SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Narratives about the process of recovering from addiction: the perspective of family members attending care services

Narrativas sobre el proceso de recuperación ante la adicción: la perspectiva de familiares que asisten a servicios de atención

Ariagor Manuel Almanza Avendaño[1], *Anel Hortensia Gómez San Luis*[2]

[1]***Corresponding author***
PhD in Psychology. Professor-Researcher, Universidad Autónoma de Baja California, Mexicali, Mexico.

[2]*PhD in Psychology. Professor-Researcher, Universidad Autónoma de Baja California, Mexicali, Mexico.*

ABSTRACT Addiction treatment services usually prioritize the recovery of the user, despite the fact that problematic consumption often leads to distress among families that requires attention. The purpose of this study is to identify types of narratives constructed by relatives of people with substance dependence disorders regarding their condition and recovery process. Additionally, we seek to understand the conditions that facilitate or hinder the recovery process from the perspective of family members. Seven in-depth interviews were conducted with a narrative approach. Progressive, stable, and regressive narratives were identified, corresponding to various stages in the addiction and recovery processes. These narratives revealed different forms of distress, obstacles to treatment, and critical junctures with respect to attending care services. Families represent a valuable resource for user recovery, and therefore must be included in the treatment process.
KEY WORDS Personal Narrative; Mental Health Recovery; Substance-Related Disorders; Family Relationships; Mexico.

RESUMEN Los servicios de tratamiento para las adicciones suelen priorizar la recuperación del usuario, a pesar de que el consumo problemático implica un malestar en las familias que requiere atención. El objetivo de este estudio es identificar los tipos de narrativas que construyen los familiares de personas con trastornos por dependencia a sustancias, acerca del padecimiento y el proceso de recuperación, así como comprender las condiciones que facilitan u obstaculizan el proceso de recuperación desde la perspectiva de los familiares. Se realizaron siete entrevistas en profundidad con orientación narrativa. Se encontraron narrativas progresivas, estables y regresivas en las que se identificaron diversas etapas en los procesos de adicción y recuperación, y revelaron diferentes formas de malestar, barreras para el tratamiento, y momentos críticos para asistir a los servicios de atención. Las familias representan un recurso valioso para la recuperación del usuario, por lo que deben ser incluidas en el tratamiento.
PALABRAS CLAVES Narrativa Personal; Recuperación de la Salud Mental; Trastornos Relacionados con Sustancias; Relaciones Familiares; México.

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

INTRODUCTION

In Mexico, 2.2% of the population presents alcohol dependence and 0.6% report dependence on controlled substances. Treatment has been sought by 13.9% of individuals with alcohol dependence and 20.4% of those dependent on controlled substances. Men show higher rates of consumption of both types of substances and attend treatment with greater frequency.[1,2] Rather than attending care services specialized in addiction, substance users often seek help from family and friends, religious institutions, or resort to self-medication, which often contributes to the progressive worsening of their condition.[3]

Three principal sources of treatment services exist in Mexico. First, the public sector, with over 400 care centers and approximately 30 residential treatment units. The second includes private professional healthcare services, and the third is composed of traditional self-help groups, about 20,000 of which exist throughout the country, in addition to 2291 inpatient mutual aid centers, popularly known as "annexes."[4]

The literature reports that families influence the development of addiction. Substance users may have been immersed in a relational triangle in which they became overinvolved with one of their parents and became distanced from or entered into conflict with the other; these conflicts within the system hinder the establishment of consistent limits. Another reason that limits are not set is the fear that one of the members will lose control, such that the substance user learns to behave under the basic premise that no limitations are imposed by their social context.[5] Other authors have considered drug use to be part of a relational pattern that makes it possible to maintain family stability and redirect conflict, which at the same time is a manifestation of the user's pseudo-individuation out of fear of experiencing separation from their family.[6] At the same time, it has been shown that there are multiple patterns or pathways through which addictive behaviors develop, which involve the intergenerational transmission of affective deficiencies, participation in a relational game in which there is overinvolvement with one parent and distancing from the other, and addictive behavior becomes a way to seek autonomy and deal with the distress caused by parental abandonment.[7]

Treatment services have prioritized the individual recovery of substance users, despite the fact that the problematic consumption of licit and illicit substances is associated with costs to families that must be recognized and addressed.[8] Previous studies have shown the wide-ranging consequences that this produces in family members, such as uncertainty, worry, ambivalence, and physical and emotional distress; conflicts and dilemmas related to dealing with the substance user; switching between diverse coping strategies; financial difficulties; withdrawal from social life, shame, isolation; and decreased quality of family relationships.[9,10] Despite this, few interventions in Mexico have focused on the needs of family members of individuals with substance abuse issues.[11]

The inclusion of family members in care services specialized in addiction is not only important for addressing their needs, but also because they can become a valuable resource in treatment by encouraging the substance user to begin the treatment process.[12,13] Along with voluntary admittance, hospitalization suggested by family members is one of the most commonly reported motives for admittance to residential help centers.[4] Previous studies have recommended including family members in treatment due to the fact that rehabilitation is a dynamic process that not only occurs over time, but is also associated with networks of other people in the same way as addiction;[14,15] during treatment, they can facilitate recovery by providing feedback, concrete and emotional support, or become a motivation for change.[16] The participation of family members not only encourages users to seek admittance into treatment, but also increases the probability that they will complete it and will obtain more favorable results.[17,19]

Interventions that involve family members can be grouped into three categories:

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

interventions that involve family members to promote the admittance and engagement of substance users with treatment, joint involvement of family members and substance users in the treatment of the latter, and interventions that respond to the needs of family members.[20] Psychoeducation, family member support, and developing coping skills are all essential elements in interventions involving family members.[21]

Among treatment options that contemplate the joint involvement of family members and substance users is multidimensional family therapy,[22] an integral, family-based treatment for adolescents with drug and behavioral problems that is oriented toward multiple systems (users, parents, families, and broader systems); also, multidimensional family therapy from a gender-based approach,[23] which focuses attention on drug consumption and family violence. On the other hand, treatments that respond specifically to the needs of family members focus on reducing stress and improving coping skills;[24] developing these same skills in indigenous families so that they may cope with excessive alcohol consumption;[11] and generally supporting families with problems related to drug and alcohol consumption.[25]

Despite the fact that the family is one context in which the early detection of problematic substance use is possible, a number of barriers exist that prevent family members from seeking the support of care services. Socially and culturally it is considered that substance use is a private issue and as such should be addressed within the family, where women are considered to bear the primary responsibility for consumption among its members; this often proves complex for women, considering that multiple celebrations and social events are often accompanied by the consumption of legal substances – primarily tobacco and alcohol – which upholds a certain social tolerance of consumption. Moreover, in some communities the consumption of legal substances like alcohol is not considered problematic. In contexts of poverty and marginalization, for example, other family necessities are given priority over treatment.

