/her to take care of my house on a weekend I was out of town
Attribution of causes	6. I know that [name of the patient]’s disease is mainly caused by social factors
	7. I know that [name of the patient]’s disease is mainly caused by genetic factors
	8. I know that [name of the patient]’s disease is mainly caused by psychological factors
Attribution of stigma	9. I believe [name of the patient] has little “willpower” and “strength of character”
	10. [Name of the patient]’s kids will certainly have problems in their lives because of their father’s/mother’s behavior
	11. In all situations of social interaction (at work, parties, bars, etc.) [name of the patient] faces great social disapproval

Source: own work

housekeeping jobs. They were characterized as noncompliant patients with the following sentence: "He/she sometimes attends the Health Center but he/she does not seem to follow the instructions given by the health professionals. His/her health condition has deteriorated in the last few years".

The targeted differences were mentioned in the first sentence of each case description: Roberto is an alcoholic (male alcoholic); Solange is an alcoholic (female alcoholic); Antonio is a diabetic (male diabetic). All participants ($N = 120$) responded to all three cases (within participants design). For each case, the participants expressed their level of agreement with eleven sentences (items) which corresponded to four perception dimensions (hereafter "dimensions"): perception of capacity of care, attitude, attribution of causes and attribution of stigma. The dimensions and the corresponding items are described in Table 1.

Data Analysis

Data were analyzed using SPSS (version 13.0). Two comparisons were made: male alcoholic *versus* male diabetic and male alcoholic *versus* female alcoholic. Multivariate analyses of variance (MANOVA) with repeated measures were conducted to evaluate possible differences in the perceptions of the cases, considering three established independent variables: case, gender, profession (physicians *versus* non-physicians) and interactions. Univariate F follow-up tests were conducted to identify possible effects of the independent variables on the considered dimensions (perception of capacity of care, attitude, attribution of causes, attribution of stigma) and on each specific causal item (social factors, genetic factors, psychological factors). Differences were considered significant at $p < 0.05$.

Results

Comparison between the Male Alcoholic and the Male Diabetic

The professionals' perceptions towards the male alcoholic and male diabetic were different, as indicated by the MANOVA [$F_{(4, 113)} = 34.308, p < 0.001$].

There were no significant differences concerning the variables gender, profession or interactions in any of the analyses.

The specific perception dimensions were also different. The "perception of capacity of care" was significantly higher in the case of the diabetic ($M = 3.98, DP = 0.73$) than for the alcoholic ($M = 3.20, DP = 0.80$), [$F_{(1, 116)} = 99.939, p < 0.001$]. The general "attitude" towards the alcoholic was "negative", with mean score below 3 ($M = 2.65, DP = 1.18$), whereas the general "attitude" towards the diabetic was "positive" ($M = 3.64, DP = 1.11$). The difference in the "attitude" dimension was significant [$F_{(1, 116)} = 59.431, p < 0.001$].

