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Original Article

Alcoholism among hypertensive patients assisted by Primary Health Care and its implications: Notes for health care

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Objective: to describe the profile of alcoholism and its implications for the health of hypertensive users of Primary Health Care services. **Methodology**: a descriptive and qualitative research study, carried out in a Primary Care Center from Minas Gerais, Brazil. Characterization data were collected and an in-depth individual interview was carried out with a semi-structured script with 40 hypertensive patients aged ≥18 years old. The data were analyzed according to the content supported by the SPSS, version 26, and IRaMuTeQ software programs. All ethical-legal aspects of the research were met. **Results**: the participants were mostly old people, married, with children, light drinkers, with beer as the most consumed beverage. The content analysis showed six discursive categories that portrayed alcoholism and its influences on the participants' life and health, as well as the justifications for this social habit. **Conclusion**: even if light, alcoholism interferes in people's lives in many ways, not limited to health; however, for having a considerable impact on it, the problem deserves extra attention, especially in the scope of care planning.

Descriptors: Alcoholic Beverages; Hypertension; Primary Health Care; Health Assistance.

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Etilismo entre hipertensos e suas implicações: apontamentos ao cuidado na Atenção Primária de Saúde

Objetivo: descrever o perfil de etilismo e suas implicações à saúde de hipertensos usuários da Atenção Primária a Saúde. **Metodologia:** investigação descritiva, qualitativa, realizada num serviço de Atenção Básica de Minas Gerais, Brasil. Foram coletados dados de caracterização, sendo realizada entrevista individual em profundidade com roteiro semiestruturado com 40 hipertensos com idade ≥18 anos. Analisaram-se os dados com apoio dos *softwares* SPSS versão-26 e IRaMuTeQ. Foram respeitados todos os aspectos éticos e legais da pesquisa. **Resultados:** as participantes eram em sua maioria pessoas idosas, casadas, com filhos, etilistas leves, sendo a bebida mais consumida a cerveja. A análise de conteúdo evidenciou seis categorias discursivas que retrataram o etilismo, suas influências sobre a vida e saúde das participantes, bem como as justificativas para esse hábito social. **Conclusão:** o etilismo, ainda que leve, interfere na vida das pessoas de inúmeras formas, não se limitando à saúde, no entanto, por impactá-la consideravelmente, merece atenção redobrada, principalmente no âmbito do planejamento do cuidado.

Descritores: Bebidas Alcoólicas; Hipertensão; Atenção Primária à Saúde; Assistência à Saúde.

Alcoholismo entre hipertensos y sus implicaciones: pautas para el cuidado em la Atención Primaria de Salud

Objetivo: describir el perfil etílico y sus implicaciones en la salud de usuarios hipertensos de los servicios de Atención Primaria de la Salud. **Metodología**: investigación descriptiva, cualitativa, realizada en un servicio de Atención Primaria en Minas Gerais, Brasil. Se recogieron datos de caracterización y se realizó una entrevista individual en profundidad mediante guion semiestructurado con 40 pacientes hipertensos de ≥18 años. El análisis de datos se llevó a cabo con el auxilio de los *softwares* SPSS versión-26 e IRaMuTeQ. Se respetaron todos los aspectos éticos y legales de la investigación. **Resultados**: los participantes eran en su mayoría personas mayores, casadas, con hijos, bebedores leves, siendo la cerveza la bebida más consumida. El análisis de contenido mostró seis categorías discursivas que retratan el alcoholismo, su influencia en la vida y en la salud de los participantes, así como las justificaciones para este hábito social. **Conclusión**: el alcoholismo, aunque leve, interfiere en la vida de las personas de muchas maneras, sin limitarse exclusivamente a la salud. Sin embargo, por tener un impacto considerable en ella, merece más atención, especialmente en el ámbito del planeamiento del cuidado.

Descriptores: Bebidas Alcohólicas; Hipertensión; Atención Primaria de Salud; Asistencia a la Salud.

Introduction

Alcoholism is conceived as a disease linked to alcohol harmful use, abuse or dependence (ICD-10 F10.2). Thus, this involves consumption of distilled beverages and/or alcohol that is periodic, permanent, habitual or conditioned by physical, behavioral and psychological dependence[1].

Diverse (inter)national scientific evidence indicates that excessive alcohol consumption is considered a contributing risk factor for the development of Systemic Arterial Hypertension (SAH). The association mechanism between alcoholism and SAH involves stimulation of the sympathetic nervous system and increased secretion of glucocorticoids and cellular uptake of free calcium ions, which, together, contribute to the increase in peripheral vascular resistance[2-4].