Postponing hospitalization is related to the desire to deal with the issue privately given the stigma attached to addiction, to encourage the tolerance of family consumption, to normalize the consumption of licit substances such as alcohol,[26] as well as to identify and link problematic consumption with a moral issue that depends on the will of the user or the exclusive support of the family.[27] Similar to what happens with substance users themselves, family members often seek initial support from non-specialized sources, such as extended family or religious institutions. Later, they may turn to mental health professionals such as psychologists or psychiatrists, particularly in the private sector. Lastly, a significant barrier is the fact that addiction is often initially conceived of as a "vice," leading to the fear that the user may be denied health services if they publicly identify as an "addict." By conceiving of addiction as a moral problem, it is assumed that willpower is the sole or central factor in eradicating the addiction.[27]

Regarding the term addiction, it should be noted that this study defines it as an experience worthy of being narrated. The narratives constructed by substance users and their families represent narratives of affliction that uncover the trajectories of individuals, beliefs, categories, and institutions, while revealing the diversity of experiences that lie behind the label of addiction.[28]

Narrating illness

Conditions such as HIV and addiction are often accompanied by processes of stigma and discrimination that involve different types of disruption (of daily life, of identity and biography), which lead to the construction of new meaning related to the self, to others, to illness, and to recovery.[29] In order to understand the ways in which family members participate in the recovery process of licit and illicit substance users, their narratives can be explored; that is, narratives that relate the processes through which family members organize the addiction and recovery trajectory,

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

emphasizing aspects that give meaning to their participation in the process.

From a social constructivist perspective, illness narratives are stories told by the patient, while family members and friends re-tell the same story from their own perspectives, in order to give coherence to distinctive events and the course of long-term suffering.[30] Narratives make it possible to not only construct the illness world, but also to reconstruct the narrative of the life history, the explanation and understanding of illness, justifications for one's actions towards others, and to remove the experience of illness from the private sphere and relate it to its social implications.[31] Furthermore, the act of narrating shapes the way in which the symptoms, treatment, and suffering generated by the illness are experienced, and influences the position taken in relation to it, as narrating allows to make way for a positive ending and to imagine means of overcoming adversity.[32]

Substance users and their family members construct narrative strategies in an attempt to locate their suffering in their personal history and to organize events related to the illness in a meaningful order over time.[32] Three general types of narratives can be distinguished. Progressive narratives are characterized by an increasingly positive evaluation of events over time, as difficulties are overcome and it is expected that circumstances will continue to improve, similar to genres such as comedy or epic. In regressive narratives, a progressively declining evaluation occurs; the situation worsens, anticipating further decrements in terms of its directionality, as in the genre of tragedy. Meanwhile, in stable narratives the arrangement of events in the account is not altered in relation to the goal or result, and directionality is maintained, whether it has a positive or negative evaluation.[33]

Frank[34] has proposed a typology of narratives told by patients who suffer from illness. The first type is the restitution narrative, that begins with physical suffering and social default, followed by the encounter with a remedy or treatment, and then a return to physical comfort and social obligations thanks to the agency of healthcare professionals. A second type is the chaos narrative, centered on the present and without any sequence, as the patient is controlled not only by the symptoms of their disease, but also by other social and economic difficulties. These narratives refer to the loss of control, vulnerability, and the limits of treatment. The third type is the quest narrative, that begin with the suffering caused by the illness and culminate in meaning constructed through the illness experience. The patient takes on agency, and their account can function as a memoir, a demand for social action, or as evidence of a personal transformation.[34]

The purpose of this article is to identify the types of narratives that family members of individuals diagnosed with substance use disorders (both for licit and illicit substances) construct regarding the condition itself and the recovery process. Moreover, an attempt is made to comprehend the conditions that facilitate or inhibit the recovery process, from the perspectives of family members who accompany substance users during treatment.

METHODOLOGY

This study was conducted at an inpatient addiction rehabilitation clinic, a therapeutic community that operates with the Minnesota Model[35] and belongs to the public sector in Ciudad Victoria, located in the central region of the state of Tamaulipas, in northeastern Mexico along the border with Texas, USA. In this region, the cumulative incidence of drug use both overall and of illegal drugs in the population aged 12 to 65 years diminished between 2008 and 2016, approaching national averages.[1,2] In addition to the previously mentioned barriers to treatment, contextual barriers related to drug trafficking and violence also exist in Tamaulipas. Both in primary care and inpatient centers, healthcare personnel, users, and families must deal with insecurity. Communities and healthcare centers have been exposed to threats, disappearances, brawls, or direct attacks against substance users or personnel.[36]

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Initially, contact was established with the institution's administration in order to present the project and obtain authorization. Researchers were first put in touch with healthcare personnel (psychologists, psychiatrists, nurses, nutritionists, and those with experience in addiction and recovery that led self-help groups). With their assistance, invitations were extended to family members (individuals who were either blood relatives or legally related to the substance user, or those with emotional ties to the user) who had lived through the addiction process and who participated once a week in self-help groups. In-depth interviews were held, which were audio-recorded and later transcribed for analysis. Interviews were carried out by the second author of this study, who at the time worked as a researcher at an institution of higher education, and therefore had no relation to the healthcare personnel, substance users, or their families. Interviews were held in programmed sessions over a period of three months.

The methodological orientation utilized was that of the narrative,[33] as an attempt was made to comprehend the trajectory from the beginning of substance use to the current moment in the recovery process.

Participant selection was purposive, according to the following criteria: adults who were family members of a substance user who had been diagnosed with a substance dependence disorder, and either they or their family member was currently in treatment. Seven family members participated in the study, five of whom were women and two of whom were men, and the majority were wives or mothers. Their ages ranged from 23 to 51 years, and their occupations were varied: homemaker, student, store owner, employee, government worker, or addiction counselor. The majority were married, and only two were either separated or divorced. Table 1 presents the characteristics of the substance users who study participants were accompanying to the treatment center.

