SMAD, Rev. Eletrônica Saúde Mental Álcool Drog. (Ed. port.)
7(2):[07 screens]
May-Aug. 2011

Original Article

The role of nursing and the formation of multipliers in relapse prevention

Marilene Gonçalves França[1];
Marluce Miguel de Siqueira[2]

Relapse prevention involves teaching individuals to identify and cope with risk situations. In this research, the goal was to qualify nursing consultations for individuals going through the relapse process through nursing/care integration, in the "Care Program for the Alcoholic". A descriptive and exploratory, qualitative-quantitative approach with content analysis was used, divided into three phases: preparation of the manual, nursing staff training and evaluation. The study revealed changes in this team's conceptions of relapse, the relation between theory and practice and its performance as a mediator in this educational process.

Descriptors: Alcoholism; Recurrence; Nursing; Health Education.

[1] RN, Secretaria Municipal de Vitória, ES, Brazil. E-mail: leninhamgf@yahoo.com.br.

[2] RN, Ph.D. in Physiological Sciences, Associate Professor, Departamento de Enfermagem, Centro de Ciências da Saúde, Universidade Federal do Espírito Santo, Vitória, ES, Brazil. E-mail: marluce.siqueira@ufes.br.

Marilene Gonçalves França
Universidade Federal do Espírito Santo. Centro de Ciências da Saúde
Centro de Estudos e Pesquisas sobre o Álcool e outras Drogas (CEPAD)
Av. Marechal Campos, 1468
Campus de Maruípe
CEP 29040-090, Vitória, ES, Brasil
E-mail: leninhamgf@yahoo.com.br

O papel da enfermagem e a formação de multiplicadores ante o processo de prevenção à recaída

A prevenção à recaída consiste em ensinar o indivíduo a identificar as situações de risco e a lidar com elas. Objetivou-se, nesta pesquisa, qualificar a consulta de enfermagem prestada ao indivíduo que enfrenta o processo de recaída, através da integração ensino/assistência, no Programa de Atendimento ao Alcoolista. Pesquisa descritiva e exploratória, qualiquantitativa, com análise de conteúdo, dividida em três fases: confecção do manual, formação da equipe de enfermagem e avaliação. O estudo possibilitou observarem-se mudanças nas concepções dessa equipe acerca da recaída, da relação entre a teoria e a prática e de sua atuação como mediadora desse processo educativo.

Descritores: Alcoolismo; Recidiva; Enfermagem; Educação em Saúde.

El papel de la enfermería y la formación de multiplicadores en el proceso de prevención de la recaída

La prevención de la recaída abarca enseñar a las personas a identificar y hacer frente a situaciones de riesgo. La finalidad en esa investigación fue cualificar la consulta de enfermería al individuo que pasa por el proceso de recaída, a través de la integración enseñanza-atención, en el "Programa de Atención al Alcohólico". Se trata de un estudio descriptivo y exploratorio, cualitativo y cuantitativo, con análisis de contenido, dividido en tres fases: preparación del manual, formación del personal de enfermería y evaluación. El estudio permitió cambios en las concepciones del equipo acerca de la recaída, la relación entre la teoría y la práctica y su papel como mediador del proceso educativo.

Descriptores: Alcoholismo; Recurrencia; Enfermería; Educacíon em Salud.

Introduction

Alcoholism is one of the most frequent infirmities in the world. Over the last decades, it has been transforming into a serious public healthcare problem. Among the largest difficulties found in the treatment programs for alcoholism, the high rates of relapses is one of the main reasons of the lack and treatment dropouts[1]. According to the literature, approximately, from 50% to 60% of alcoholics presented relapses in the first moths after the treatment[2].

In the attempt of reducing the relapse rates and failures in the treatment of alcoholism, several models were proposed in the past. Currently, the model that has received greater emphasis is called cognitive behavioral model[2], that helps the patients to examine the particular way how they build and understand their world and aid them to experiment new ways to better relate with all the aspects in life.

It is known that addictive behaviors (like alcohol dependency and other drugs) are defined as patterns of acquired habits, which can be modified with the application of new learning procedures. The subjects can learn to change and to accept the personal responsibility for their own recovery. The habit change procedure involves at least three distinct stages: *compromise and motivation* (preparation for change), *implementation of the action for specific behavioral change* (for example, quit the use of drugs) and *maintaining long-term behavior*[2].

