ORIGINAL ARTICLE

Spontaneous harm reduction: a barrier for substance-dependent individuals seeking treatment?

Redução espontânea de danos: barreira para a procura de tratamento por dependentes de substâncias psicoativas?

Bruno José Barcellos Fontanella,[1] Egberto Ribeiro Turato[2]

Abstract

Objective: Greater information regarding motivations and treatment barriers faced by substance-dependent individuals has clinical and public health implications. This study aimed to formulate hypotheses regarding psychological, social and family variables that can be constructed as motivations or subjective barriers for the early seeking of formal treatment. Methods: A qualitative study was conducted in an intentional sample (selected through saturation and variety of types) of 13 substance-dependent individuals who sought treatment. In-depth, semi-structured interviews were conducted using open questions, and the transcribed data were subjected to qualitative analysis. Results: Four types of spontaneous harm reduction measures were identified, according to the subjective logic of each participant: having some periods at rest (not using and recovering from adverse effects); caretaking by close acquaintances (relatives, partners, drug dealers and alcoholic beverage sellers); selectivity regarding substance source, type and means of administration; establishing "healthy" limits of ingestion. Conclusions: The measures identified might represent barriers to the early seeking of treatment but might also represent spontaneous learning of abilities beneficial to future treatment. Health care professionals should take into consideration their existence and should address them in clinical settings. Issues representative of the formulated categories should be presented in structured questionnaires used in future quantitative studies of barriers to treatment in this population.

Keywords: Substance-related disorders; Alcoholism; Patient acceptance of health care; Delivery of health care; Interview, Psychological; Qualitative research; Harm reduction

Resumo

Objetivo: O conhecimento das motivações e barreiras para que um dependente de substâncias psicoativas chegue a tratamento tem importantes implicações clínicas e para a saúde pública. O objetivo do trabalho é formular hipóteses sobre variáveis psicológicas e sociofamiliares configuráveis como motivações e barreiras subjetivas *para a procura mais precoce por tratamento formal pela população de dependentes de substâncias psicoativas. Métodos: Pesquisa qualitativa exploratória sobre amostra heterogênea (quanto a variáveis clínicas e sociodemográficas) e intencional (fechada por saturação e variedade de tipos) de 13 dependentes de substâncias psicoativas que procuraram tratamento. Entrevistas semidirigidas com questões abertas e análise qualitativa de conteúdo da transcrição, com formulação de categorias de motivações e barreiras para tratamento formal. Resultados: Dentre as barreiras ao tratamento, foram identificados quatro tipos de medidas espontâneas de redução de danos, de acordo com a lógica subjetiva dos entrevistados: descansos do uso (períodos de tempo sem uso para recuperação de efeitos indesejáveis); cuidados de pessoas próximas (parentes, colegas, comerciantes/traficantes das substâncias); eleição de boas procedências, variedades de substâncias e vias de administração; estabelecimento de cotas de uso de substâncias que não fariam mal. Conclusões: As medidas identificadas podem representar barreiras à procura precoce de tratamento e também significar treinamento espontâneo de habilidades benéficas a um futuro tratamento; os clínicos devem considerá-las, abordando-as e discutindo-as nos atendimentos clínicos; tópicos representativos das categorias formuladas devem constar dos questionários estruturados sobre a freqüência das diferentes barreiras ao tratamento nesta população.*

Descritores: Transtornos relacionados ao uso de substâncias; Alcoolismo; Aceitação pelo paciente de cuidados de saúde; Cuidados médicos; Entrevista psicológica; Pesquisa qualitativa; Redução do dano

Laboratory of Clinical-Qualitative Research of the Department of Medical Psychology and Psychiatry of the UNICAMP School of Medical Sciences
Study based on the (Medical Sciences) doctoral thesis entitled: "Treatment seeking by individuals dependent on psychoactive substances: a qualitative clinical study" [UNICAMP, 2000]. Presented as a poster at the *XX Congresso Brasileiro de Psiquiatria* in 2002.