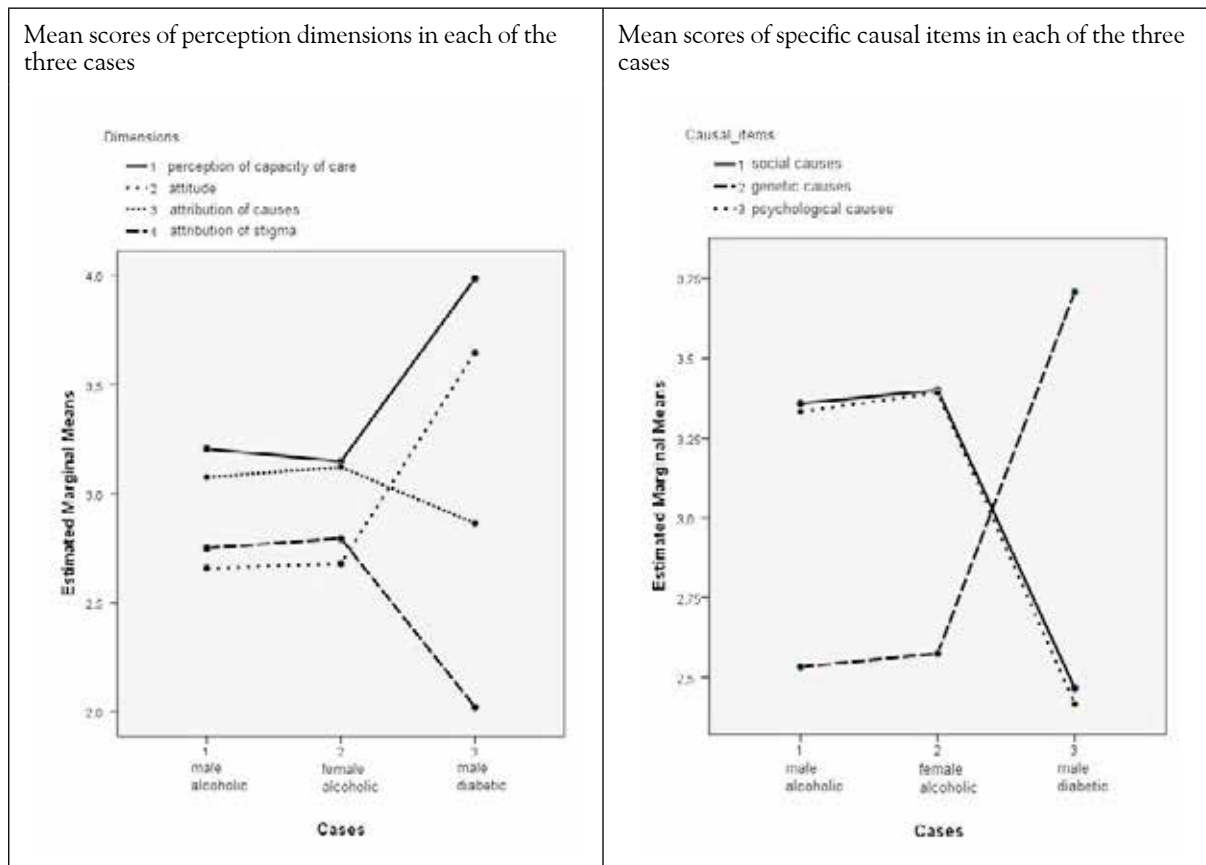
The analysis showed no significant difference in the "attribution of causes" dimension (mean values of the three corresponding causal items). However, there were differences in the perception of each type of cause. Professionals believed that the "social factors" were more important for the alcoholic ($M = 3.35, DP = 1.2$) than for the diabetic ($M = 2.46, DP = 1.2$), [$F_{(1, 116)} = 25.557, p < 0.001$]. They also believed that the importance of "psychological factors" was higher for the alcoholic ($M = 3.33, DP = 0.99$) than for the diabetic ($M = 2.41, DP = 1.11$), [$F_{(1, 116)} = 35.772, p < 0.001$]. Conversely, professionals granted more importance to "genetic factors" to the diabetic ($M = 3.7, DP = 1.14$) than for the alcoholic ($M = 2.53, DP = 1.16$), [$F_{(1, 116)} = 66.686, p < 0.001$].

It was verified that professionals mostly disagree with the "attribution of stigma" to the alcoholic ($M = 2.75, DP = 0.8$) as well as to the diabetic ($M = 2.02, DP = 0.72$), considering mean scores below 3.00. However, they were less likely to disagree with the "attribution of stigma" in the case of the alcoholic [$F_{(1, 116)} = 55.293, p < 0.001$].

Comparison between the Male Alcoholic and the Female Alcoholic

The professionals' perceptions towards the male alcoholic and the female alcoholic were different, as indicated by the MANOVA [$F_{(4, 113)} = 2.519, p = 0.04$]. However, concerning investigated dimensions, only the perception of "attribution of

TABLE 2
Mean Scores of Perception Dimensions and Specific Causal Items in Each of the Three Cases



Source: own work

causes” was different (mean values of the three corresponding causal items). The importance given to this dimension was higher in the case of the female alcoholic ($M = 3.12$, $DP = 0.87$) than in the case of the male alcoholic ($M = 3.07$, $DP = 0.86$), [$F_{(1, 116)} = 4.473$, $p = 0.03$]. No significant differences were verified for the other three dimensions.

Regarding the causal items, there were no differences in the perception of “social factors” or “genetic factors”. A tendencial difference in the perception of “psychological factors” was observed. The “psychological factors” tended to be more important to the female alcoholic ($M = 3.39$, $DP = 1.01$) than the male alcoholic ($M = 3.33$, $DP = 0.99$), [$F_{(1, 116)} = 3.774$, $p = 0.05$]. The differences between the mean scores found on each case can be visually evaluated in Table 2, concerning perception dimensions and specific causal items.

Discussion

The Alcoholic as an Atypical and Difficult Patient

The diabetic patient was considered as a reference point from which the perceptions towards the alcoholic patient were analyzed. Two factors justified this choice. First, diabetes is a priority and a frequent target of professionals’ practice (Escorel et al., 2007). Second, it was considered that diabetes would be seen as disease mainly “caused” by biological factors, which can be confirmed using data. The association with biological (“genetic”) factors implies that the disease can be well-recognized within the traditional cure-centered framework, in which the professional is “the only authorized expert” and is expected to “heal the patient” with drugs and health

instructions. The diabetic represented the “typical” PHC patient whose treatment difficulty would also be perceived to be “typical” or “normal”.