Relapse prevention is a treatment program that raises awareness in a sense of anticipating the situations take places the subject at risk of relapsing, allowing them to prevent them, modify them, face them, that is, learn to deal with such situations[3]. It is also important, to understand

the determining factors for the return of the alcoholic to drinking, and to know how to use such information to reduce the relapse rates. This is one of the first steps in the development and implementation of the types of relapse prevention strategies[2].

It is indispensible, however, that in this process there is the motivation to change, that is, readiness state or willingness to change as fundamental strategy for the continuance of the new behavior, once the motivation controls all of the change process. With the intention of understanding how people change, the Transtheoretical Model[4] was developed, which describes the readiness to change as a stage of transformation that the subject goes through. This model is based in the premise that the behavioral change is a process, and that people have different levels of motivation and readiness to change[5].

In this context, health education has a relevant role, since, when talking about education, it is mentioned articulation knowledge, attitudes, behaviors and personal practices that can be shared with society. What that means is that the educational process favors the development of autonomy, at the same time the social objectives are achieved[6].

As a result of this finding, recently, nursing started to use the social-cultural referential in the formation of human resources for the education of patients, in the attempt to enable teaching and assistance founded on a process of awareness, in which the conception teaching/learning is based on the conjecture of the transforming education that has as its core the formation of critical conscience, enabler of the refection on professional practice and on the commitment to society[7]. Considering that the nurse cannot intervene in a reality, without having the theory capable of providing elements so that the intervention achieves the proposed means; this study had the objective of qualifying the approach to the subject situated in a process of relapse, through the integration of teaching/learning in the nursing appointment of the Program of Alcoholic Care (PAC), in order to contribute to the prevalence of alcoholic abstinence and for change to their lifestyle.

Methodology

It is a descriptive and exploratory research, with a qualiquantitative approach, having as base the cognitive behavioral theory[2] and the motivational[4]. The study had as scenario the Program of Alcoholic Care, due to the interdisciplinary work proposal directed to alcoholics and their family, which includes the adoption of participative assistance and awareness-raising methodology[8]. The work was structure in three stages: The first stage, the Manual of Relapse Prevention was made to be used during the nursing appointment. Seeking to provide subside to this construction, a theoretical review was made on the issue "relapse prevention", in the data bases BIREME and BDENF, encompassing the period from 2000 to 2005, besides the use of specialized journals, books and educational manuals. Therefore, four areas of the manual's range were designed: a) concept of relapse prevention, b) instructions for relapse prevention, c) activities for relapse prevention; and d) where to seek help. Then, there was the proper production of the educational manual "*Projeto Viva Vida – an experience of prevention: what do you need to know about relapse prevention?,* with the elaboration of educational and illustrative texts. Soon after, a dry-run of the manual was applied in alcoholics attending the ambulatory treatment of PAA-HUCAM-UFES, for familiarization of the content and its validation. The second stage consisted in the formation of the nursing crew from the PAC, seeking the development of theoretical-practical competences to approach relapse prevention. The formation occurred in the form of theoretical seminars, with group discussion, divided into four modules: a) sensibilisation, b) relapse process, c) relapse prevention and d) relapse prevention strategies. Each module had the duration of 10 class/hours. The meetings were every fifteen days. The third stage, had the evaluation of the nursing crew in two moments: initial, in order to identify the crew's perception regarding the issue relapse prevention, and final, to identify the changes due to the education received.

The questionnaire used in the initial stage (pre-formation) was comprised of two parts – identification of the subjects and perceptions surrounding relapse prevention. After explanations on the study, and willing signature of the consent forms, the participants answered the questionnaire. Four illustration charts were built to enable the procedures of grouping, categorization, analysis and data interpretation. In the second moment (post-formation), the focal group took place[9] to assess the benefits acquired from the formation. The group had duration of approximately one hour, with the participation of the nursing crew of PAC that had received the formation on relapse prevention.

Due to the nature of the study and in conformity to the focal group technique, the selection of the sample was on purpose. The minute was divided into two themes: the first, related to the content of the training, and the second, with the benefits acquired from the formation. The group was led by a moderator and counted with the participation of an observer. Besides the observer's notes, the statements were recorded, using two recorders, placed adequately in relation to the distribution of the participants, in order to obtain a clear and comprehensive recording; then, the statements were transcribed, carefully, in full.

In the data analysis, the reading of the transcriptions and mentioned statement regarding the consequent benefits to formation were made. Therefore, the thematic categories were defined that, later on, were analyzed. Content analysis was used[10], based in the proposed theoretical referential, using the theme as unit of Record, and organizing the data in thematic categories.