[1] Department of Mental Health, Medical School, Universidade Federal de Minas Gerais (UFMG), Belo Horizonte (MG), Brazil
[2] Department of Medical Psychology and Psychiatry, School of Medical Sciences, Universidade Estadual de Campinas (UNICAMP), Campinas (SP), Brazil

Financing: Conselho Nacional de Desenvolvimento Científico e Tecnológico - CNPq (process: 142480/1992-4)
Conflicts of interest: None
Submitted: 26 July 2004
Accepted: 29 January 2005

Correspondence
Bruno José Barcellos Fontanella
Av. Barão de Itapura, 1518 / 308
13020-432 Campinas, SP, Brazil
Phone: (19) 3232-1910
E-mail: bruno.fontanella@uol.com.br

Introduction

Although many of the barriers to treatment seeking among psychoactive substance (PAS) -dependent individuals may be objective (resulting, for example, from a poor health care system or the characteristics of the treatment programs offered), it is important to become familiar with how these barriers are subjectively evaluated by the dependent individuals themselves. The knowledge of what these factors are helps progressively improve questionnaires for quantitative studies of the frequency with which the various barriers to and motivations for treatment seeking arise.

Various barriers have been mentioned in the literature, and it is curious that some of them may actually represent motivations for treatment seeking among other people (fear of losing their jobs, for example).[1] Therefore, it is relevant to understand the personal significance that these factors have, and studies using qualitative methods may contribute to that.

The expression "harm reduction" was coined in the 1980s, when the practical application of this concept began to be further discussed in the face of the emergence of the AIDS epidemics.[2] However, the preventive logic of reduction or minimization of harm has permeated health science practices regarding substance use and abuse for more than a century.[3-4] After a progressive historical evolution during the 20th century (which began with morphine-dependent individuals being given a medical prescription for this drug), harm reduction seems to currently constitute one of the most important scientific paradigms in the field of community health and can be applied to various health problems. Of note among such health problems is substance abuse and dependence. In this area, the concept of harm reduction does not exclude the goal of abstinence but includes other proposals for pragmatic measures to minimize the harmful consequences of PAS use, taking into consideration the decision-making capacity of patients and caregivers. Therefore, it contributes to a less hierarchical model of the patient-clinician relationship, based on a posture of respect for the choices of each.

The objective of the present study was to construct hypotheses regarding psychological, social and family variables that might constitute motivations and subjective barriers to formal treatment seeking among PAS-dependent individuals and to study how these motivations/barriers are perceived and experienced by these individuals. We discuss one of the categories formulated: the supposed barriers to early treatment that seem to correlate, from the perspective of the PAS-dependent individual, with a personal logic of harm reduction. This logic would be present in daily and spontaneous behaviors to minimize the harmful consequences of PAS use.

Methods

The study used a qualitative method applied to the clinical area.[5] Semi-structured interviews with open questions were used. These interviews began with the general theme "How did you seek treatment?", which was complemented, if not spontaneously mentioned, with the following subthemes: "triggering factors"; "what you understand by treatment"; "aspects of use that you want to modify"; "why you did not seek treatment earlier"; "how you pictured the professionals who would treat you"; "what they should be like"; and "influence of previous treatment experiences".

We tried to catalyze the expression of the participants by facilitating and stimulating their reflections on the themes. Urged to play an active role in the interview and to express themselves in their own words, the participants modeled the interviews according to their particular psychological structures.[6] In other words, interviewee personality was the principal structuring factor of the interview, and interviewer control was limited to the introduction of the themes.

The result was 13 recorded interviews (19 hours total duration), transcribed by a technician and reviewed by the interviewer (first author). The complete transcriptions remain available for further review.[7] We carried out a content analysis,[8] which is explained hereafter. The authors performed fluctuating readings of the transcriptions in order to delve into the material and formulate descriptive categories, codifying the motivations and barriers to treatment seeking reported by the interviewees and those induced by the interviewers, a process that results from the identification of clinical, psychological and social phenomena in the behavior of the participants.[8] These categories were discussed using a theoretical chart that resorted to phenomenological psychopathology, psychoanalysis and medical psychology.