The dimension “perception of capacity of care” referred to the feeling of being able to provide care to the patients, as well as to the perception that the Family Health Center could efficiently handle the cases and tackle patients’ noncompliance (change patient behavior towards health instructions). Investigated professionals perceived greater capacity of care to the diabetic. Compared to this “typical patient”, the alcoholic’s condition was perceived to be significantly more complicated. These data are consistent with many studies that have identified the perception of obstacles when approaching alcoholism (e. g. Johansson et al., 2005; Lock et al., 2002; Ronzani et al., 2009) and reinforce recommendations of improving professionals’ continued training and implementing clearer care protocols for alcohol problems in PHC.

Concerning the “attitude” dimension, items referred to the actions of hiring and trusting the patient. Even after reading the statement that patients were in all cases “well-known and competent professionals”, it was found that professionals were less likely to agree that they would hire and trust the alcoholic. In contrast to the diabetic, it was observed that the evaluative disposition regarding the alcoholic was mostly negative, which is consistent with previous research (Ronzani et al., 2009). The Family Health Strategy proposes “proximity” between professionals and patients, through longitudinal care. However, the “physical” proximity does not necessarily imply “psychosocial” proximity and does not automatically transform negative attitudes towards the alcoholic.

Drug dependence is typically perceived to originate from controllable causes (according to this perspective, the alcoholic “chooses” to drink and to generate harm). Unlike genetic causes, social and psychological causes are seen to be at least partially flexible, therefore controllable. Professionals were more likely to agree that diabetes has mainly genetic causes and that alcoholism has mainly psychological and social causes. The perception of controllable causes may imply the attribution of responsibility to

the stigmatized person for his/her own situation or problem, engendering anger, aggressive behaviors and aid denial (Weiner, 1993).

Professionals were less likely to disagree with the “attribution of stigma” to the alcoholic. This dimension included a “negative” stereotype (“little willpower and strength of character”), the element of “social contagion” (“kids will certainly have problems”; Cf. Campos, 2005) and the element of “social reprobation” (Goffman, 1963/1986). The professional-patient social relation may be described as asymmetric (Link & Phelan, 2001).

The continued training of these professionals can presuppose that they already share information about the importance of lowering stigma to provide effective care to problematic alcohol users. At the same time, it is important to consider that the relations between information, attitude and behaviors are not univocal. Changes in perception and attitudes do not necessarily transform practices (Neiva & Mauro, 2011).

In sum, the perceptions of the alcoholic and the diabetic were different. Social and psychological factors were perceived to be the main causes of alcoholism. The alcoholic was objectified as an “atypical and difficult” patient to which there was less capacity of care and towards whom there were negative attitudes and socio-cognitive elements related to stigma. The alcoholic had more negative social judgments than the diabetic even if both “chronic ill patients” were described as noncompliant.

These results are consistent with the assertions of Fineman (1991). The apprehension of the alcoholic’s noncompliance is not restricted to its objective biomedical definition. Instead, noncompliance is a complex socio-subjective category that involves multiple beliefs of professionals towards patients.

The Female Alcoholic Patient

Considering the ensemble of variables, a significant difference was identified in the answers gave by participants to the cases of the male and the female alcoholics. This result is consistent with analyses

that described differences in the perception of male and female alcoholism (Gaussot, 2005).

However, the only dimension that showed significant difference was the “attribution of causes”. In the case of the female alcoholic, professionals emphasized causes in general (mean value within social, genetic and psychological factors). This emphasis may originate from a feeling of greater difficulty to explain female alcoholism, based on the idea that a “phenomenon that is harder to explain” must have “more causes” or “more problems” associated with its etiology.

This is consistent with the representation of female alcoholism as an “unnatural” phenomenon that harms shared beliefs, images and values attributed to femininity (in opposition to the somehow “natural” male alcoholism). The tendencial effect concerning the greater attribution of psychological causes to the female alcoholic is also consistent with this interpretation. In traditional representations, female alcoholism is seen to be a consequence of psychological problems (Gaussot, 2005).

The other perception dimensions showed no significant differences. It is important to highlight that, despite identified differences, participants responded very similarly to both cases. Data indicate that the investigated professionals did not perceive differences regarding the degree of difficulty in providing care to a female alcoholic nor did they express differences concerning attitude or attribution of stigma.

A possible explanation of this finding is the lack of specific and systematic protocols to approach alcohol problems in the considered municipality. Some Family Health Centers counted on structured protocols for addressing tobacco use (e. g., cognitive-behavioral group therapy and nicotine replacement therapy), but there were no structured intervention strategies for tackling alcohol problems. The lack of systematic contact with alcoholic men and women for treatment purposes may be responsible for the lack of differentiation.

Data indicate that professionals perceived female alcoholism as more difficult to explain than male alcoholism but not necessarily more difficult to approach.

