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Artigo Original

Coping strategies of craving in crack-cocaine dependents in treatment in Therapeutic Communities*

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Objectives: to identify and describe the coping strategies used in the face of craving by crack-cocaine users who were under treatment in the Therapeutic Communities. Method: the sample consisted of 133 men. The instruments were a socio-demographic questionnaire and on drug use screening, the Mini-Mental State Examination and the scale of questions on craving. The analysis used was descriptive and frequency statistics for exploratory analysis with significance level of 5%. Results: the results demonstrate a predominance of the Willpower category and Dodge in response to craving. Conclusion: these results are important contributions in understanding the coping of craving, signaling the importance of relapse prevention work, of the family and of effective treatments.

Descriptors: Coping Strategies; Craving; Treatment; Therapeutic Communities.

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Estratégias de enfrentamento do c*raving* em dependentes de *crack* em tratamento em Comunidades Terapêuticas

Objetivos: identificar e descrever as estratégias de enfrentamento utilizadas perante o *craving* por usuários de *crack* que estavam em tratamento internados em Comunidades Terapêuticas. Método: a amostra foi composta por 133 homens. Os instrumentos utilizados foram: Questionário sociodemográfico e rastreio do uso de drogas, Mini-Exame do Estado Mental e uma Escala de Perguntas sobre *craving*. A análise utilizada foi a estatística descritiva e de frequências para análise exploratória com nível de significância de 5%. Resultados: os participantes relataram um predomínio da categoria Força de Vontade e de comportamento de Esquiva em resposta ao *craving*. Conclusão: esses resultados são importantes contribuições na compreensão do enfrentamento do *craving*, sinalizando a importância do trabalho da prevenção de recaídas, da família e tratamentos eficazes.

Descritores: Estratégias de Enfrentamento; *Craving*; Tratamento; Comunidades Terapêuticas.

Estrategias de afrontamiento en *craving* de dependiente de crack em tratamiento en Comunidades Terapéuticas

Objetivos: el objetivo del estudio fue identificar y describir las estratégias de afrontamiento utilizadas frente al craving por consumidores de crack que estaban em tratamiento internados en Comunidades Terapéuticas. Método: la muestra consistió en 133 hombres. Los instrumentos fueron: cuestionario sociodemográfico y la detección del consumo de drogas; Mini Examen del Estado Mental y Craving Cuestionario. El análisis utilizada fue descriptiva y las estadísticas de frecuencia para el análisis exploratorio con un nivel de significación del 5%. Resultados: los resultados muestran el predominio de la categoría de fuerza de voluntad y el comportamiento de Esquivar en respuesta a las ansias. Conclusión: estos resultados son importantes contribuciones en la comprensión de la cofia antojo, lo que indica la importancia de la labor de prevención de recaídas, la familia y los tratamientos eficaces.

Descriptores: Estrategias de Afrontamiento; *Craving*; Tratamiento; Comunidades Terapéuticas.

Introduction

The use of crack, which is a cocaine base with sodium bicarbonate by the pulmonary route (crack), has become a public health problem in Brazil, given the harmful effects of the substance on the body and the costs with treatment[1]. The pattern of abusive, continuous and repetitive consumption of crack is triggered by craving[2].

The definition of craving or *fissura*, as it is popularly known in Brazil, has still been discussed[3]. For the World Health Organization (WHO) Expert Committee on Chemical Dependence, craving can be defined as a desire to repeat the experience of the effects of a given substance – composed of cognitive, affective, behavioral, and physiological components[4]. Other researchers describe it as the desire to experience the effects of the drug; strong momentum to use the substance; expectation of positive results; process of cognitive evaluation and non-automatic cognitive process[2-3].

Although the II National survey of alcohol and drugs pointed out that the proportion of people who have ever experienced crack cocaine is 0.1% among adolescents and 1.3% in adults, and that crack is not the most commonly used illegal substance in the country[5], the effects and intensity of craving increase problems related to the use of the drug[2]. This is because the cocaine present in crack cocaine is a potent stimulant of the central nervous system, with a high potential for dependence, since the almost immediate euphoria triggered by the use reinforces and motivates new episodes of consumption[6]. In the addiction to crack, craving is usually finalized when the user reaches a physical, psychological and/or financial exhaustion. Their coping gains relevance in the treatment of crack dependents[7].