We tried to make the sample heterogeneous regarding clinical and sociodemographic variables by intentionally choosing 13 subjects (Table 1) who sought treatment and were articulate so that they could provide data for the formulation of the intended hypotheses. The sample was initially closed by saturation: we interviewed, sequentially, 9 subjects

Table 1 – Characterization of the sample: gender, age, ethnic group, marital status, occupation, employment status, substance and duration of dependence*

Interviewee	Characteristics
A	♂ 50y, white, married, advertising man, unemployed. Dependent on alcohol for 15 years, harmful use of intravenous cocaine for 20 days
B	♂ 29y, black, married, electrician, employed. Dependent on alcohol for 7 years
C	♂ 18y, white, single, telephony technician, unemployed, dependent on intranasal cocaine for 2 years
D	♂ 24y, white, single, no occupation, unemployed, dependent on intranasal cocaine for 5 years
E	♂ 39y, white, widower, engineer, employed, dependent on alcohol for 2 years
F	♂ 36y, white, married, metalworker, dependent on alcohol for 7 years
G	♂ 22y, white, single, commercial employee, dependent on intranasal cocaine for 3 years
H	♂ homosexual, 29y, white, single, self-employed commercial worker, dependent on intranasal cocaine for 2 years
I	♂ 39y, white, married, draftsman, dependent on alcohol for 4 years
J	♀ 20y, mixed, single, no occupation, unemployed, dependent on marijuana for 1 year
K	♂ 23y, mixed, single, industrial worker, employed, dependent on crack cocaine for 1 year
L	♂ 43y, mixed, married, industrial worker, dependent on alcohol for 6 years
M	♂ 34y, white, single, retired due to disability, dependent on codeine (currently administered orally, previously administered intravenously) for 9 years

**Interested readers can access the complete table with the characterization of the participants of the sample. In that table, there are also data on family composition, schooling, length of time the interviewee has been using the substance on which he/she is dependent, other abused substances, involvement in religious activities and place where the interviews were carried out (current data in Fontanella, 2000[7]).*

who met the inclusion criteria (see below) until new interviews did not substantially add new data to those already obtained, in the judgment of the interviewers. Subsequently, we included another 4 subjects for variety of type (elements that, being representative of certain clinical and sociodemographic characteristics, filled some gaps of the sampling desired by the authors: a woman, an opiate-dependent individual, a crack-cocaine dependent individual and an individual who was coerced into seeking treatment by the company where he worked). Of the 13 participants, 6 were restarting treatment (having abandoned previous treatment), and the others were seeking treatment for the first time. All participants in the study gave written informed consent, allowing their words to be transcribed and made public. Total anonymity was guaranteed, and citations that could, even indirectly, reveal their identities were omitted. The research was approved by the UNICAMP's Ethics Committee (process number 233/94).

The following were the inclusion criteria: adherence to initial treatment (having attended at least three office appointments or having been hospitalized for seven days); being in the three initial weeks of treatment; having maintained adherence after an acute situation that triggered hospitalization or medical appointment had been resolved (acute withdrawal syndrome, disruptive behaviors with family crisis, severe acute intoxication, etc.); diagnosis of dependence upon at least one psychoactive substance (ICD-10: F1x.2); principal complaint being related to said diagnosis; being aware of the diagnosis; and having agreed to participate in the study. An additional inclusion criterion is considered particularly important: the first author interviewed his own patients (in his office or in an inpatient psychiatric clinic in the city of Campinas, SP) because some of the phenomena investigated could be related to the clinician-patient encounter. Being exactly the natural setting where certain difficulties in treatment seeking would occur, these difficulties would thereby be more easily observed. In qualitative studies, bias resulting from intentional samplings does not necessarily need to be avoided but should be recognized and discussed.

The objective of some procedures was to maximize the validity and reliability of the interviews as an instrument of data collection: facilitation of interviewee expression; good interviewer-interviewee rapport; "the interviewer as an instrument";[6] stable interview setting; and introduction of the same general theme and subthemes to all of the interviewees. With regard to the content analysis, this search for maximization relied on the following: triangulation among the data analysts (the authors who, after codifications and independent analyses, discussed the consensual categories, as well as those categories that later became consensual); exemplification and use of theories in the discussions of the results; auditing by independent researchers (members of the laboratory of qualitative research to which the authors are linked); judgment of experts in the area (thesis examining board); audio record of the 19 hours of interviews and their transcription (corresponding exactly to what was said by the interviewer and the interviewees); and search for distortion of the hypotheses formulated.