The results and the analyses show an ensemble of perceptions associated with alcoholism and alcoholic patients. It is possible to consider that these perceptions are part of a socially constructed reality concerning social roles and social identities. This issue can be approached from the perspective of the Theory of Social Representations.

Social Representations and Social Identities

Social health psychology has demonstrated the important role of social representations on the construction of health practices, highlighting emotions and beliefs related to the fear of biologic and “symbolic” contagion. Professionals construct representations of patients considering not only the technical-scientific knowledge, but also social categories, beliefs and images deep-rooted in culture (Morin & Apostolidis, 2002).

Given the proximity between Family Health Centers and communities and the high general prevalence of alcohol problems, it is reasonable to suppose that “alcoholism” and “alcoholic patients” were “collective objects” sufficiently important to generate social representations among investigated health professionals. Social representations are shared “theories of common sense”, collectively constructed knowledge that serves to guide the actions over the object, reinforcing social identities (Moscovici, 2007).

According to the TSR, the investigated perceptions can be seen as part of a collective phenomenon: the contextualized production of knowledge and social reality itself. Data provide some insights on two characteristics of the studied context: the emphasis on cure-centered rationality (despite guidelines of comprehensive care) and the social status differences between professionals (middle classes) and patients (low SES classes). It is possible to analyze the relations between professionals and patients as social relations (Morin & Apostolidis, 2002), constructed on the basis of multiple symbolic backgrounds (e.g. the social meanings attributed to the “favelas” and to its “multi-problem families”, crime, drug traffic, bars and promiscuity).

As a form of deviation, alcoholism is associated to lower social classes (Conrad & Schneider, 1992). The image of the alcoholic as an “atypical and difficult” patient could contain the underlying belief that alcoholism is a natural consequence of the “degeneration” historically associated to poverty (Matos, 2000). The emphasis on social and psychological causes of alcoholism (possibly related to beliefs about “poverty and degeneration”) was accompanied by negative judgments and the perception of less capacity of care. Professionals seemed to share the belief that they and the Family Health Centers were only capable of providing traditional cure-centered solutions, implying distance between professionals and patients and patient depersonalization. These perceptions and beliefs can be related to social identity protection (differentiation reinforcement) against identification with the outgroups, i. e. patients in general (low SES persons) and alcoholics in specifically.

Despite the national guidelines of health promotion and multidisciplinary collaboration, Brazilian PHC continues to focus on cure-centered rationality and procedures (Sousa & Hamann, 2009). This focus can undermine the comprehensive approach to chronic conditions and especially their social and psychological determinants. The improvement of mental health care and specifically the implementation of interventions to tackle alcohol problems must face the challenge of reconstructing the representations of health care among professionals.

Primary Health Care professionals may also be defined as “social workers” capable of dealing with social and psychological determinants of health. Psychologists, integrating multi-disciplinary health teams, can play an important role in highlighting these factors (Arrivillaga-Quintero, 2009). It may be important to emphasize the capacity of extant Family Health resources to perform psychosocial care (e. g., the visits of community health workers, the longitudinal care provided by physicians, nurses, etc.). The implementation of systematic recording of mental health outcomes, for example, can help enhance professionals’ awareness of the socio-psychological effects of their interactions with patients.

Final Considerations

Results supported hypothesis 1 and did not support hypothesis 2. This indicates that, even if female alcoholism was possibly regarded to be “more difficult to explain”, professionals did not perceive more stigma or less capacity of care concerning a female alcoholic than to a male alcoholic.

The study had several limitations. Data were gathered in only one municipality and therefore may be biased by local factors. Methodological procedures were restricted to socio-cognitive aspects of relations between professionals and patients without direct observation of interactions. It is possible that the lack of greater difference in the perception of female and male alcoholism can be due to methodological limitations. The questionnaire was focused on professional context and all participants responded to all three cases. The professionals may have inferred the researcher’s intention to compare the cases and may have decided to express the idea of non-discrimination between male and female patients.

However, it is possible to consider that the study has a reasonable possibility of generalization to similar contexts, low SES urban areas of (Brazilian) large municipalities (more than 100,000 inhabitants). The questionnaire was able to explore some dimensions of the perception of Family Health professionals towards alcoholic patients, being one of the few Brazilian studies on the topic. The interpretation of data raised issues and insights that can be important for the implementation of health policies and health care strategies.

Analyses indicated the need to enhance professionals’ continued training to manage “alcoholism” and the wider variety of alcohol problems. They also indicated that the continued training and the implementation of health care strategies must not be restricted to technical biomedical aspects and must also approach psychosocial processes such as social representations and social identities. The promotion of a redefinition of the social identity of PHC health professionals was suggested, integrating the roles of “social and

mental health workers” and highlighting extant resources to tackle social and psychological health determinants.

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