A study investigated the coping strategies used to manage craving situations in 35 subjects, depending on the ICD-10 criteria[6]. The results pointed out that some coping strategies are correlated with the motivation to stop using crack and also with the time of treatment (hospitalization) and abstinence.

In a study that consisted of predicting craving and the consequent use or not of the substance in 205 users of inhaled cocaine and crack cocaine in a treatment outpatient clinic, the results showed that users of smoked cocaine had more craving episodes than users of inhaled cocaine[8]. There was also a significant association between dependence, in which the frequency of use predicted more craving situations, whereas the abstinence interval predicted fewer episodes. Another important point is that the lack of effective coping strategies significantly increases the chances of relapse and therapeutic abandonment.

In a national survey, crack users answered the reasons that led to the beginning of substance use, of whom 58.28% stated curiosity and 29.19% stated that family problems or affective losses were the main reasons[9]. These data correlate positively with the strategies employed by recovering crack users for craving administration.

Regarding coping strategies, it is important to emphasize that they are characterized as a response to (behavioral or cognitive) stress in order to reduce their aversive qualities, in this case, the use of crack. The person can then choose coping strategies according to their individual repertoire (many strategies may be useful for the same situation) and the reinforcement of previous experiences[6].

A large portion of users of crack as well as of alcohol and other drugs is received by the Therapeutic Communities. The Therapeutic Communities are places that offer shelter to users of all types of drugs, usually in remote places and in a transitional residential character, in which the length of hospitalization varies between six and nine months for adults. It usually occurs in these institutions the use of the religious-spiritual model for all substances[10] and the resistance to the use of drugs for the craving[11].

Thus, in view of the difficulty of dealing with crack craving situations, added to the high number of users and the limitation of the treatments offered, research should be conducted on the strategies adopted by users in facing these situations. The objective of this study is to describe the strategies used by crack dependents in treatment in Therapeutic Communities in the main cities of the state of Rondônia for administration of craving.

Methods

This is a descriptive-exploratory study with quantitative analysis, with crosscutting and field procedure.

The sample consisted of 133 men who met the DSM-IV-TR criteria for cocaine/crack dependence[12]. All of them were hospitalized in therapeutic communities and reported that the last use of crack had been more than six months prior to the research. Although the participants of this study could fit the criteria for dependence of other psychoactive substances, the use of crack was mentioned as the main motivator for searching treatment. Participants with a score lower than 25 points in the Mini-Mental State Examination and with psychotic disorders or symptoms were excluded.

The data were collected in Therapeutic Communities, previously mapped by the State Superintendence of Policies on Drugs (SEPOAD) of Rondônia, in the main cities of the state, namely Porto Velho, Cacoal, Ji-Paraná, Rolim de Moura, Vilhena and Ariquemes.

The following instruments were used to collect data: 1)Informed Consent Form; 2)Identification questionnaire prepared by the researchers based on screening instruments on drug use, consisting of open and closed items that address socio-demographic and socioeconomic characteristics; 3)Mini-Mental State Examination (MMSE)[13] to evaluate cognitive deficits, which may compromise data collection and be affected by heavy crack use; and 4)the Question Scale on Craving, adapted and based on the "Questionnaire on Beliefs about Drug Use"[14]. The questionnaire consists of a quantitative and a qualitative part. The first part comprises 50 questions, in which situations are exemplified and the subject is invited to imagine experiencing them, and then they must answer about the will to use the drug and the chance of having a relapse. The qualitative part consisted of questions concerning the refusal to use the substance and the strategies used.

The data collection was done after the mapping of the Therapeutic Communities for the care of chemical dependents in the state of Rondônia and previous contact with those in charge. After the authorization of those in charge, the choice of participants was randomly performed according to the even numbers, based on the number of people being treated on the place. The interviews were individual, in an adequate physical space, indicated by the institution itself. The sessions lasted on average 30 minutes and the collection occurred during the period of July 2012 and April 2013.

The information collected was organized into a spreadsheet in the Statistical Package for the Social Sciences (SPSS), version 20.0. Data analysis consisted of descriptive statistical tests and frequencies for exploratory data analysis. The level of significance was set at 5%.