The research was structured according to the ethical precepts of Resolution nº196/96, of the National Health Council (CNS), approved by the Ethics Committee of CSS/UFES (n°.079/07).

Results

Profile of the members participating in the nursing crew

The sample consisted of tem participants: nine undergraduate students in nursing and one nurse. The profile of the clientele showed that 70% of the participants were between the ages of 20 to 30, followed by <20 years old (20%). Regarding distribution, according to education level, it was seen that 90% of the interns had incomplete undergraduate degrees, that is, there was 30% in the fifth semester, 40% in the sixth, 10% in the fourth and 10% in the third semester. Only one subject (10%) with more than 20 years of undergraduate in nursing had the age between 40 and 50 years old. According to ethnicity, it was observed that most of the subjects were white (60%), followed by mullatos (30%) and only 10% were black. Most of the subjects declared to be Catholics (50%), spiritualist (30%) and protestant (20%). As for the distribution of the sample according to marital status, a significant number of singles (90%) was seen, and only 10% were married. Regarding the time they were working at the PAC, it was seen that most of them reported six months working in nursing appointments (60%), followed by working from seven to twelve months (20%), thirteen to eighteen months (10% and more than eighteen months (10%).

Formation of the nursing crew

The participants, before the formation, considered that the concept of relapse was linked to the pattern of consumption made by the individual, when they would return to their old behavior (50%). In this stage, some responses were confusing and demonstrated insecurity when it comes to the concept of what is relapse (20%). However, after the formation, the concept of relapse showed to be more elaborate and more concise, when it is mentioned that relapse is to return using the substance after the abstinence period (50%) as well as when it is considered the return to alcohol consumption, in the same amount or more than before (50%). And still, relapse was mentioned as a period of learning, so that the individual can elaborate prevention strategies (10%).

Regarding the difference between the concept of lapse and relapse, the answers showed to be satisfactory and well thought up (70%). However, some people did not know the difference between both referred situations (10%). It was noticed that after the formation, all of the participants understood the difference between lapse and relapse.

As for the perception of lapse and relapse during treatment, only 20%, considered lapse and relapse as elements that are part of the treatment process; other 20%, considered lapse and relapse as reasons to continue the treatment, they should not be considered as failure. This aspect is concerning, when together with another two types of responses (20%): when relapse is seen as disbelief and, still, when they reported that the treatment is not being effective.

The reasons related to the interpersonal conflicts (discussions, disagreements, fights, jealousy etc.) were predominant (80%), followed by the ones associated to social pressure (70%), negative emotional states (60%) and those related to negative physical-physiological states (50%). After the formation, the reasons explained by the participants were varied; however, a significant difference was when the reasons referring to the negative physical-physiological states, going from 50% before the formation decreasing to 20% later.

When initially questioned, some theory was known about relapse prevention, 70% of the participants reported not knowing this type of theory, being that only 10% made reference to the motivational theory. After the formation, when questioned again if they knew any theory of relapse prevention, 100% of the interviewees answered that they knew. Based on this knowledge, when asked about the motivation in the relapse process, most of the participants (40%), considered motivation essential for the individual to remain abstinent, or still, with positive attitude for treatment effectiveness (20%). On the other hand, 20% considered that the lack of motivation is a predisposing factor for relapse. Maybe, that is why, the motivation perceived by the participants as essential so that the subject can achieve abstinence presented an increase from 40% to 75%.

As for the concept of relapse prevention, 40% of the answers considered relapse prevention as a set of strategies to face the risk situations. On the other hand, another 40% understood relapse prevention as knowing and preventing the reasons that led them to it. And still, 10% of the answers mentioned a set of actions that can contribute maintaining alcoholic abstinence.

After the formation, when questioned if they had put into practice any relapse prevention strategies, 90% answered yes and only 10% said no. It is seen that 55.5% of the participants mentioned the use of the relapse prevention manual, as the strategy put to practice. On the other hand, 22.2% made reference of the orientation on risk factors that lead to relapse, as well as the other 22.2% used the advice as technique so that the subjects avoid risk situations.

After the formation, it was verified that the participants mentioned the advisement again (12.5%), substitute activities of risk behavior (12.5%) and motivational techniques (12.5%) as strategies to face relapse and its predecessors. Other made reference to cognitive behavioral techniques (12.5%) and techniques for lifestyle changes (12.5%).