SAH is characterized by high pressure levels (systole ≥ 140 mmHg and/or diastole ≥ 90 mmHg) on blood vessels, even at rest, and can cause functional changes in target organs such as heart, lungs and brain[4-5].

Two groups of risk factors for the occurrence of SAH are considered, regarding the exacerbation and/or emergence of other Cardiovascular Diseases (CVDs), the non-modifiable ones (psychosocial stress, prematurity, low birth weight, family history, chronic kidney disease, aging, low income, male gender and sleep apnea) and the modifiable ones (diet, sedentary lifestyle, overweight, hypercholesterolemia, Diabetes *Melittus* (DM), smoking, alcoholism and hypernatremia/hypokalemia)[5-7].

It was found that there is a scientific gap related to alcohol consumption among hypertensive people monitored by a Primary Health Care (PHC) service that advances in an associated or non-associated manner with the presence of other comorbidities, mainly because they understand that, regardless of the amount/frequency of alcohol consumed by the individuals, its impacts are not only limited to health, but it also has socioeconomic, psychological and family, among others, implications, which can be associated with the occurrence of negative outcomes in multiple human dimensions and from the perspective of the concept of expanded health care.

Therefore, it is justified to know the reality of hypertensive patients regarding alcoholism and its implications, mainly because it can contribute to the re-planning and feasibility/execution of health care actions, according to the demands recognized from the perspective of the people being cared for.

In addition to that, the knowledge generated can assist in fighting against the conditions that lead to stereotyping, discrimination and prejudice directed at drinkers linked to the addiction. And thus, for being conditions that exert negative impacts on these people's lives, dependence and/or abstinence must be prevented.

Thus, this study is relevant because it can contribute to health care with a multiprofessional and interdisciplinary approach capable of reaching the transdisciplinary dimension, revealing the backstage in which alcoholism occurs, in the expectation of valuing even the participants' discursiveness, aggregating qualitative results, whose meanings go beyond purely quantitative approach models, thus contributing to the chosen research scenario by portraying the local reality of the group of hypertensive people.

It is also worth mentioning that this research also brings about contributions to teaching, as it demonstrates the scenario and context in which alcoholism is established in the lives of hypertensive patients, which, in itself, entails an adaptation of care and ways of approaching them regarding alcoholism control or cessation at the primary health level.

Therefore, the following guiding questions emerged: Which is the alcoholism profile of hypertensive patients monitored by a PHC service? Which are the consequences of alcoholism in the life of hypertensive individuals? Which are the justifications used by the participants for alcoholism? How should health care be rethought to meet health needs?

Given the questions listed, the objective of this research was to analyze the profile of alcohol consumption and its influence on the health of hypertensive people monitored by a PHC service. Thus, the objective was to describe the profile of alcohol consumption and its implications for the health of hypertensive PHC users.

Methodology

A descriptive and qualitative research study discussed in the light of the (inter)national literature about the object investigated. Convenience sampling, consisting of 50 hypertensive patients registered at a Basic Health Unit (BHU) in the southern region of a health macro-region from Minas Gerais (MG), Brazil.

The inclusion criteria were the following: hypertensive individuals aged ≥18 years old. The Mini-Mental State Examination with a cutoff point ≥ 23/30 among older adults (people ≥ 60 years old) was used to identify possible dementia in the pre-data collection phase, aiming at selecting participants with a cognition level compatible with the individual interview approach. There were no follow-up losses due to use of the scale.

Those who postponed the interview for ≥ three appointments were excluded, totaling ten losses. Thus, 40 hypertensive patients accepted to participate in the research after an invitation made by the supervising nurse at the BHU, who performed a weekly schedule for data collection, according to the availability of the researcher/participant binomial.

Data collection took place between March and July 2020 and the interviews lasted ±30 minutes, carried out in an individualized Nursing consultation environment for

hypertensive patients, established according to the (inter) national recommendations regarding monitoring in routine consultations for hypertensive and cardiac patients to be performed by the nurse and physician of the Family Health Strategy (FHS)[3-5,7]. It is also worth mentioning that, in addition to the individualized approach to data collection, the use of surgical masks by the researcher and the participant was also respected, in addition to the use of alcohol gel, an airy and ventilated environment, besides respecting the minimum distance of 1.5 meters as recommended by the Ministry of Health in combating the COVID-19 pandemic.

The data collection instrument was structured as follows: 1) Sociodemographic, professional and economic characterization and profile of alcohol consumption; 2) Individual, in-depth and recorded interview using a semi-structured script that allowed the participants to freely discuss the topic based on guiding questions; and 3) Field diary.