The project was approved by the Research Ethics Committee of the Federal University of Rondônia (Opinion No. 367,336, CAAE 03725212.8.0000.5300), and all participants received clarifications and signed the ICF before completing the instruments.

Results

The mean age of the sample was 31 years (SD=8.76). Other sociodemographic data are found in Table 1.

Table 1 – Sample composition and social profile.

Description	n%
Marital status	
Single	98 74
Married/living with a partner	18 13.5
Separated/divorced	17 12.8

(to be continued...)

Table 1 – *continuation*

Description	n%
Having children	
Yes	75 56.8
No	57 43.2
Degree of schooling	
Inability to read or write	2 1.5
Incomplete elementary school	60 50.4
Complete high school	14 10.5
Incomplete high school	21 15.8
Complete elementary school	20 15
Incomplete higher education	6 4.5
Complete higher education	3 2.3
Current employment situation	
Unemployed	67 50.4
Full-time job (35 hours or more work per week)	36 27.1
Informal/autonomous job	21 15.8
Part-time job (<35 hours per week)	9 6.8
Had spent the night on the street in the last six months	
Yes	27 20.3
No	106 79.7

In relation to the evaluation of the craving scale, the chi-square test was used to evaluate whether there were statistically significant differences between the categories. A statistically significant difference was detected between the answers (x^2=176.3, SD=8, p<0.01).

Table 2 lists the data about what the former user did at the time of the craving. In response, the *willpower* category presented higher frequency than the other categories, followed by responses related to *family-related thoughts*, being statistically equal to the category *negative thoughts about the drug*, but different from the other categories of responses. The frequency of responses to the categories *religious thoughts*, *used alcohol or other substances*, *no money to buy the drug* and *social activities* did not differ between them.

Table 2 – Strategies used to face the desire

Categories of responses	n	%
Willpower	58	43.6
Family-related thoughts	15	11.3
Negative thoughts about the drug	12	9.0
Religious thoughts	7	5.3
No money to buy the drug	4	3.0
Social activities	2	1.5
Used alcohol or other substances	2	1.5
Others	6	4.5
Total	133	100

Table 3 corresponds to the behavioral act related to the moment of refusal. The analysis found a statistically significant difference between the responses (x^2=43.3, SD=5, p<0.01). The category that differs from the other answers was the *search for professional help*, and other categories were statistically equal to each other.

Table 3 – Strategies used to avoid substance use

Categories of responses	n	%
Daily activities	20	15.0
Religious activities	16	12.0
Work/social activities	16	12.0
Sleeping	15	11.3
Use of other drugs	12	9.0
Search for professional help	4	3.0
Others	20	15.0
Total	133	100

In Table 4, there was a statistically significant difference between the answers (x^2=41.6, SD=6, p<0.01). The category *decision for behavior change* is statistically greater than *seeking to perform other activities, fear,* and *preference for another substance*. *Decision for behavior change* and *no desire at the moment* are statistically equal. The category *performing other activities* is statistically greater than the *preference for another substance*

Table 4 – Reasons for refusing to use the substance

Categories of responses	n	%
Decision for behavior change	27	20.3
No desire at the moment	17	12.8
Environmental or social restriction	17	12.8
Seeking to perform other activities	12	9.0
Fear	7	5.3
Preference for another substance	4	3.0
Others	21	15.8
No answer	28	21.1
Total	133	100

In Table 5, there was a statistically significant difference between the answers (x^2=67.5; SD=8; p<0.01). The categories *affective thoughts* and *use of other substances* do not differ from each other, but are statistically superior to the other categories.

Table 5 – Strategies that helped you to refuse the use of the substance

Categories of responses	n	%
Affective thoughts	28	21.1
Religious thoughts	17	12.8
Negative thoughts about drugs	16	12
Activities for distraction	10	7.5
No desire at the moment	4	3
Use of other substances	3	2.3
Search for help from third parties	1	0.8
Others	22	16.5
No answer	32	24.1
Total	133	100

Discussion

Regarding the sociodemographic characteristics, the sample has characteristics similar to those reported in other studies. In general, we found that crack users are mostly men, unmarried, under-educated, aged between 18 and 35 years and having no job/fixed income[6,15-16]. These data corroborate with the profile described in the National Survey on the Use of Crack[10], which signaled the crack user population as significantly socially vulnerable.