The interviews began with the following opening question: "can you tell me the story of when your family member began using, up until the current moment of treatment?" Regarding the consumption stage, the following topics appeared: the beginnings of substance use, beliefs and feelings about substance use, actions taken regarding substance use, consequences of substance use, indicators of its worsening, and relationships with social support networks and care services. With respect

Table 1. Characteristics of the consumption patterns of substance users who attended a rehabilitation center in Tamaulipas, Mexico.

Case	Relation to substance user	Sex of substance user	Age of substance user	Substances consumed	Duration of consumption (years)	Duration of recovery (years)	Number of times substance user has been hospitalized
1	Wife	Male	51	Alcohol, morphine	22	2	5
2	Wife	Male	56	Alcohol	9	23	0*
3	Mother	Female	19	Marihuana, LSD, alcohol	3	1	2
4	Mother	Male	23	Marihuana, solvents	1	2	2
5	Uncle	Male	43	Alcohol	10	0	0
6	Wife	Male	50	Alcohol, non-prescribed medication	28	2	1
7	Father	Male	20	Alcohol, marihuana, cocaine, crack	4	2	4

Source: Own elaboration.
*Has only attended Alcoholics Anonymous groups.

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

to the treatment stage, issues were explored such as motivations for admittance and actions necessary to facilitate it; beliefs and feelings regarding recovery; participation in treatment and perceived changes during this process.

The duration of interviews was between one and three hours. Initially, categorical analysis of narratives was carried out in order to identify beliefs, feelings, practices, and interactions on the part of family members with respect to external instances during the addiction and recovery process. Subsequent holistic analysis was carried out in order to identify the type of narrative utilized in each case and the different stages that family members passed through.[37] These stages represent periods of time in which the addiction is lived in a certain way. The transitions from one stage to another mark significant changes in the trajectories of addiction and recovery. Lastly, previously identified categories were utilized to understand the elements that facilitated or hampered the recovery process in each of the stages.

The objective of the research was explained to participants and they were asked to provide informed consent. The research protocol was approved by the Research Ethics Committee of the "Migration, Development, and Human Rights" Academic Group at the Universidad Autónoma de Tamaulipas.

RESULTS

Progressive narratives: the recovery of substance users and their families

Recovery refers to the process through which substance users and their family members regain what they lost in the addiction process: mental, physical, and emotional health; healthy relationships, social networks, and jobs, among others. It also includes a period of sobriety or nonproblematic substance use. Progressive narratives were those in which the substance user's and their family's recovery was extended over time, and in some cases there were signs that a transformation was underway in the user or their family member. Three types of progressive narratives were identified.

In primary progressive narratives, change occurred first in family members, who encouraged hospitalization and later changes in substance users. This type corresponds to Cases 1 and 3, poly-substance users whose family members identified as codependent. The initial stage of this narrative was termed "normalization of consumption," given that it was not perceived to be problematic because no illicit substance use was detected, the substance user was able to remain functional both economically and socially, and was even positively credited for continuing to be a good provider or for refraining from exercising violence. Although this stage is often recounted in a brief manner, it may have lasted for several years.

> *Well, it was both normal and strange, to me it was normal, he would go out all the time to drink, lose himself, sometimes he would get depressed, sometimes much more.* (Wife, Case 1)

The second stage was termed "suffering due to substance use." This stage is characterized by an increase in the frequency of consumption on the part of the substance user, or the consumption of illicit substances, often with friends and in secret. Family members would begin to detect psychosocial deterioration, note changes in their "character" or health, educational or work problems, or that they would go missing for several days. Other consequences included financial troubles or conflicts between the substance user and family members, including abusive behavior towards their children. Additionally, family members were overwhelmed by responsibilities in the home and health problems. Difficulties setting limits with respect to substance use existed within families, or there was disagreement on how to handle it.

> *His drinking kept getting worse, because he always drank, but no matter what he was there at important times, you know,*

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

> *times when I needed him. But after my third child was born, the day after I got out of the hospital, he supposedly went to Tampico to pay the hospital bills and he disappeared for 15 days. All that was really hard.* (Wife, Case 1)

Previous difficulties make it likely for substance use to be perceived as problematic, generating ambivalence toward the user. Family members employed numerous strategies to deal with the problem, such as seeking escape or distraction, living for their children, expressing their discomfort with the user, or attempting to maintain stability in their daily life and to get used to the situation. While some family members sought out psychological treatment in this stage, they more commonly sought out personal support from extended family or a religious community, given that the substance user did not attend care services. Extended family at times became involved in a negative manner, either by blaming the family member or by suggesting that they accept the substance use. Furthermore, family members lacked guidance in how to deal with the problem, which was associated with a lack of consideration given to care services.

The third stage was termed "change in the management of substance use." This refers to the moment when the family member with the most active role as an agent in the recovery process "hits rock bottom." These circumstances were not only produced by an intensification of substance use, but also because external organizations detected work or school-related problems, as well as critical events such as a suicide attempt or an extended disappearance. Such circumstances produced a change in the sentiments of family members toward the substance user, giving way to various manifestations of distress, such as detachment, anger [rage], distrust, shame, sadness, or worry. Moreover, the family member's perception of the problem shifted upon realizing that the substance user would not be able to change on their own, and that promises of change and the support of the family would not be enough, but rather specialized care would be necessary. Thus began a pilgrimage to find the most appropriate institution, which could be affected both by the visibility of care services as well as their quality. One manifestation of the discrimination against drug users is the lack of care services and the fact that treatment centers that violate their human rights are tolerated.

In this stage family members may attend individual or group therapy, but they also encourage substance users to seek psychiatric care, family interventions, or admittance to a residential center. Usually, offering to accompany them to these services is not enough, and limits must be set in order to force them to attend. It should be noted that families do not frequently attend primary care facilities, but resort directly to rehabilitation centers. This change appears to be gradual and intermittent; that is, it involves alternating periods of hospitalization and relapse, in which substance users revert to consumption after a period of sobriety. Periods of hospitalization also become control mechanisms when families are no longer able to manage the substance user's consumption on their own.