In the sociodemographic, professional and economic characterization stage, the data were collected according to the collection instrument developed by the authors and previously validated by five experts in the field of Cardiovascular Nursing.

For data collection for the stratification of the participants' self-reported alcoholism profile, the WHO 2018 recommendations were adopted, considering a standard dose equivalent to approximately 10-12 grams of ethanol, corresponding to a 330 mL beer can, a 100 ml glass of wine or a 30 ml dose of spirits[1].

The semi-structured script for the in-depth individual interview was elaborated based on the (inter)national recommendations regarding the monitoring of routine consultations for hypertensive and cardiac patients to be carried out by the FHS nurse and physician, with a focus on the "alcoholism" modifiable risk factor for SAH[3-5,7].

Thus, the objective was to achieve the following contents: the alcoholic beverage in use; how long they have been drinking; frequency of alcohol consumption; types of alcoholic beverages consumed; if they drank or stopped drinking at some point in their life and, if so, the abstinence period (without drinking any type of alcoholic beverage); and if they consider that drinking harms health or Blood Pressure (BP) control. Aiming at capturing the justification for alcoholism, some questions were followed by the expression "why?".

The interviews were collected until, in a partial analysis of the results, the ability to reflect (amount and intensity) the multidimensionality of a given phenomenon was identified, in search of quality of the results[8].

The characterization data were treated in the *Statistical Package for the Social Sciences* (SPSS) software, version 26, by descriptive statistics. The interviews were transcribed in full in the Microsoft® Office Word for Windows 2016 software and, subsequently, formatting of the *corpus* was performed to use the *R Interface Pour les Analyzes Multidimensionnelles de Textes et de Questionnaires* (IRaMuTeQ) software by lexical analysis. *IRaMuTeQ* enables the following analyses: classic textual statistics; research of specific groups; Descending Hierarchical Classification (DHC); similarity analysis and word cloud[9].

Thus, DHC was chosen, in which, after processing and grouping the words according to occurrence, the software proceeds to the aforementioned classification, creating a dendrogram of the classes. These were formed according to the relationship of the processed Initial Context Units (ICUs), which presented homogeneous words. For the classification and relationship between the classes, these ICUs were grouped according to the occurrence of the words through their roots, originating the Elementary Context Units (ECUs) and resulting in the creation of a dictionary with reduced forms through the *chi square* test (X^2)[9].

This study was part of a matrix research entitled "Social Representations of Primary Health Care Users on Cardiovascular Diseases: Evidence for Nursing Care", approved by the Research Ethics Committee (*Comitê de Ética em Pesquisa*, CEP) under Opinion No. 3,466,543, of 07/27/2019. The participants' consent was confirmed by signing the Free and Informed Consent Form (FICF), after ensuring their anonymity and confidentiality. Therefore, all the ethical and legal aspects of research involving human beings were met.

Results

Table 1 presents the sociodemographic characterization corresponding to the 40 participants.

Table 1 - Sociodemographic, professional and economic characterization of the participants. Juiz de Fora, MG, Brazil, 2021 (n=40)

Sociodemographic, professional and economic profile	***f***	**%**
Gender		
Women	21	52.5
Men	19	47.5
Total	**40**	**100**
Age (years old)		
18 - 59	14	35.0
60 - 79	23	57.5
> 80	3	7.5

(continues on the next page...)

Sociodemographic, professional and economic profile	*f*	%
Total	**40**	**100**
Self-declared skin color		
White	21	52.5
Brown/Black	19	47.5
Total	**40**	**100**
Marital status		
Married	23	57.5
Stable partner	12	30.0
Single	5	12.5
Total	**40**	**100**
Children		
Yes	35	87.5
No	5	12.5
Total	**40**	**100**
Religion		
Catholic	22	55.0
Evangelical	16	40.0
Others	2	5.0
Total	**40**	**100**
Schooling		
Illiterate	2	5.0
Elementary School (≤ 9 years of study)	14	35.0
High School (between 9 and 12 years of study)	24	60
Total	**40**	**100**
Profession		
Industrial activities	16	40.0
Domestic services	14	35.0
Merchants	10	25.0
Total	**40**	**100**
Retirement		
Yes	34	85.0
No	06	15.0
Total	**40**	**100**
Income		
No income	4	10.0
< 2 minimum wages	34	85.0
≥ 2 minimum wages	2	5.0
Total	**40**	**100**

The participants' alcoholism profile consisted mostly of drinkers (60%) stratified according to consumption as light, moderate and intense (Table 2); the predominant consumption of beer was attributed to weekly family gatherings by the presence of children/grandchildren and friends, and other alcoholic beverages were generally associated with casual encounters and going out with their age peers (field diary records).