Results and discussion

The interviewees had no theoretical knowledge of the concept of harm reduction, nor had they received any professional orientation in this regard, although approximately half of the sample was restarting treatment. However, in the analysis of the interviews, we observed that they instituted, spontaneously or through close acquaintance, measures that were protective against complications related to PAS abuse:

1) Rest from use

The interviewees reported assigning periods of "down time" (no substance use) for recovering from side effects. For example, J. and D. said they reserved two days of the week for "taking a break" from cocaine:

"Now I use it less often, only on weekends. I start on Wednesday and continue until Sunday; Monday and Tuesday is for resting a little." (J.)

"I was resting, OK? Monday and Tuesday, beginning of the week, nobody would get out of the house... leave snorting for the weekend." (D.)

When persecutory delusions presented during the intoxication became more frequent and constant, D. inverted the "rest" and started not using the substance on weekends, avoiding exposure to a greater number of people since D. considered this a factor that intensified and triggered the episodes of "paranoia", as he named these symptoms.

Similar protective effects are sought when one "slows down" on the day following a day of heavy use (I.) or when one seeks hospitalization, as was the case for M., who reported using hospitalization to partially recover, "physically and psychologically", from abusing codeine (injected and, subsequently, administered orally) in an attempt to revert to a physical state in which effects no longer experienced could be "re-lived" "as in the beginning":

"After I left the hospital, I started using drugs again. My body had already gotten unaccustomed. As in the beginning, my drug use increased gradually, but I was still using less often." (M.)

This type of measure may have a parallel function regarding the reduction of a very specific harm: the harm to the psychic economy, due to the fact that the substance does not satisfy as before, or brings unpleasant associated effects that do not let it be perceived as an object that always gratifies, protects and never frustrates (that is, an "ideal object", from a psychoanalytical viewpoint[9]). In this case, the intended harm reduction is an attempt to rebalance the psychic situation that faces threats after dependence is installed since, thereafter, the suffering resulting from the lack of it will interpose the pleasure derived from using it. In the case of M., the desired effects were not obtained for two reasons: the development of pharmacological tolerance and the oral administration (since M. no longer had any accessible veins), and these did not allow for a sufficient concentration of codeine to produce a "rush". Therefore, he seeks hospitalization, "rests" (that is, tries to reduce the pharmacological tolerance) in order to regain, after discharge, the intense pleasure previously derived from using the substance.

2) Agreeing to be taken care of by relatives, friends, merchants and drug dealers

Some social relationships that the interviewees had with other users made them feel they were the target of protective measures (I., F.) on the part of these people. The interviewees perceived this protection as a contributing factor in the maintenance of their consumption pattern. This protective relationship was also felt in the contacts with sellers of alcoholic beverages (F.) and drug dealers:

"This drug dealer was the one I was closer to. He said 'C., the thing is, you've got to be smart about it.' He gave me support. He told me to stop, gave me support. He is a great guy." (C.)

The social contacts that the interviewees had with the drug dealers/merchants seem to have been complex and ambiguous. If, on the one hand, they perceive pressure against treatment, on the other hand, they feel warned, for example, about the problems that certain substances would cause. In this example, an interviewee mentions a colleague who introduced him to crack and advised him in an ambiguous manner:

"He arrived and said 'have you ever used crack?' I said 'no'. 'I will put some for you, but this stuff here is bad, this stuff here you cannot get addicted to'." (K.)

The participants also reported taking measures instituted or suggested by close relatives in order to prevent complications resulting from the use. For example, they tried to negotiate a more controlled use, and K. referred to "safe" places for crack use (a crack-house, a friend's mother's house):

"There was a place only a buddy and I used, which was his house. His mother did not use it, but she knew that we used it. And she only let us smoke in her house, only if it was me." (K.)

For the interviewee, the colleague's mother tried to protect them from using it in dangerous places. Similarly, M.'s mother bought codeine herself in order to prevent him from stealing money and house objects, reducing the harm of an even greater deterioration of the family relations:

"When I did not have money, my mother gave me money to buy syringes, needles and codeine every day." (M.)