The final stage is termed "remaining in the appropriate institution." Substance users stabilized, regularly attended treatment, and adopted the therapeutic ideology promoted by the institution, which conceived of drug use primarily as a psychological disorder. Therefore, it was assumed that intensive and chronic treatment was necessary, necessitating lifestyle changes and the involvement of family in the recovery process. Family members identified as codependent and admitted to feeling responsible for the substance use, particularly among women and when a positive change was perceived in the user. Similar to the substance user turned patient, they attended groups for family members or family sessions and adopted certain therapeutic practices in their daily lives, including understanding their own disorders and the role of their family of origin in their development, as well as "not carrying other people's baggage." In this stage they were able to perceive changes in the substance user, such as reconnecting with family, becoming more

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

responsible, or distancing themselves from friends who continue to consume. Changes occurred within the family with respect to expressing emotions toward the substance user, setting limits, reducing conflict, increasing emotional closeness, improving communication, involving the user in household tasks; furthermore, the family member focused on changing negative aspects of herself, making the substance user feel less alone. A sense of growth and transformation through suffering was expressed, along with a change in their social network, which incorporated healthcare personnel and family members of other substance users.

> *Here that I learned I had a disorder called codependency. In fact, my mother lives far from here, about 40 kilometers from the city... I wouldn't even go two or three days, because I thought that if I left something bad would happen to him. It was like I felt like his lucky charm, you know? I mean, if I were at home with the kids, he would come. And if I would go anywhere, you know, something bad would happen to him.* (Mother, Case 3)

A second type of progressive narrative corresponds to Case 2, in which the substance user sought help for alcohol consumption. In this narrative, the substance user's individual change preceded transformation in the family. As in the case of the previous narrative, there was a stage of "suffering due to substance use," but it differed in the following stage of "joining Alcoholics Anonymous." In this account, the substance user accepted that their consumption was a problem, voluntarily attended an Alcoholics Anonymous group without being hospitalized, and remained in recovery with little involvement of family in treatment, at least at the beginning. The family member later adopted the therapeutic ideology: she began to consider substance use as the result of a disease and an addictive personality; she identified as codependent, and began to engage in the therapeutic practices promoted by the 12-step program.

> *I started with the group because of my husband's addiction, but I realized that addiction isn't the problem, it's not the substance... when I explain it to people I tell them, you're going to have a mourning process, but over the substance, not the addiction, the addiction is inside of you, alcohol is alcohol and it doesn't hurt you, marihuana is marihuana, it's a plant, pills... if they are medical, they are for a treatment, but they can hurt you, they hurt you when they enter your body, so the disease is inside you, and what is the disease? Obsession.* (Wife, Case 2)

Although the therapeutic ideology is internalized and a personal transformation takes place in both the substance user and the family member, this narrative has a final stage that is not present in other accounts, termed "a new life." In this stage, both family members have become counselors and help other patients in their recovery, but also with other aspects of life not related to substance use, such as starting a business, dealing with financial difficulties, and encouraging growth as a couple (Table 2).

The third type of progressive narrative corresponds to Case 6, in which the user presented poly-substance consumption, had been hospitalized only once, and whose family member did not identify as codependent. In this narrative, changes also occurred in the substance user and the family member, but these changes were more abrupt and occurred over a shorter period of time. The initial stage was termed "attending to the crisis." Prior to the crisis, the user's alcohol consumption was not considered problematic, and he was perceived as functional given that he was employed, responsible, and a good provider. Compared with previous accounts, in this case there was no prolonged stage of suffering due to addiction nor a pilgrimage to find adequate treatment. A critical event had occurred; the substance user had attempted suicide at a moment in his life when he had begun to consume benzodiazepines without a prescription and different important events

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Table 2. Types of progressive narratives constructed by family members of substance users who attended a rehabilitation center in Tamaulipas, Mexico.

Type of narrative	Stages			
Progressive I: Changes in the user, then in family members	-	Suffering due to substance use	Joining Alcoholics Anonymous	A new life
Substance of concern: Alcohol	-	Consequences of substance use in the financial, professional, and family spheres Emotional distress and ambivalence toward the user Substance use is considered a problem, and that it can be managed by the family Support is sought from non-specialized sources: extended family or religious institutions	Substance user has an epiphany, voluntarily attends group User's family member adopts therapeutic ideology, and identifies as codependent Changes in consumption, character, family relationships, and social functioning (both in patient and in family member)	Internalizing therapeutic ideology Becoming counselors and helping others Focusing on other aspects of life such as financial difficulties, starting a business, or couple's issues New meaning is given to growth through suffering
Progressive II: Changes in family members, then in the substance user	Normalization of consumption	Suffering due to substance use	Change in the management of substance use	Remaining in the appropriate institution
Poly- substance use (alcohol + cocaine + morphine; alcohol + marihuana)	Consumption is not perceived as problematic Illicit substances are not consumed or consumption is not detected Positive view of the substance user; remains functional socially and economically	Increase in consumption and psychosocial deterioration Emotional distress and ambivalence toward substance user Substance use is considered a problem, and that it can be managed by the family Support is sought from non-specialized (extended family or religious institutions) and specialized sources (individual therapy)	Family member "hits rock bottom" Intensification of deterioration and critical events Intensification of distress Perception that the substance user would not be able to change on their own and specialized support is needed Meandering search for adequate treatment Succession of hospitalizations and relapses	Patient becomes stable and attends treatment Family member adopts therapeutic ideology and identifies as codependent Attends groups for family members and adopts certain therapeutic practices in their daily lives Changes in consumption, family relationships, and social functioning; a process of transformation is perceived

Source: Own elaboration.

coincided such as the loss of his business, the death of his mother, and taking over care of his sick father. The family experienced emotional distress, but they were able to quickly respond to the crisis, and primarily received specialized services such as a thanatological intervention, individual and family therapy, and psychiatric care for the substance user. They also received support from extended family and the religious community. The substance user's wife set limits in order to encourage the user to seek hospitalization.

> *I mean, he came here fine, we didn't have to trick him to get him here or drag him here or anything like that… on his own, yeah, but like knowing that whatever happened if he didn't get help, you know, I would have taken my daughter and left*. (Wife, Case 6)

In the second stage, "staying in treatment," processes similar to those in previous narratives took place. The difference is that in this case hospitalization immediately followed the crisis, family members accompanied the substance user in treatment, and attended activities at the rehabilitation center, even though they did not identify as codependent. Changes were observed in consumption, the "character" of the substance user, and in family relationships, but no sense of personal transformation or growth was present as was the case in previous narratives.