Table 2 - Characterization of the alcoholism profile and type of alcoholic beverage consumed by the participants. Juiz de Fora, MG, Brazil, 2021

Alcoholism profile (n=40)	*f*	%
Non drinkers (Never drank)	04	10
Former drinkers (Drank in the past, but do not drink in the current year)	12	30
Drinkers (Current)		
Light (Consuming up to 5 standard doses/month)	13	32.5
Moderate (Consuming 5-15 standard doses/month)	07	17.5
Intense (Consuming more than 15 standard doses/month or drinking daily)	04	10
Total	**40**	**100**
Type of alcoholic beverage consumed by the current drinkers (n=24)		
Beers	22	91.67
Wines	13	54.17
Spirits (*cachaça*, vodka, brandy, etc.)	10	41.67

In the lexical analysis, the DHC dendrogram consisted of 41 ECUs, which represented 75.93% of the analyzed material and is presented distributed into six classes, based on successive binary divisions of the *corpus* (Figure 1).

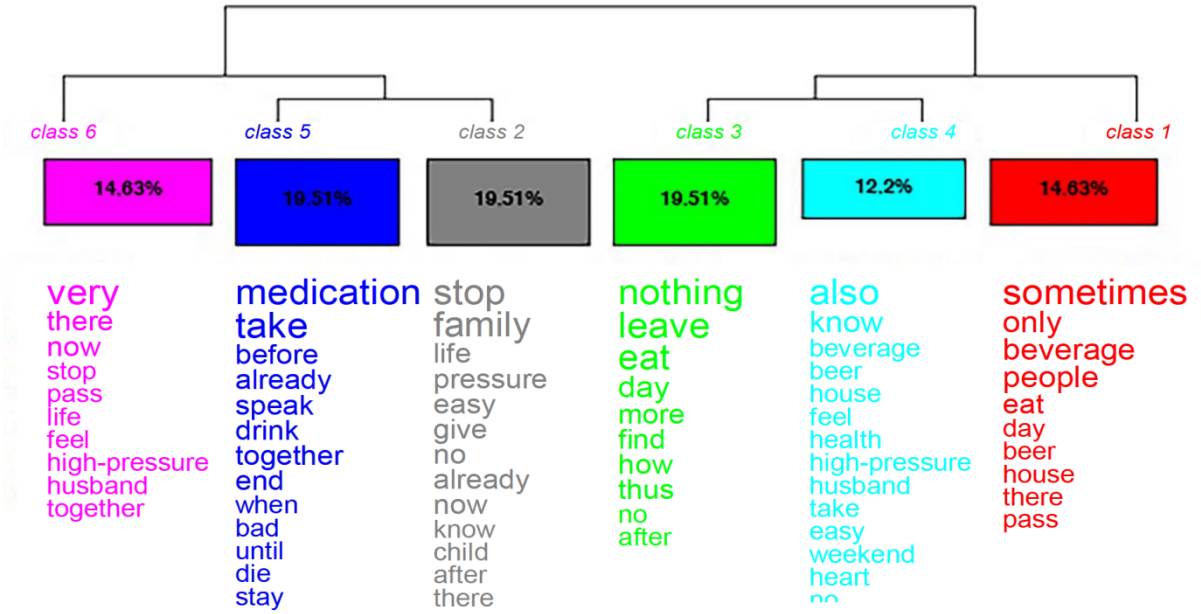

Figure 1 - *IRaMuTeQ* DHC dendrogram, according to the semantic contents of the participants. Juiz de Fora, MG, Brazil, 2021

The *corpus* was initially divided into two axis-blocks (axes 1 and 2), which continued to be divided. Thus, from left to right, axis 1 was subdivided into class 6 and sub-axis 1, which was subdivided again into classes 5 and 2. And axis 2, in turn, was also subdivided, generating class 1 and sub-axis 2, forming classes 3 and 4. Thus, at the end of the cleavage process, the analyzed *corpus* was divided into six classes.

With a view to a better visualization of the software's *cluster* analysis, the classes were named obeying the discursive content in the participants' statements (Figure 2).