This interviewee also reported some less direct help, mentioning that his fiancée "made believe" that the situation was under control, thereby, from the interviewee's viewpoint, keeping their relationship more stable.

An implicit family agreement not to interfere with E.'s use of alcohol was perceived by E. as a sign of affection:

"In order to put up with what my wife put up with, you have to like someone very much, don't you? She really liked me a lot." (E.)

At the time that these events took place, the interviewees still had not sought help to control their use but retrospectively recognized the attitudes taken by these close acquaintances as protective.

Third-party care was included among the subjective barriers because it would have postponed treatment seeking and helped maintain the pattern of use already considered problematic by the interviewees. It is an even more complex situation since it may be difficult for the dependent individuals to discriminate between (ego-dystonic) pressure from (ego-syntonic) concern of close acquaintances.

Carroll and Rounsaville found significant differences among cocaine abusers regarding the control strategy of "asking others to help control the use", which was more common in the group undergoing treatment – likely reflecting another strategy that is significantly (and obviously) different in the two groups: the treatment seeking itself.[10]

Brennan and Moos studied alcoholics and found that those who had more support from their family and friends sought treatment less often.[11] They formulated the hypothesis that this was due to the "informal assistance" that would replace professional help. In the present sample, the case of H. ratifies the plausibility of this hypothesis since the parents were "elected" as caregivers, and H. visited the clinician only bureaucratically. Other examples, previously mentioned, are less extreme, but are also equally representative of how social and family support may constitute a subjective barrier to treatment for some time. This discussion is complementary to, yet different from, the barrier to treatment represented by "pressure to use and not seek treatment" since this "informal assistance" is an attempt at harm reduction and not a direct stimulus to substance use.[7]

3) Surviving dangerous activities

The interviewees reported believing that, taking the necessary precautions and respecting a certain "quota of use" (see below), they would be magically protected from dangers. Surviving dangerous situations in life was regarded as a natural and expected result of certain activities. J. reported "chasing death" and feeling "excited" by the possibility of overdose and by activities such as bungee jumping and parachuting. D., in turn, referred to a car accident and to holding a bomb when it exploded, subsequently claiming not to care about the risks: "I couldn't care less."

Ordeal fantasies seem to be common in the psychic dynamic and in some sociocultural manifestations, even of the non-PAS-dependent individuals.[12] The idea is that surviving situations and activities that are potentially lethal would reveal a kind of supernatural protection. Surviving these situations/activities would be pleasant and would reinforce a state of omnipotence, confirming the efficacy of the manic mechanisms.

The authors who proposed the ordeal hypothesis believe that, when dependent individuals expose themselves to severe intoxications (or engage in extreme sports or other potentially lethal activities, such as going to dangerous drug trafficking areas, etc.), they would be aiming, in contrast to what one would imagine, to reaffirm their capacity to escape death (which, at the end of the rituals, would be defeated).[12-13] They would thereby attempt to overcome compulsive use (generally perceived as unpleasant and as something that only softens cravings and other withdrawal symptoms), feeling again the intense original sensations experienced when they started using the substance.[12] The report of the sample studied ratifies the ideas of these authors since, by resorting to ordeal rituals, some interviewees would be using an extra defensive resource to deal with their fears and worries (something subjectively protective), postponing seeking treatment since they feel more capable of dealing with the problem alone.

4) "Good" patterns of use, routes of administration and substances

Following the same logic, the dependent individuals elected substances and means of using them that were considered good, correct or harmless when compared to others.

B. reported a conversation with a friend in which they considered the advantages of some substances over others, weighing prices and side effects. This alcohol-dependent interviewee reported having been abstinent for six years and starting to drink again after tasting an *aguardente* (sugar cane rum) that was different from those previously tried, one that

"did not burn" (B.) and was therefore considered a good sugar cane rum.