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Stable narratives: changes in the family member, but not in the substance user

This narrative corresponds to Case 5, a substance user who consumed alcohol and who did not attend treatment. The first stage was termed "life with the substance user's consumption." In comparison to progressive narratives, there was no stage of suffering associated with the consumption nor was there the presence of a crisis. The substance user's family conflicts were among the primary consequences of substance use. The family recognized that there was a problem, but they had become accustomed to it. The family member, in this case male, pointed out that he had neglected his own relationships and his own health due to being so focused on the substance user's consumption. His search for treatment had not only to do with the substance user's consumption, but also with the fact that he suffered from depression, at a time when he had to deal with stressful life events such as the separation from his spouse and an automobile accident.

> *When I started to look for help for my depression I realized that I had been carrying some harmful baggage from living with an alcoholic.* (Uncle, Case 5)

The second stage of the account was termed "following treatment for codependency." Despite the fact that the substance user continued consuming without attending treatment, the family member adopted the ideology of care that considers addiction to be a disease and that the user will seek treatment once they "hit rock bottom." He identified as codependent, attended groups for family members, and adopted practices encouraged by 12-step philosophy in his daily life: recognizing the influence of family on the origin of the problem, taking responsibility for his own actions, sharing with a group, honesty, managing his emotions, "not carrying others' baggage," deciding what he wants for himself, being humble, making an inventory, making amends, helping others who are suffering from a similar problem, knowing himself in order to understand the disease, and relating to a higher power. As was the case in progressive narratives, he expressed a sense of growth through treatment, but there were no indicators of intensified distress throughout the account, nor were there indicators of recovery on the part of the substance user (Table 3).

Regressive narratives: waiting for recovery

Regressive narratives are characterized by the predominance of tragic sentiments in the account, either because the substance user has been unable to recover, or because the recovery has been partial and short-lived, with a latent risk of relapse looming. Two types of regressive narratives were found. In the first type, there was problematic substance use over various generations and the family member identified as a "recovering addict." This account corresponds to Case 4, in which the user presented poly-substance consumption and had been hospitalized multiple times.

The first stage of the narrative was termed "living a life of suffering." The substance user's mother told of her own childhood and adolescence, making reference to her father' problematic alcohol consumption, having suffered abuse, having to go to work from the time she was a young girl, and going to live with other family members due to her situation at home. The family member began to consume alcohol as an adolescent, was homeless for a time, engaged in sex work to survive, and had several children with different men, none of whom supported her economically or in raising her children. She later moved in order to be closer to her family of origin and began to work in the family business. She decided to live on her own with her sons, and she continued to consume and became involved with a man who also consumed. In this stage of the narrative she did not refer to her son's substance use, but rather her own history of consumption as a preamble to his problem.

The second stage was termed "becoming aware of consumption." It took time for the

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Table 3. Types of progressive and stable narratives constructed by family members of substance users who attended a rehabilitation center in Tamaulipas, Mexico.

Type of narrative		Stage
Progressive III: Changes in both, post-crisis	Attending to the crisis	Staying in treatment
Poly-substance use (alcohol + benzodiazepines)	Prior consumption is not considered problematic; substance user was considered functional	Immediate hospitalization following the crisis
	Critical event that led to hospitalization (suicide attempt)	Patient attends continued care at the center and AA group
	Intensification of emotional distress	Family member attends family interventions and engages in therapeutic practices in daily life
	Primarily attends specialized care services (individual and family therapy, psychiatric consults)	Partial adoption of the therapeutic ideology, family member does not identify as codependent
	Family member sets limits to encourage hospitalization	Changes in consumption, character, and family relationships
		No sense of personal transformation post-crisis
Stable: Changes in the family member, not in the substance user (without intensification of decline)	Life with the substance user's consumption	Following treatment for codependency
Substance of concern: Alcohol	The problem is recognized, but family becomes accustomed to it	Family member attends groups for substance users' families and identifies as codependent
	Slight suffering is observed, no crises related to consumption or indicators of serious psychosocial deterioration on the part of the substance user	Adopts the therapeutic ideology and engages in therapeutic practices in daily life
		Feels a sense of personal transformation
	Family member has an epiphany through different life events that lead to the search for care	Substance user continues to consume and is not in treatment. Family member expects that they will do so when they "hit rock bottom"

Source: Own elaboration.

family member to realize that her son had a substance use problem. She did not recognize red flags such as school problems and did not heed the recommendations of school personnel that she seek specialized care. The mother recognized her sons' substance use problem when they were adolescents, but there were family conflicts and feelings of disconnection, anger, ambivalence, mistrust, and concern. Different viewpoints regarding the management of substance use developed, leading the mother to fluctuate between setting limits and not maintaining them. She turned to informal support networks to a lesser degree, such as the religious community and extended family. The mother attempted to recover by returning to an Alcoholics Anonymous group, but did not commit to treatment. Her son, meanwhile, was admitted for the first time to a rehabilitation center. Both of their recovery processes were hindered by a critical event in the family: the murder of her other son. This took place after a period of drug consumption, a series of hospitalizations, and having no place to live in a context of high levels of violence associated with organized crime.

The third stage was termed "attempts at recovery." In this stage the mother referred to herself as a "recovering addict" and considered that she needed to get help in order to accompany her son in his treatment, who had voluntarily admitted himself. The mother began to attend her own Alcoholics Anonymous group, as well as family sessions or family groups that had been organized by the rehabilitation center. The mother considered substance use to be a disease and adopted practices based on the 12-step philosophy. The mother identified changes in herself in terms of responsibility, no longer consuming

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

and distancing herself from friends that consumed, emotionally connecting with her son, improving their communication, and involving him at home. In this stage, the mother became committed to her own recovery, but the substance user remained hospitalized in a new attempt at recovery. Several obstacles that limited this process were observed: adapting to "confinement," the availability of substances in daily life, and the lack of personal interest in treatment.