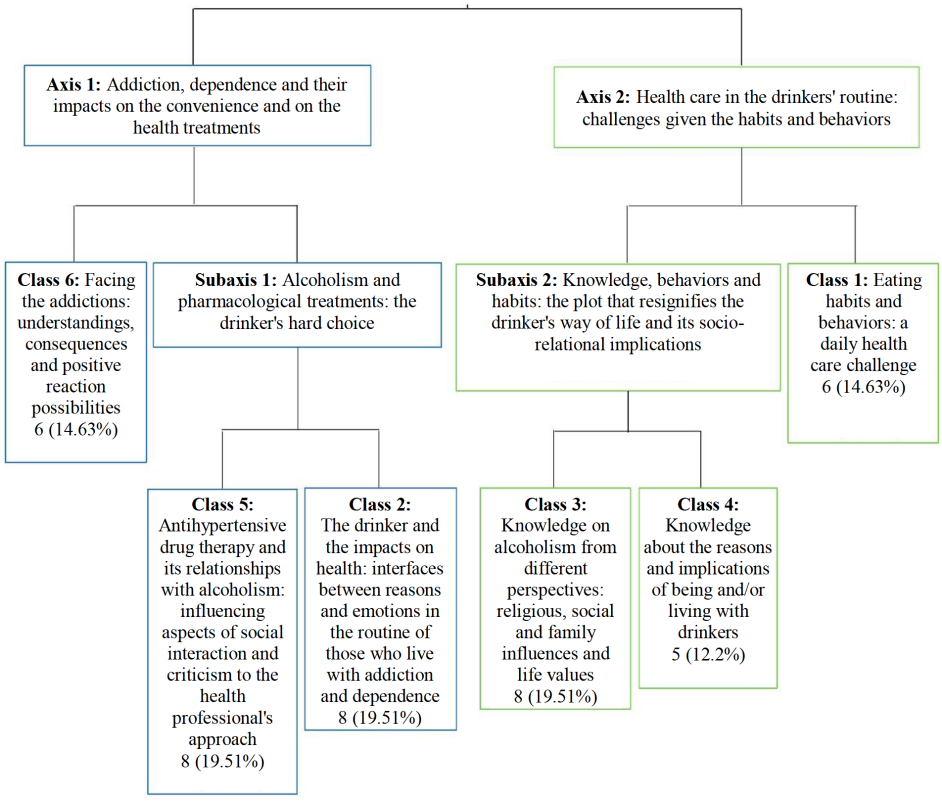

Figure 2 - Schematic organization chart of the structure of the classes resulting from *IRaMuTeQ*'s lexical analysis. Juiz de Fora, MG, Brazil, 2021

The discursive contents reveal the impacts of alcoholism on the participants' lives in multiple dimensions, from their own health to family and society life. Such perspective is observed through the six classes generated by the lexical analysis, as follows.

In *class 6 – Facing addictions: understandings, consequences and positive reaction possibilities*, the participants seem to recognize the harms caused by alcohol consumption, as well as the need and benefits from changing their habits. On the other hand, there are also aggravating factors of alcoholism and other addictions, for example, use of drugs by young people and the smoking habit, respectively.

Today, young people drink and consume drugs a lot. In my time, it was only cachaça (X^2: 21.80 - P34); *My husband already drinks a lot and that bothers us a lot. I prefer smoking because I know what I'm doing* (X^2: 21.80 - P19); *Now it's been 15 years since I have a new life. I'm free from it* (X^2: 4.44- P22).

In *class 5 – Antihypertensive drug therapy and its relationship with alcoholism: influencing aspects of social interaction and criticism of the health professional's approach*, the association between alcohol consumption and antihypertensive pharmacotherapy is a complex reality, as it involves inappropriate lifestyle habits, such as not taking the medication to be able to drink, or even taking it with alcoholic beverages, as illustrated below:

I don't even drink as much as I used to because of my high blood pressure, but once in a while I do. Sometimes, not taking the medication to have a frozen one doesn't kill anyone. (X^2: 84.16 - P01); *The hardest time to go without drinking is when there's a barbecue at home. The children all live in the backyard, anything has a barbecue. When I know beforehand, I don't even take the medication so I don't get sick* (X^2: 79.58 - P17); *This business of you, health professionals, talking to us that we can't drink because of the medication is a torture. Saying it's bad and such. Since it's bad, I don't take it together and that's it. Weekend is just joy and I leave the medication for the week* (X^2: 76.44 - P08); *The husband stops taking the medications when he's going to drink and my brother already takes them with cachaça. Then they stay there, feeling sick* (X^2: 76.05- P15).