Some participants of the sample developed a peculiar perception of the effects of some substances or some routes of administration. One of them (C.), dependent on inhaled cocaine, no longer contemplated injectable use after witnessing a friend's physical reactions. Also a cocaine user, G. said the following about marijuana and intravenous drug use:

"Marijuana does not cause any harm. At least to me, it has never caused any harm. I'm sure of it. [Injectable drugs...] I've never wanted that stuff. Syringes scare me to death, actually. I can't stand that stuff." (G.)

Therefore, G. is "sure" that there are good substances, which, for example, could be resorted to if the use of cocaine, the reason for his medical appointment, were interrupted. This same interviewee, although he did not try this "treatment", believed that LSD could treat cocaine dependence. G. believed that LSD had this "good" side.

"LSD, it even gets you to stop using cocaine because its effect is almost exactly the same, everything together, the effect of marijuana and cocaine together." (G.)

Also dependent on cocaine, D. dismissed the possibility of using it in the form of crack:

"I will never use it, it does not appeal to me at all. The smell must be terrible. It is only a smell of I don't know what with I don't know what there... powder with something. It doesn't work, no way." (D.)

On the other hand, a crack-dependent individual dismissed the possibility of using intravenous cocaine, which would cause a "silly madness" (K.), as well as of sniffing glue, sniffing amyl nitrate or smoking marijuana, which would make your body feel "weird" (K.), an effect that K. felt crack did not have.

Other theories about the effects and interaction of substances were formulated, with more or less plausibility. F. tried not to associate alcoholic beverages with medication. H., for example, had the self-perception that cocaine and alcohol interacted in a one-way-fashion: "It is not cocaine that makes me turn to alcohol, but alcohol that makes me turn to cocaine." H. also perceived the countering effect that alcohol has on the insomnia caused by cocaine use and therefore believed that alcohol treats cocaine intoxication.

J. attributed the cocaine overdose that led to an outpatient clinic and psychiatrist visit to the "quality of the 'blow', which was not good" (J.). Following J.'s logic, if the quality had been "good", these problems would not have arisen, and trying to use higher-quality cocaine therefore means harm reduction.

5) "Healthy" use limits

"'Try it, a little shot won't do you any harm, no it won't ...'" (C.)

"I got by for a long time, I thought that 'I could burn the candle', so to speak, I could handle a little more." (D.)

The "little shot", meaning inhaling a line of cocaine, seems to connote, to C., the innocuousness of the act: a little amount of cocaine would do no harm.

The quote from D. reveals a belief that there was still space for use, both in terms of his physical health and in terms of his family relations. Although D.'s self-evaluation was of "a very strong dependence" D. weighed the costs and benefits, not seeking treatment until the perceived costs were much higher, when a vaguely pre-established use limit was exceeded. D., therefore, made the mechanism of evaluation of the cost-benefit relationship explicit. To others, this reasoning is less evident but also leads to the idea of imagining a "safe limit" to avoid more severe consequences:

"Then he abused [the drug] as much as he could, then he started feeling bad." (J.)

Final comments

We observed, based on the reports of the interviewees, that certain initiatives regarding the tertiary prevention of PAS dependence (and that can be depicted as harm minimization or reduction) are not put into practice based solely on initiatives or suggestions of the public health policies regarding this problem. On the contrary, they seem to be usually instituted based on spontaneous individual initiatives, permeating the user's daily life. Although there is a general consensus that the idea of harm reduction was reborn in the 1980s, with the AIDS epidemics,[4] informally, it is likely that this logic has never ceased to be part of the daily routine of PAS users throughout history.

The harm reduction measures presented and discussed herein have not always been consciously taken with the objective of preventing the consequences of the abuse. In addition, some seem to have no objective efficacy, perhaps only reinforcing fantasies of an omnipotent-magical control over death or other possible harmful consequences of the abuse. However, these measures were perceived by the interviewees as having some efficacy and corresponding to some objectives, set by themselves, thereby maintaining a certain pattern of consumption. The interviewees did not contemplate, at least temporarily, use cessation. The measures are, therefore, intermediate objectives between abstinence and uncontrolled use, which is precisely the logic put into practice by the harm reduction policies. The interviewees postponed or prevented, from their viewpoint, some complications of PAS abuse and believed they were more protected and capable of maintaining this pattern of use.