> *When he told me, "I want to check myself in to rehab, I don't want to do drugs anymore," that's when his godfather told me, "start believing it, he already gave you the proof." That's when I started to believe a little, just a little, you know? When my son started coming here to the clinic and everything, and I started becoming more involved in the group, but I realized that that is just a small part of it. I´ve been coming to the group for almost four years and I just realized it."* (Mother, Case 4)

The second type of regressive narrative is characterized by a lack of recovery reported by both the substance user and the family member. Corresponding to Case 7, this account was narrated by the father, and involved a user who presented poly-substance consumption and had been hospitalized a number of times. In this account, no history of substance use over multiple generations was reported, but rather began with a stage of "becoming aware of consumption." It was detected later because the substance user had left home at an early age due to a teenage pregnancy, and so the consumption remained hidden. The substance use was detected due to multiple psychosocial consequences: disappearances for several days, relationship issues and changes in living situation, engaging in robbery in order to consume, alterations in "character," difficulties keeping a job, and health problems. As was mentioned in other narratives, within the family there were sentiments of anger, mistrust, and disconnection with the substance user. Conflicting viewpoints existed regarding the management of the substance use, but gradually limits were set in order to encourage hospitalization. They faced a lack of information regarding specialized treatment as well as stigma directed toward substance users, which was expressed in the quality of public sector services available. The substance user was admitted various times due to relapses, as well as changes in the care centers.

> *He would get mad at his wife and come back home, an then he would go back with her, and so on. One time he took my son-in-law's credit card. That's when we realized that he was the one responsible for the things that had gone missing. And we asked him what was going on. I said, you know what? I am going to hand you over to the police, and that's when he said, "I just can't anymore." You can't what? What is wrong with you, what's going on? "It's that I… I'm an addict."* (Father, Case 7)

The second stage was termed "waiting for recovery." Family members accompanied the substance user in another attempt at hospitalization, but there were no signs of progress; the substance use had become chronic and the psychosocial deterioration had worsened. A sense of distress and negative sentiment toward the substance user prevailed, and there was worry that he would relapse again. The father attended family sessions or family groups at the rehabilitation center, but he did not identify as codependent nor did he adopt practices based on the therapeutic ideology. He reported no change in himself or in the substance user, nor was there a transformation in the meaning attributed to a life of substance use. The following obstacles to the substance user's recovery were observed: temptations to consume, family conflicts, the availability of substances, maintaining social ties centered around substance use, as well as mistreatment received both at rehabilitation centers and at residential help centers (Table 4).

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

Table 4. Types of regressive narratives constructed by family members of substance users who attended a rehabilitation center in Tamaulipas, Mexico.

Type of narrative	Stage		
Regressive I: No change in the substance user, family member in recovery	Living a life of suffering	Becoming aware of consumption	Attempts at recovery
Poly-substance use (alcohol + marihuana + inhalants)	Family member focuses on own history of suffering (father's alcohol abuse, mistreatment, family conflicts, bouts of homelessness, sex work for survival, having children with multiple partners) Problematic substance use begins in adolescence and is maintained throughout adulthood Difficulty raising children, continuation of conflicts with family of origin, and lack of support systems	Detecting sons' substance use in adolescence Continuation of mother's substance use, lack of commitment to her own treatment Distress over son's substance use and difficulties in setting limits Son is admitted to a center and relapses Critical event: another of her sons is killed (used drugs, lived in different places, had been in and out of rehabilitation centers)	Mother identifies as a "recovering addict," joins an Alcoholics Anonymous group Son is voluntarily admitted and she accompanies son in family interventions sponsored by the center Mother adopts therapeutic ideology and engages in practices consistent with it in daily life Mother identifies changes in herself in terms of no longer consuming, changing social relationships, being more responsible, and relationship with her son Son remains in treatment, but they are still waiting for significant changes
Regressive II: No change in the family member or in the substance user	-	Becoming aware of consumption	Waiting for recovery
Poly-substance use (alcohol + marihuana + cocaine + crack)	-	Not only does substance user not live with family, substance use is hidden and the problem is detected only later, when psychosocial deterioration becomes evident Emotional distress and conflicting viewpoints regarding the management of substance use Meandering search for treatment; series of admittances and relapses	Admitted again, but no indications of progress and fear of another relapse Distress and negative feelings toward the substance user prevailed Family member attends sessions for families at the center but does not identify as codependent and does not adopt therapeutic practices in daily life No changes are reported in the family member or in the substance user

Source: Own elaboration.

DISCUSSION AND CONCLUSIONS

Before attending care centers, substance users resort to self-care or seek help from members of their immediate social circle such as family members.[3] Although this study found that family members often encourage the hospitalization of substance users,[4] this process is often delayed, which can contribute to the problem of substance use becoming chronic.

One finding of this study is that family members and substance users individually do not tend to turn to primary care centers when the consumption becomes problematic. This is possibly related to the stigma associated with addiction, where attending a care center might imply publicly identifying as an "addict," which from the point of view of moralizing discourses is connected with "vice." Nonetheless, it is also possible that this is due to the disconnect between care centers and communities, as family members did not often have sufficient information regarding different treatment alternatives. The principal options chosen by participants included Alcoholics Anonymous groups and "annexes," or residential mutual aid centers. It has been pointed out that the latter often present deficiencies in the quality of care services offered, but also violate the human rights of substance users.[38] The lack of access to dignified care

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

services is a manifestation of discrimination against substance users, which contributes to continued problems of consumption and increased psychosocial deterioration.

As shown in other studies,[9,10] family members experience different forms of emotional distress, such as anger, sadness, worry, mistrust, and ambivalence. Conflicts between substance users and family members take place, in addition to estrangement, rejection, and negative feelings. Substance users' psychosocial deterioration may affect their ability to continue working, which can lead to financial problems, compounded by the costs associated with their condition. Moreover, family members may develop physical and mental health issues.

Despite the burdens that this condition implies for them, few care services are directed specifically at family members.[11] This study has identified other forms of care, including family groups and the incorporation of family members in the substance user's treatment. Another way of accessing care services directed at family members is when they identify as codependent, which occurs more commonly among women, given that there are gender-based differences in care given to substance users. It should be examined if the use of the "codependent" diagnostic label on the part of health services contributes to pathologizing certain behaviors encouraged in women in their sociocultural context,[39] and if it further encourages the exclusion of other family members from treatment, such as men, children, and adolescents.