In *class 2 – The drinker and the impacts on health: interfaces between reasons and emotions in the daily life of those who live with addiction and dependence*, the participants recognize the difficulties adopting effective changes in lifestyle habits, in abandoning alcohol consumption and its negative interference in their life and health, with special emphasis on SAH, and also emphasize the role of the family as an important social support source, as noted below:

I know that it's not easy to stop drinking, but with the help and support of the family, I managed to do it, it's been eight years now. (X^2: 35.29 - P36); *I stopped drinking a while ago, then I came back and now I stopped again. It's like that, you know, when I see that it gets ugly with the pressure and the heart, I get tired when breathing, I stop* (X^2: 29.40 - P12); *People look at us and tell us to stop drinking as if it was easy, they don't know what a lifetime of alcohol dependence is* (X^2: 27.63 - P29); *I'm very nervous, anxious and irritable and, in order to withstand the stress that family gives us, it's just getting pissed off. I feel my blood pressure doesn't stay the same when I drink. The nurse is also tired of pulling my ear* (X^2: 24.96 - P13); *I've been to AA, that thing of arriving at the head of the table and explaining that the drunken person loses their family, money, morals and I don't know what is there* (X^2: 16.22- P04).

In *class 1 – Eating habits and behaviors: a daily health care challenge*, alcoholism has unspeakable consequences in the participants' lives, which involve, for example, irregular eating and anxiety, as noted below: *When I drank, sometimes I went for days without eating properly, other days I didn't even eat. It was that routine there, just drinking and that was it. I didn't even know where or who I was with* (X^2: 52.84 - P06); *Yeah, I sometimes have a beer. There are days when I leave work in a hurry, dying to get home, just for a cold beer* (X^2: 48.68- P31).

Class 3 – Knowledge of alcohol consumption from different perspectives: religious, social and family influences and life values portrays the knowledge, social interaction and beliefs incorporated in coping with alcoholism in a favorable or unfavorable manner, as noted below:

I know that blood pressure goes up in those who drink, besides that they usually spend days just drinking and not eating anything. I was never like that, when I drank, it was a little, but after I became an Evangelical, I don't drink anymore, that's the devil's thing (X^2: 44.72 - P07); *Oh, I don't miss anything I like. I drink, smoke, even eat and such. We're all going to die due to the heart some day* (X^2: 42.95 - P37); *We have to do things while we're healthy, after we get sick, nothing else can be done, eat what you like, drink, nothing works* (X^2: 34.49 - P26); *My wife fights with me so much, but so much because I'm always drinking, it makes me mad, I go there and drink even more. If it wasn't so much hassle, I wouldn't even drink so much* (X^2: 19.05- P16).

In *class 4 – Knowledge about the reasons and implications of being and/or living with drinkers*, it is observed that it is necessary that socio-family support networks and those coming from health services and professionals not only know the drinker's profile, but also that they are able to understand the reasons for and the implications of being a drinker from the participants' perspective, as mentioned by themselves: *I think that my son will also start to feel sick from so much saying: "Stop that drinking". He found something for him to attend, to start going out, he went to one, three, four meetings and he said: "I'm not going anymore" (X2: 21.59 - P03); For me, drinking is what alleviates daily fatigue and entertains me with friends. I know it's not good for health, but I feel good and that's what matters (X2: 8.24- P01).*

Discussion

Among the participants, there was predominance of women, older adults, married individuals, with children, Catholic, with high schooling levels and retired (Table 1), a result similar to that found in other research studies[6,10]. Alcoholism is generally prevalent among men, and the increase in its occurrence among older adults is a situation that requires special attention from health professionals, as it is a modifiable risk factor for CVDs[3-5,11-12].

The alcoholism profile predominantly consisted of light drinkers, with beer as the preferred alcoholic beverage (91.67%) (Table 2) and attributed to the occurrence of weekly family gatherings, according to field diary records. Even knowing that alcohol consumption is an important risk factor for CVDs and lack of blood pressure control, most of the older adults consume alcoholic beverages in a light to moderate manner, justified by their difficulties modifying their lifestyle habits[12-13].

In this context, consumption of alcoholic beverages in high amounts (>30 g) is associated with the occurrence of higher morbidity and mortality rates, due to worsening of the CVDs. However, the consumption threshold translated into health risk is not consensually established, not even the relationships of dependence on other factors added to the amount ingested, frequency of consumption and type of alcoholic beverages consumed[3-5].

The most consumed beverage by the participants was beer, as it is easily accessible in the home context and in intergenerational coexistence, justified by casual gathering during the weekends[14]. It is also worth mentioning that the participants reported being more reclusive and restricted to the home environment due to their health conditions as a risk group at the time of pandemic confrontation, according to field diary records; however, this did not prevent them from having access to alcoholic beverages, which was made possible by their family members most of the times.

In Brazil, fake news disseminated via media/social contacts that drinking alcohol would increase the chances of not being contaminated by COVID-19 were installed, a mistake proposed to the community and, therefore, a significant increase was noticed in the consumption of alcoholic beverages since the beginning of 2020[15-16]. It is evident that acknowledging their health limitations, whether due to drug treatment or for any other reason, does not prevent alcohol consumption, with managing the consequences of their habits remaining as the only option.