The participants pointed out changes in the concept of relapse prevention, in reporting that, despite knowing the concept, the view on relapse expanded, in a way to understand the process in a more complex way, as follows in the following statement: *[...] I think that the concept of relapse was known since we've entered at PAC I think that what we learned here, has evolved our concept, widened our vision (P1).*

It is important to mention that the statements excerpts highlighted during the transcription of the statements, which occurred during the focal group, are presented here codified by the letter "P" which indicates the participant,

followed by Arabic algorism, to differentiate one participant from the other.

Regarding facing the relapse by the technicians, the participants reported difficulties to deal with relapse during treatment, sometime attributing the blame on themselves or to the intervention proposed. Therefore, they faced relapse as a personal failure or the treatment, which can be expressed by the statement below. *[...] a patient has a relapse. I was very upset about it, I don't know why there was such a controversial feeling. I was stunned, very nervous, I don't know why, and it is like this, you cannot blame yourself (P2)*. However, after the formation, the participants started to understand that the relapse is a common event during treatment, and that it can be a facilitating element in the recovery process, from the moment it serves as a support for learning and reflection in the adoption of new attitudes, as seen in the statement below. *[...] now we understand relapse as part of the treatment, and starting from there, is when the subject will be able to make a stronger decision, you see? Learning* (P3).

Regarding the importance of recognizing the events prior to the relapse, the participants reported that one of the difficulties found is not to have the knowledge of what can lead the subject to return to the behavior of using and abusing alcohol, that is, on the priors that cause the lapse or relapse, as specified in this statement. *Sometimes we don't see this in the treatment, sometimes the patients had a relapse and you cannot identify the factor the led them to have the relapse or lapse* (P4).

After the formation, the participants realized that several risk factors can lead to relapse, not only the interpersonal determinants, but also the intrapersonal, as seen below. *In my case, the contribution was mostly the theoretical part and the therapies applied to relapse prevention, I gained more from it, you know? Because I, perhaps, my point of view contemplated the external part a lot, some factors, internal conflicts, feelings, emotions, creed, values I would not see it in the patients, not a lot. I saw more what the family relationships, external factors that could have contributed, the environment, whatever, culture, but mostly the internal part, I did not have such a critical point of view* (P4).

Another benefit pointed out by the participants is how important is to ally theory and practice, in a way that the first can subsidize the second, for a better experience of the practice. *[...] I thought it was very rich, because sometimes you are using in the service the cognitive behavioral therapy only you do not realize that. Because sometimes, we think we are doing our best, the best, but it is amazing how much a theory, a theoretical mode is fundamental in our experience in assistance* (P5).

The understanding of the change process was mentioned as a benefit of the formation, once a acquired behavior can take a long time and effort to be modified, as explained in the following statement. *[...] I think it was important to participate in this course, because I could learn how the stages to abstinence are difficult, understand? How difficult is the behavioral change of the individual even and when you understand this initial process, you really start to see the relapse as part of the process, due to the fact that it is really difficult to change a habit you have had for many years* (P6).

The formation allowed the participants to evaluate their practice in nursing assistance. They reported that this new content will enable a new posture when they return to the clinics. *[...] I believe that with this course, new things will come to us, ok? Certainly, it generates the desire to change the assistance we give there. Not that it is bad, but there is room for improvement. The course showed that* (P5).

After participating in the formation, the participants understood that it is their responsibility is a enabling element in the change process, and that the subjects are the ones suppose to take on the responsibility for the modification of their behavior, as seen in the statement below. *The professional must lead the patient to recognize that it is their responsibility, lead them by what they accomplished in the treatment, the established goals, their responsibility for maintaining or not the abstinence, the risks that it can bring him due to the consequences. It is showing them that they are responsible. They have the power of decision to continue or not, but the professional has to be by their side to help in this treatment process* (P6).

Discussion

In this study, the of the participants were between the ages from 20 to 30 years old (70%), incomplete undergraduate level (90%) and single (90%). These data is justified because most (90%) of the participants is comprised of undergraduate students, attending university, which corroborates with the findings of IBGE [11]. In relation to the time of activities in the PAC, most of them reported six months of working in nursing clinic (60%). This fact is possible thanks to a "rotation" system, in the said program, by the nursing students at the PAC, in order to allow that their extension activity does not interfere with their education, at the same time it enables the student to act in the development of activities of teaching/assistance, research and extension.

The data obtained regarding the formation of the nursing crew reveal that the lack of a more in depth understanding, or even more complex, of what a relapse process in chemical dependency is; factor that can influence in the addict's process of recovery.