Regarding the narratives, different types were identified. Among progressive narratives, we were able to identify quest narratives that emphasized a process of personal transformation.[34] These may be continuous, with a central role given to the substance user as agent, or discontinuous, with regressive periods characterized by suffering and fluctuations between hospitalization and relapse. At the same time, we found a progressive restitution narrative, which rather than focusing on personal transformation, put emphasis on the recovery of the substance user and the family after a period of crisis, thanks to treatment at the rehabilitation clinic. The restitution narrative was characterized by a shorter time span and an abrupt and continuous change that occurred more rapidly. The progressive and stable narratives identified in the study were similar to certain types of narratives related to the recovery process identified elsewhere: narratives of Alcoholics Anonymous, growth, and codependency.[40] In contrast, regressive narratives were characterized by the persistence of distress and of uncertainty regarding relapse, a lack of trust in treatment, and the absence of a full acceptance of the therapeutic ideology. Recovery remains elusive, and the substance user often shows signs of greater psychosocial deterioration. In these accounts there may be a history of substance use over various generations, as well as gender-based violence and structural violence.[41]

Although this study does not intend to pathologize family members, some of the elements that contribute to making substance use chronic include difficulties setting limits, fluctuating between different consumption management strategies, and disagreements among family members regarding how the problem should be handled. Furthermore, minimizing or normalizing substance use and keeping the issue a matter only dealt with by family also limit the possibilities of finding support in systems external to the family.

Recovery is facilitated when family members "hit rock bottom." This moment compels family members to recognize their own emotional distress and consider that it has reached a limit, especially when critical events occur or the substance user's psychosocial deterioration increases along with the burden implied by the condition. This is not only an affective process, but also a symbolic one, in that it involves changes with regard to problematizing the substance use; that is to say, there is recognition that it is not only a question of vice, that it is not solely dependent on the will of the substance user or their family, and that specialized care is needed. Although admitting the problem on the part of the substance user and accepting voluntary hospitalization can expedite this process, family members may also encourage certain limits to be set. In addition to early detection and opportune

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

intervention in substance use problems, it is necessary to highlight that families require care alternatives that are visible in their communities and that provide quality treatment in order to avoid pilgrimages to find appropriate institutions.

Contact with care services implies another important change: moving from dealing with the problem within the family, to dealing with it in a non-institutionalized setting by involving informal support networks, to attending care services specialized in addiction. At this point it is crucial for family members to not only accompany the substance user in treatment, but also to receive care in order to modify the way that they have handled the relationship with the user up to that point, as well as the ways they have responded to the substance use or dealt with relapses.[42] This facilitates the adoption of the rehabilitation center's ideology of care.[43,44]

Although there are narratives in which epiphanies or critical events lead to sudden and continuous change, in the accounts change is principally observed as a discontinuous process, which includes successive periods of suffering, hospitalization, and relapse, which gradually facilitate the recovery process.[45] We find that different recovery scenarios exist: both recover, the family recovers but not the substance user, neither recovers, or the substance user recovers but not the family. The last of these is hypothetical, given that no such case was identified in the results analyzed. Moreover, change can occur in multiple directions, such as the substance user taking on agency encouraging the recovery of the family, or family members taking on more agency and fostering change in the substance user. Care services can look to families as a resource in early detection, opportune intervention, and accompaniment in recovery; while they can also provide specialized services directed to them, given the burden associated with the condition that can build up over time.

REFERENCES

1. Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Instituto Nacional de Salud Pública, Comisión Nacional contra las Adicciones, Secretaría de Salud. Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco 2016-2017: Reporte de Alcohol [Internet]. México: INPRFM; 2017 [cited 26 Aug 2019]. Available from: https://tinyurl.com/y9zzygv3.

2. Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, Instituto Nacional de Salud Pública, Comisión Nacional contra las Adicciones, Secretaría de Salud. Encuesta Nacional de Consumo de Drogas, Alcohol y Tabaco 2016-2017: Reporte de Drogas [Internet]. México: INPRFM; 2017 [cited 26 Aug 2019]. Available from: https://tinyurl.com/y7vbylru.

3. Berenzon S, Medina-Mora ME, Lara MA. Servicios de salud mental: veinticinco años de investigación. Salud Mental. 2003;26(5):61-72.

4. Marín-Navarrete R, Medina-Mora ME, Tena-Suck A. Addiction care in Mexico: a challenge for non-specialized health professionals. Salud Mental. 2016;39(5):241-242.

5. Schwartzman J. Addict abstinence and the illusion of alternatives. Ethos. 1977;5(2):138-150.

6. Stanton MD, Todd TC, Heard DB, Kirschner S, Kleinman JI, Mowatt DT, Riley P, Scott SM, Van Deusen JM. Un modelo conceptual. In: Stanton MD, Todd TC. Terapia familiar del abuso y adicción a las drogas. Barcelona: Gedisa; 1985. p. 25-42.

7. Cirillo S, Berrini R, Cambiaso G, Mazza R. La familia del toxicodependiente. Barcelona: Paidós; 1999.

8. Selbekk AS, Sagvaag H, Fauske H. Addiction, families and treatment: a critical realist search for theories that can improve practice. Addiction Research & Theory. 2014;23(3): 196-204. doi: 10.3109/16066359.2014.954555.

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

9. Orford J, Velleman R, Copello A, Templeton L, Ibanga A. The experiences of affected family members: a summary of two decades of qualitative research. Drugs: Education, Prevention and Policy. 2010;17(Suppl 1):44-62. doi: 10.3109/09687637.2010.514192.

10. Orford J, Velleman R, Natera G, Templeton L, Copello A. Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. Social Science & Medicine. 2013;78(2):70-77. doi: 10.1016/j.socscimed.2012.11.036.

11. Natera G, Tiburcio M. Tailoring an intervention model to help indigenous families cope with excesive drinking in central Mexico. Salud Mental. 2007;30(6):32-42.

12. Madsen P, Marsden-Hughes H. Exploring the processes involved in long-term recovery from chronic alcohol addiction within an abstinence-based model: implications for practice. Counselling and Psychotherapy Research. 2013;13(3):201-209. doi: 10.1080/14733145.2012.733716.

13. Wagner V, Bertrand K, Flores-Aranda J, Acier D, Brunelle N, Landry M, Brochu S. Initiation of addiction treatment and access to services: young adults' accounts of their help-seeking experiences. Qualitative Health Research. 2016;27(11):1614-1627. doi: 10.1177/1049732316679372.

14. Wisely C. The logic of recovery and injection drug use. Journal of Substance Use. 2013;18(1):56-64. doi: 10.3109/14659891.2013.761024.

15. Candil A. Acompañar a usuarios intensivos de drogas: el papel de las redes de proximidad en los tratamientos ambulatorios. Antípoda, Revista de Antropología y Arqueología. 2016;26:179-196.

16. Brown S, Tracy EM, Jun M, Park H, Min M. Personal network recovery enablers and relapse risks for women with substance dependence. Qualitative Health Research. 2015;25(3):371-385. doi: 10.1177/1049732314551055.