The sample was particularly composed of men, since there were difficulties in finding treatment facilities for women in the state. There were only three institutions serving women and all of them with a very number of people being treated. In addition to pointing out the lack of facilities for the treatment of chemical dependence in the female population of the state of Rondônia, the low number of institutions that attend women suggests that the specificities in the care to be offered in the treatment of chemically dependent women may be a factor that discourages leaders of therapeutic communities to offer treatment for this portion of the population. Because of this factor, it was not possible to make a comparative analysis between men and women on the objectives of the study. We highlight the fact that the use of this substance by women has increased and that they seek treatment earlier, mostly due to complications or when because they become pregnant[17].

With regard to the strategies that participants reported using for craving,among the categories of answers to the question *What did you say to yourself to overcome craving?* (Table2), the predominant answer was *willpower,* with 43.6% (n=58). This data demonstrates that the strategies used to control craving are very particular to each user and context, so that the same strategy can work with one and fail with another[2].

The concept of self-efficacy refers to the perceptions individuals make about themselves[18]. The elaboration of these perceptions can be used as a device to achieve objectives, obtaining control over the environment itself, composing the psychological mechanisms of motivation. In this sense, cognition plays a key role in people's ability to construct reality and self-regulation[19]. Self-regulation, in this case, is related to the willpower to change the behavior of use and consequently drug use, and not as a main resource to deal with craving, as reported by the participants investigated here.

In verifying what they did instead of using crack (Table3), we could see that individuals engaged in religious activities, such as going to church, singing, reading the Bible, and in everyday activities, such as interacting with family, playing sports, watching movies. Thus, in the studied sample, we observed the religious behavior and the role of the family as adjuvants in the

refusal or overcoming of craving. It should be noted that the data were collected with people who were being treated in religious-based therapeutic communities, which has been a point of discussion about the effectiveness of this treatment model, which works with different perspectives, such as the 12 steps, where coping strategies are dictated by religious/spiritual work[20]. It is important that treatment integrates prevention and guidance models to the whole family, such as the Strengthening Families Program[21].

There has been discussion on the effectiveness of the *treatment/intervention* modality and on how this model may interfere with the strategies used by individuals to handle craving situations, as indicated in Table3. Also, questions have been raised about the interventions used by Therapeutic Communities in the state of Rondônia, since these institutions are mostly of a religious nature, and there has been a marked increase in the number of these institutions, which has not been followed by the hiring of specialists to deal with and handle with the craving of the patients.

In relation to the strategies that helped participants to refuse using the substance (Table5), 23.1% of the respondents used family-related thoughts, such as the fear of leaving them helpless and the fear of disappointing parents or spouses. This category was statistically superior to the category of religious thoughts. This data may indicate that family-related thoughts act as a protective factor to avoid substance use, but it is important to assess whether the family provides the necessary support and is not a risk environment.

The results described in Table5 indicate that the coping strategies of the respondents were varied, which highlights the fact that many participants have their own thoughts as a strategic resource. Thoughts have been subdivided into affective and religious, and those negative related to drugs, and they take on a feature common to many users who try to stop or control use by taking into account family and religion. This may occur because before entering treatment, the person who is highly religious or spiritual may have the ability to visualize life events and stressors through a scheme of control by religion/spirituality. Thus, it is possible that through religion, or condemnation of use, one is able to rebuild their world[22].

In one study, crack users became visibly motivated to adhere to treatment when they realized they could have their family ties reconquered[23]. Another study[24] corroborates the argument that social support is associated with the subjective needs of the individual and, moreover, it is related to the capacity of emotional support of family and friends in reducing stress and solving interpersonal conflicts. Regarding this, regardless of the treatment model studied, it is clear that the longer the isolation and withdrawal days, the more reduced the craving events will be[25]. Because of this, social support must be integrated and stimulated in the treatment. This interaction between the user and the society, which awaits them outside of treatment, can contribute to fewer relapses, contributing to the maintenance of the desired abstinence. Social support helps in the interaction between the user and society and this mutual influence can help in their treatment, contributing to the maintenance of the desired abstinence. Ideally, the family should adopt a collaborative stance to contribute to the recovery of drug addicts. In this way, craving, which can disrupt treatment, can be overcome more easily and quickly with the help of the family.