In the present study, some participants (20%) showed insecurity in the concept of relapse; however, after the formation, the perceptions became more elaborate and concise, corroborating with the concepts of several authors[12-13], in considering relapse as a process in which the alcoholic, in recovery, goes back to ingest the same quantities or even larger quantities, after a period of abstinence or, still, when the relapse is seen as a complex event, which happens by a series of cognitive, behavioral and affective processes, seen as critical point, from which the individual can return to abstinence or develop a complete pattern of relapse, depending on the way the subject faces such episode[2].

When facing and the difference of lapse and relapse during treatment, it was possible to see that after the formation, all of the participants understood the distinction between both processes and their importance, in realizing the lapse correspond to a relatively smaller alcoholic ingestion, in relation to what occurred before the beginning of the treatment, besides referring to an act of initial drinking, sporadic, a slip up, that could happen to

the alcoholic during the treatment. Such fact is relevant, since this difference is indispensible in approaching the alcoholic because the way the subject concepts and faces the lapse can determine if it will be followed or not by a relapse. After being emphasized that relapse and lapse are common during treatment and they must be dismithified, because *"[...] it is not about falling from grace, but a behavior that must be understood objectively"*[14], many participants changed their statement, starting to consider relapse as part of the treatment or, still, as a learning opportunity. Such fact is mentioned, because the "failure rates" can leave the healthcare professionals with the impression of personal impotence and low efficacy, which leads, eventually to the development by the professional, with the expectation of "unmodification" of the alcoholic subject[2].

Among the reasons that lead to relapse, we highlight the ones related to negative physical-physiological states that were 50% before the formation, decreasing to 20% after. This fact is relevant , because the healthcare professionals must consider, besides the biological factor, which also has its relevance in dependency, the relations that the subject establishes with the environment and the other people. Some authors[2,12], seeking to decrease the probability of relapse, reinforces the need for the identification of the intrapersonal and interpersonal determinants that antecedes them, since they are seen as risk factors in the perception of self efficacy of the subject.

In relation to the concept of relapse prevention, it is important to mention that the answers presented restrictions, in a sense of understanding the factors that would make the subject avoid the use of substances or, still, maintaining abstinence. No mention was made regarding changes in lifestyle. However, it can be seen that the understanding on what is relapse prevention widened, after the formation, because some participants made reference not only to strategies to avoid relapsed, but also changes in the life style habits of the subjects[3,15].

The strategies used as facing resource correlated the strategies of relapse prevention[2]. However, only 11.1% of the participants referred the motivational techniques. Considering that motivation is a fundamental strategy in the process of change, such rate is considered below, since it is primordial that the subject takes responsibility for their change during treatment and this is essential knowledge for the healthcare professional who works with alcoholics.

The participants declared, before the formation (70%), did not know any theory regarding the treatment of chemical dependency. This is a relevant data, since the theories serve to give basis to the interventions in healthcare and improve the intended assistance. Another relevant factor is that only 10% made reference to motivational theory, which is odd, since evaluating the motivation for change, independently from the treatment used, seems to be an important factor in the use of interventions that are adequate to the patient's needs[4]. Under this perspective, the relation theory/practice cannot be seen in an isolated and separate manner, but it must be understood as a relation of complementarity, in a sense that the theory fundaments the necessary and enough competence for the exercise and performance of the practice.

Most of the participants (40%) considered motivation essential for the subject to become abstinent; others judged the lack of motivation is a predisposing factor to relapse (20%). Such findings are justified, because the adherence to treatment depends on the subject's motivation, since abandoning the use of a substance is very linked to a series of behavior in which motivation is bound[16]. For this reason, motivation, which was seen by the participants as essential so that the subject can achieve abstinence, presented an increase from 40% to 75%, relevant data that characterizes the shift in view on the process of change, once the subject needs to be motivated to want change. The understanding of the change process was mentioned as a benefit from the formation, since the acquired behavior can be modified with the application of the procedures from new information, enabling modifications in the lifestyle of the subject, slowly and gradually[2].

Other benefits from the formation were around the change in professional conduct, and the role of facilitator in the change process, once the intervention in a reality requires redefinition of the professional's action, and implies new proposition, conceptual, methodological, ideological and practical, in order to reach such goal[7]. In this perspective, the liberating education[17] is based in this transforming practice, in which it establishes a critical and conscious way of thinking and acting in the search for the transformation of the existing knowledge. The individual, then, "leaves the position of patient" and becomes capable of taking on responsibility for the indispensible modifications for the relapse prevention and existential rehabilitation, becoming the agent of their own therapeutic process[3]. Therefore, the professional must learn to consider the subject as the center of the educational process, in the search for their autonomy and participation in the elaboration of educational proposals[18].