We considered, therefore, that, on the one hand, these measures served the mechanisms of reasoning and negation of the worries regarding the perception of the dependence, apparently contributing to the postponement of treatment seeking. However, they also seem to represent spontaneous learning of certain cognitive abilities to understand the measures of harm reduction proposed in the treatment programs, with what is considered greater practical efficacy.

Spontaneously instituted harm reduction is particularly important when we discuss the question of self-treatment for PAS abuse and dependence since we suppose that, especially in developing countries, most of the people experiencing this condition end up dealing with this situation alone and do not seek treatment.[4]

We call attention to a methodological peculiarity of this qualitative study carried out in a clinical environment. The sample only included patients of the interviewer himself (the first author) who adhered to the initial treatment. This was directly due to the objectives of the investigation: to formulate hypothesis on the barriers to and subjective motivations for treatment.

In view of this, we made two suppositions about tactics of maximization of the validity of the data collected. The first is that adherence to the initial treatment would mean the establishment of a reasonable bond of confidence with the clinician. The second is that this therapeutic bond would facilitate exposure of the more intimate subjectivity not only in clinical appointments, but also in open interviews for research purposes (that is, the therapeutic bond would also favor the researcher-participant relationship).

Therefore, we suppose that the interviewee capacity for introspection and verbalization of the most intimate subjective content regarding the themes proposed would be facilitated if the clinician and the researcher were the same person. The possible biases of this type of data collection do not have to be avoided in qualitative studies; as they are identified, they should be highlighted and discussed.

Despite the methodological considerations made above, the results obtained in the present study are in fact limited by factors related to the sample. It is possible that the inclusion of PAS-dependent individuals belonging to subpopulations that even less frequently seek health services (for example, homeless boys and girls, people from rural areas and the elderly) or with specific comorbidities (such as AIDS) would add new elements to the discussion. The same applies to the fact that the sample did not include adult women or individuals from subpopulations that did not adhere to or have never sought treatment.

We suggest that, for future studies on the motivations for and barriers to treatment seeking in this population, these spontaneous practices of harm reduction be investigated by including them in the structured questionnaires.

References

1. Fontanella BJ, Turato ER. Barreiras na relação clínico-paciente em dependentes de substâncias psicoativas procurando tratamento. Rev Saúde Pública. 2002;36(4):439-47.
2. Marlatt GA. Redução de danos no mundo: uma breve história. In: Marlatt GA, Bueno D. Redução de danos: estratégias práticas para lidar com comportamentos de alto risco. Porto Alegre: Artes Médicas; 1999. p. 29-43.
3. Berridge V. Aids, drugs and history. Br J Addict. 1992;87(3):363-70.
4. Working Party of the Royal College of Psychiatrists and the Royal College of Physicians Drugs: dilemmas and choices. London: Gaskell; 2000.
5. Turato ER. Tratado da metodologia da pesquisa clínico-qualitativa. São Paulo: Vozes; 2003.
6. Bleger J. Temas de psicologia: entrevista e grupos. São Paulo: Martins Fontes; 1989.
7. Fontanella BJ. Procura de tratamento por dependentes de substâncias psicoativas: um estudo clínico-qualitativo. [doctoral thesis] Campinas (SP): Universidade Estadual de Campinas; 2000.
8. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1979.
9. Segal H. Introdução à obra de Melanie Klein. Rio de Janeiro: Imago; 1975.
10. Carrol KM, Rounsaville BJ. Contrast of treatment-seeking and untreated cocaine abusers. Arch Gen Psychiatry. 1992;49(6):464-71.
11. Brennan PL, Moos RH. Functioning, life context, and help-seeking among late onset problem drinkers: comparisons with nonproblem and early onset problem drinkers. Br J Addict. 1991;86(9):1139-50.
12. Valleur M. Hedonismo. Ascese. Ordálio. In: Olievenstein C, organizador. A clínica do toxicômano. Porto Alegre: Artes Médicas; 1989. p. 39-51.
13. Charles-Nicolas A, Coguic A. clínica das toxicomanias. In: Bergeret J, Leblanc J, organizador. Toxicomanias: uma visão multidisciplinar. Porto Alegre: Artes Médicas, 1991. p. 62-77.