Given this reality, the percentage of former drinkers presented in this study (Table 2) corroborates the expectations of the "Strategic Action Plan for Confronting Chronic Non-Communicable Diseases (CNCDs) in Brazil, 2011-2022", with regard to an estimate that there may be a significant reduction in the risk factors for CNCDs. Among a series of global goals, a reduction in the consumption of alcoholic beverages to 12% by 2022 is included, therefore being able to reduce the morbidity and mortality rates related to alcoholism[17].

In the lexical analysis, class 6 indicated a stance by the participants in order to face the addiction and the ways of treating alcoholism, through recognition of its implications in quality of life and health. In addition to that, they see the need to stop being drinkers and to change lifestyle habits, as well as the benefits resulting from this course of action. Changes in lifestyle habits in relation to the consumption of Psychoactive Substances (PSAs), such as smoking and alcoholism, require personal engagement in treatment and rehabilitation, which portrays an own desire, in addition to the existence of a network of socio-family support and by the health professionals, in favor of coping with addiction, dependence and abstinence[1,5,18].

Facing alcoholism requires an understanding of it regarding its classification by the drinkers, which reflects its severity as a disease. It is classified as follows: 1) Acute: it is alcohol consumption above the body's tolerance limits, considering that each person is affected in a particular way, with different symptoms and equivalent to the intoxication level; 2) Chronic: it has behavioral and socioeconomic aspects typical of chronicity and is characterized by compulsive alcohol consumption, in which the person becomes progressively tolerant to intoxication and develops signs/symptoms associated with compulsion to consume the drug, tolerance and/or to the withdrawal syndrome[1-2].

The practice of alcohol consumption and pharmacological therapy for SAH, evidenced in class 5, are difficult realities to be managed even for health professionals who provide guidance since, as it can be seen, it is a habit of these participants not to take antihypertensive medications to be able to drink, or even taking them along with alcoholic beverages. Added to this are the difficulties adjusting to social life and respecting their own limitations; therefore, they choose temporary suspension of the medication to participate in socialization opportunities.

Discontinuous use/disuse of antihypertensive pharmacotherapy, justified by the consumption of alcoholic beverages, is a serious problem, as absence of the medication in the body, by itself, is already capable of elevating the blood pressure levels. This fact is aggravated by alcohol consumption, which exerts an (in)direct influence on the regulatory mechanisms of pressure increase. In addition to that, the habit of taking the drugs and consuming alcohol at the same time can result in the occurrence of potential drug interactions (inhibiting, stimulating or canceling the action of different medications, especially antihypertensives)[3-5,7,11].

In class 2, it is observed that the drinkers themselves admit the difficulties of modifying their habits and

abandoning alcoholism and the negative interference of alcohol in SAH and in the body, as well as they recognize the role of socio-family support as a conditioning factor in reinforcing their decision. On the other hand, issues underlying the drinking habit need greater attention, for example, family problems that lead the addict to seek a way out in alcohol, which allows inferring that the drinker's own family also needs care to promote changes that strengthen their bonds.

The family can and should be a source of positive support in coping with life and health problems, as well as psychosocial stress; however, when family relationships are insufficient and/or conflicting, the individual can become susceptible to chemical dependence in use of PSAs such as alcohol and tobacco[6,12-13,18].

Moderate or intense alcohol consumption significantly affects the increase in BP, through a cascade of reactions through which the substance is capable of inducing and oppressing the body, as well as the central nervous system, affecting hormones and enzymes responsible for homeostatic control. Alcohol corroborates with SAH by inhibiting the release of renin within the cells, preventing the renin-angiotensin-aldosterone cycle from being complete, which represses he opening of the sodium channels, causing retention of intracellular fluid which, in turn, increases the amount of sodium in the bloodstream, causing vasoconstriction and increased blood pressure[19].

Thus, among the harms caused by alcoholism, there are also liver cirrhosis and portal hypertension with its complications; acute/chronic pancreatitis; acute/chronic esophagitis and acute/chronic gastritis; DM; Korsakoff's Dementia; alcoholic polyneuropathy; immunosuppression; tumors: mouth, pancreas, etc.; and CVDs, such as coronary heart disease, cardiomyopathies and heart failure. It is also worth mentioning the association between alcohol consumption and the genesis of higher rates of traffic accidents and domestic violence[3-5,11].