17. Edwards ME, Steinglass P. Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy. 1995;21(4):475-509. doi: 10.1111/j.1752-0606.1995.tb00176.x.

18. Epstein EE, McCrady BS. Behavioral couples treatment of alcohol and drug use disorders: current status and innovations. Clinical Psychology Review. 1998;18(6):689-711. doi: 10.1016/s0272-7358(98)00025-7.

19. Meads C, Ting S, Dretzke J, Bayliss S. A systematic review of the clinical and cost-effectiveness of psychological therapy involving family and friends in alcohol misuse or dependence. Birmingham: University of Birmingham, Department of Public Health and Epidemiology; 2007.

20. Copello A, Velleman R, Templeton L. Family interventions in the treatment of alcohol and drug problems. Drug and Alcohol Review. 2005;24(4):369-385. doi: 10.1080/09595230500302356.

21. Lucksted A, McFarlane W, Downing D, Dixon L. Recent developments in family psychoeducation as an evidence-based practice. Journal of Marital and Family Therapy. 2012;38(1):101-121. doi: 10.1111/j.1752-0606.2011.00256.x.

22. Liddle HA, (ed.). Multidimensional family therapy for adolescent cannabis users, Cannabis Youth Treatment Series, Volume 5. Rockville: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Service Administration; 2002.

23. Fernández C, González J, Barrera, G. Modelo de terapia familiar multidimensional con perspectiva de género. México: Centros de Integración Juvenil; 2006.

24. Orford J, Copello A, Velleman R, Templeton, L. Family members affected by a close relative's addiction: the stress-strain-coping-support model. Drugs: Education, Prevention and Policy. 2010;17(Suppl 1):S36-S43. doi: 10.3109/09687637.2010.514801.

25. Natera G, Tiburcio M, Mora J, Orford J. Apoyando a familias que enfrentan problemas por el consumo de alcohol y drogas. México: INPRFM-Pax; 2009.

26. Natera G, Mora-Ríos J, Tiburcio M, Medina P. An international perspective: constructing intervention strategies for families in Mexico. Drugs: Education, Prevention and Policy. 2010;17(Suppl 1):S193-S202. doi: 10.3109/09687637.2010.514787.

27. Nuño-Gutiérrez BL, Álvarez-Nemegyei J, González-Forteza C, Madrigal-de León E. La adicción ¿vicio o enfermedad? Imágenes y uso de servicios de salud en adolescentes usuarios y sus padres. Salud Mental. 2006;29(4):47-54.

28. Raikhel E, Garriot W. Addiction trajectories. London: Duke University Press; 2013.

29. Almanza AM. Narrativas acerca del VIH: la mirada del paciente y de su red social. Riga: Publicia; 2015.

30. Kleinman A. The illness narratives. Nueva York: Basic Books; 1988.

31. Hydén L. Illness and narrative. Sociology of Health & Illness. 1997;19(1):48-69. doi: 10.1111/j.1467-9566.1997.tb00015.x.

32. Good B. Medicina, racionalidad y experiencia: Una perspectiva antropológica. Barcelona: Bellaterra; 2003.

33. Gergen K. Realidades y relaciones: Aproximaciones a la construcción social. Barcelona: Paidós; 1996.

34. Frank A. The wounded storyteller: Body, illness and ethics. Chicago: The University of Chicago Press; 1995.

35. García B. El modelo Minnesota: Un método de tratamiento para las adicciones. [Tesis de maestría]. Bilbao: Universidad de Deusto; 2011.

36. Gómez-San Luis AH, Almanza-Avendaño AM. Barriers to addiction prevention and treatment in communities with organized crime: the perspective of health providers. Salud Mental. 2018;41(2):73-80.

SALUD COLECTIVA. 2020;16:e2523. doi: 10.18294/sc.2020.2523

37. Lieblich A, Tuval R, Zilber T. Narrative research. Reading, analysis and interpretation. California: Sage; 1998.

38. Marín-Navarrete R, Eliosa-Hernández A, Lozano-Verduzco I, Fernández-De la Fuente C, Turnbull B, Tena-Suck A. Estudio sobre la experiencia de hombres atendidos en centros residenciales de ayuda mutua para la atención de las adicciones. Salud Mental. 2013;36(5):393-402.

39. Harkness D, Cotrell G. The social construction of co-dependency in the treatment of substance abuse. Journal of Substance Abuse Treatment. 1997;14(5):473-479. doi: 10.1016/s0740-5472(97)00121-9.

40. Hänninen V, Koski-Jännes A. Narratives of recovery from addictive behaviours. Addiction. 1999;94(12):1837-1848. doi: 10.1046/j.1360-0443.1999.941218379.x.

41. Lozano-Verduzco I, Romero-Mendoza M, Marín-Navarrete R. Violence narratives of Mexican women treated in mutual-aid residential centers for addiction treatment. Substance Abuse Treatment, Prevention and Policy. 2016;11(1):39-49. doi: 10.1186/s13011-016-0083-0.

42. O´Grady C, Skinner W. Journey as destination: a recovery model for families affected by concurrent disorders. Qualitative Health Research. 2012;22(8):1047-1062. doi: 10.1177/1049732312443736.

43. Burke AC, Clapp JD. Ideology and social work practice in substance abuse settings. Social Work. 1997;42(6):552-562. doi: 10.1093/sw/42.6.552.

44. Klingemann J. Lay and professional concepts of alcohol dependence in the process of recovery from addiction among treated and non-treated individuals in Poland: a qualitative study. Addiction Research & Theory. 2011;19(3):266-275. doi: 10.3109/16066359.2010.520771.

45. Kougiali Z, Fasulo A, Needs A, Van Laar D. Planting the seeds of change: directionality in the narrative construction of recovery from addiction. Psychology & Health. 2017;32(6):639-664. doi: 10.1080/08870446.2017.1293053.

CITATION
Almanza Avendaño AM, Gómez San Luis AH. Narratives about the process of recovering from addiction: the perspective of family members attending care services. Salud Colectiva. 2020;16:e2523. doi: 10.18294/sc.2020.2523.

Received: 31 Aug 2019 | Modified: 4 Apr 2020 | Accepted: 14 Apr 2020 | Publication online: 19 May 2020

https://doi.org/10.18294/sc.2020.2523

This article was translated into English by Joseph Palumbo.