Final Considerations

Thinking in qualifying nursing assistance, in the approach of relapse prevention, enabled the participants to review their concepts surrounding the process mentioned above, including the existing relation between theory and practice and their role as mediators in this educational process. In investigating the contributions related to acquired knowledge and also changes in attitudes in relation to its practice. Another factor that was mentioned was the role of the nurse, who must act as an enabler of the change process, in showing the subjects the possibility that they have to restart, and motivate them in order that they find reasons to start tracing new path. In concluding this study, the importance of conducting other research is observed for this investigation proposal, which enables a greater understanding of how much the building of the healthcare professional's knowledge that must be put to practice in their social relations. This knowledge must be evaluated and rebuilt in the daily life of the professional's development.

References

1. Siqueira MM, Garcia MLT, Souza RS. O impacto das faltas às consultas em um programa de dependentes de álcool. J Bras Psiquiatria. 2005;54(2):114-9.
2. Marlatt GA, Gordon JR. Prevenção à recaída: estratégia e manutenção no tratamento de comportamentos adictivos. Porto Alegre (RS): Artes Médicas; 1993. 524 p.
3. Knapp P. Prevenção à recaída. In: Ramos SP, Bertolote JM, Campana AAM, Gruber AC, Woitowitz AB, Andrade AG, Neumann BG, Galperim B, et al. Alcoolismo hoje. 3ª ed. Porto Alegre (RS): Artes Médicas; 1997. p. 173-96.
4. Prochaska JO, Diclemente C. Transtheorical therapy: toward a more integrative model of change. Psycother Theory, Res Pract. 1982;20:161-73.
5. Oliveira MS, Laranjeira R, Araujo RB, Camilo RL, Schneider DD. Estudo dos estágios motivacionais em sujeitos adultos dependentes do álcool. Psicol Reflexão Crítica. 2003;16 (2):265-70.
6. Ministério da Educação (BR). Secretaria de Educação Fundamental (BR). Parâmetros Curriculares Nacionais. Brasília; 1997.
7. Nakatani AYK. Processo de enfermagem: uma proposta de ensino através da pedagogia da problematização [dissertação]. Ribeirão Preto (SP): Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo; 2000.
8. Macieira MS, Gomes MPZ, Garcia MLT. Programa de Atendimento ao Alcoolista do HUCAM da UFES (PAA-HUCAM-UFES). J Bras Psiquiatria. 1993;42(2):97-109.
9. Gatti BA. Grupo Focal em Ciências Sociais e Humanos. Brasília: Líber Livro; 2005. 77 p.
10. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1977. 281 p.
11. IBGE (Fundação Instituto Brasileiro de Geografia e Estatística). Censo Demográfico de 2000. [acesso 8 out 2007]. Disponível em: http://www.ibge.gov.br/censo/.
12. Silva EA, Ferri CP, Formigoni MLOS. Situações de recaída em pacientes dependentes de álcool e outras drogas durante o tratamento: um estudo preliminar. J Bras Psiquiatria. 1995; 44(6):311-5.
13. Büchele F, Marcatti, M, Rabelo DR. Dependência química e prevenção à "recaída". Texto & Contexto Enferm. 2004;13(2):233-40.
14. Edwards G, Marshall EJ, Cook CCH. O tratamento do alcoolismo: um guia para profissionais da saúde. 4ª ed. Porto Alegre (RS): Artmed; 2005. 242 p.
15. Figlie NB, Bordin SL, Laranjeira R. Aconselhamento em Dependência Química. São Paulo (SP): Roca; 2004.
16. Jungerman FS, Laranjeira R. Entrevista motivacional: Bases teóricas e práticas. J Bras Psiquiatria 1999;48(5):197-207.
17. Freire P. Pedagogia do Oprimido. 17 ed. Rio de Janeiro: Paz e Terra; 1987. 213 p.
18. L'abbate S. Educação em saúde: uma nova abordagem. Cad Saúde Pública. 1994;10 (4):481-90.

Received: Feb. 28th 2010
Accepted: July 19th 2011

How to cite this article:

França MG, Siqueira MM. The role of nursing and the formation of multipliers in relapse prevention. SMAD, Rev. Eletrônica Saúde Mental Álcool Drog. (Ed. port.). May-Aug. 2011 [cited: day month year];7(2):[07 screens]. Avaible from: URL