Other consequences of alcohol consumption on the participants' quality of life/health were presented in class 1, which even reflect negligence with their diet, as they often stop eating due to alcohol consumption, leading to more complex consequences. Among them, it is worth mentioning the potentiation of the effects of alcohol related to drunkenness, resulting from the facilitation of the drug absorption process by the gastrointestinal tract, favored by the absence of food content in it; occurrence of hypoglycemic events and syncope, as well as nutritional deficits with different severity levels, associated with chronic alcoholism[10-12].

Anxiety is another factor that deserves attention in the interdisciplinary approach, as it results from the existence of everyday stressors, linked to psychosocial stress, another modifiable risk factor for CVDs that deserves attention in care planning[6,18].

In class 3, knowledge, social interaction and beliefs are incorporated into coping with alcoholism, as it is perceived that the participants know how much alcohol alters their BP and make choices that generally neglect their health, as well as they adopt religious beliefs that lead them to having a different world view and to modifying their behavior, modulating it to what is conceived as acceptable, according to the needs for social belonging. Engagement of a person in a religious matrix can positively contribute to their adherence to the treatment in order to reduce or stop consumption and become abstinent from the consumption of alcohol and the other PSAs. It is noteworthy that the existence of a religious support network favors psychological/spiritual support in living with the group[12,20]. Therefore, the importance of the family, religious, social and health professionals support network in coping with the disease is herein reiterated[12,14,20-21].

In class 4, it is observed that it is necessary not only to know how much a drinker consumes, but also to understand why they drink and, thus, try to formulate strategies to help them change their habits, since the support of the family, Alcoholics Anonymous (AA) and health services for the participants appears to be still incipient. It is summarized as a need for family members/caregivers and health professionals to envision treatment of alcoholism and to rethink health care, so that they consider/include the view of the drinkers themselves and perspectives in the planning and execution of interventions aimed at ceasing alcohol consumption at the primary health care level and in specialized services such as AA[10-12].

In the speech of another participant, it is noticed that he recognizes the harms of drinking; however, it is through it that he has fun and regains his strengths, in the face of the tiring life routine. Therefore, certain dichotomy is evidenced in the participants' view towards the ambivalence of values, seen as a health problem that has multidimensional determinants[3-5,7], which must be mandatorily considered in the planning of cardiovascular health care for these individuals[1,3-5,7,14-16].

It is noted that the study limitation was due to the COVID-19 pandemic, as there was greater difficulty accessing hypertensive patients undergoing PHC monitoring, requiring the adoption of additional measures so that data could be captured, which extended the collection period.

This research contributes by showing the context in which hypertensive drinkers are inserted, as well as by presenting situations that are transversal to the drinking habit, which influence behaviors that are harmful to health. In this sense, the role of the family is evidenced, both in supporting abandonment of alcoholism, and in the conflicts that justify and drive dependence; therefore, it is

also necessary to analyze the drinkers' family members, in order to know the impacts of coexistence for both and to propose more plausible health care actions that include all those involved.

Conclusion

The alcoholism profile of hypertensive patients monitored by a PHC service consisted mostly of light drinkers and, even so, it has consequences for the quality of life and health of hypertensive patients, especially cardiovascular complications such as blood pressure changes and disuse or irregular use of the antihypertensive pharmacotherapy prescribed. The justifications stated by the participants for alcohol consumption encompassed different situations, such as addiction and abstinence, understanding alcohol consumption as an escape strategy for different stressors, or even as a favorable opportunity for socialization, among others.

Thus, although light, alcohol consumption interferes in people's lives in numerous ways, not limited to health; however, as it exerts a considerable impact on it, it deserves extra attention, especially in the context of care planning. In fact, relativization of the antihypertensive treatment (as well as others) is a harmful practice, mediated by the choice of drinking alcohol over use of the medications or by their simultaneous use, bringing about crucial consequences for partial/total therapeutic failure, in addition to deterioration in the health status.

On the other hand, therapeutic failure can also be based on poorly planned care, which does not take into account the drinker's values, knowledge and reality, which is why it is considered important to know their reality to jointly devise a better form of care and, indirectly, ensure adherence to the treatment. It is not enough to say no to consumption or to explain the harms caused by alcohol, as there is a complex plot behind the drinking habits, which, for them, justifies neglecting health care. Thus, in Nursing consultations it is possible to see a real opportunity to correct ineffective approaches and place the individual and their needs in the focus of care planning.

Such being the case, it is noticed that the chances for changing habits and abandoning alcohol use increase when there is a safe social support network, which needs to rely on the health professionals, on the family members and on a good social and family life. In a certain way, the family nucleus of these individuals also needs care, mainly because it is understood that the impacts caused by alcohol extend to the codependents who deal with the consequences on a daily basis, which justifies carrying out future research studies that take into account their participation.

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