Conclusions

The present study lists the main coping strategies used by dependents in treatment in Therapeutic Communities located in the state of Rondônia. The data obtained in this study evidences the need to address coping strategies during the treatment, since the role of the family was much evoked by the participants. Addressing family aspects can mean greater power to face the harsh routine of staying abstinent, which is demanded by many who expect the user to change crack use. Moreover, these findings can be used in the design of training and improvement courses for institutions, such as the religious Therapeutic Communities, which offer care services to people with disorders due to substance use, in the planning of contextual and effective treatments in the crack addiction, thus benefiting the recovering individual and the entire community and care network.

The study has some limitations, such as not covering data with women and the large number of people who did not know how to answer the questions. These problems should be solved in later studies that demonstrate how the treatment process takes place within therapeutic communities and their relationship with the craving events.

The results of studies aimed to understand pre-treatment coping strategies against craving may contribute to the development of treatment protocols and to better planning of therapeutic activities throughout the drug user care network, especially in the model of hospitalization treatment in religious communities that are criticized for not having many specialized professionals. It may also help understanding the phenomenon of treatment in regions vulnerable to crack abuse, as the case of the state of Rondônia, located near the producing and exporting countries of coca, Peru and Bolivia, mainly where the substance can arrive in a more pure state.

It is important to emphasize that knowing the strategies of handling and coping with craving is essential so that the recovering person can appropriate those that are pertinent to them, and also to recognize the risk situations so that they can avoid or face them. Both the work of Relapse Prevention and Social Skills Training are enhanced when the patient brings their previous successful experiences in overcoming the craving and the offer of use. All these practices in Therapeutic Communities must be rethought and require the assistance of trained professionals specialized in chemical dependence. The family support should also be added to this strategies, which is a factor that is still little addressed in a professional way and that still distorts from the current reality in the treatments offered not only in the state investigated here, but throughout the country.

References

1. Oliveira LGD, Nappo SA. Caracterização da cultura de crack na cidade de São Paulo: padrão de uso controlado. Rev Saúde Pública. 2008;42(4):664-71.
2. Chaves TV, Sanchez ZM, Ribeiro LA, Nappo SA. Fissura por crack: comportamentos e estratégias de controle de usuários e ex-usuários. Rev Saúde Pública. 2011;45(6):1168-75.
3. Araújo RB, Oliveira MDS, Pedroso RS, Miguel AC, Castro MDGTD. (2008). Craving e dependência química: conceito, avaliação e tratamento. J Bras Psiquiatr. 2008;57(1):57-63.
4. United Nations International Drug Control Programme (UNDCP), World Health Organization (WHO). Informal Expert Committee on the Drug-Craving Mechanism. United Nations International Drug Control Programme and World Health Organization. Technical report series 5: 92-54439 T 1992.
5. Laranjeira R, Madruga CS, Pinsky I, Caetano R, Mitsuhiro SS, Castello G. II Levantamento Nacional de Álcool e Drogas (LENAD) – 2012 [Internet] São Paulo: INPAD/UNESP; 2013 [Acesso 7 ago. 2016]. Disponível em: http://inpad.org.br/wp-content/uploads/2014/03/Lenad-II-Relatório.pdf
6. Araujo RB, Pansard M, Boeira BU, Rocha NS. As estratégias de coping para o manejo da fissura de dependentes de crack. Clin Biomed Res. 2010;30(1) 36-43.
7. Marques AC, Seibel SD. O craving. In: Seibel SD, Toscano JR, organizadores. Dependência de drogas. São Paulo: Atheneu; 2001. p.239-48.
8. Da Silveira DX, Doering-Silveira E, Niel M. Jorge MR. Predicting craving among cocaine users. Addictive Behav. 2006;31(12):2292-7.
9. Bastos FIPM, Bertoni N. Pesquisa Nacional sobre o uso de crack: quem são os usuários de crack e/ou similares do Brasil? Quantos são nas capitais brasileiras? [Internet] Rio de Janeiro (RJ): ICICT/FIOCRUZ; 2014 [Acesso 8 ago 2016] Disponível em: http://www.arca.fiocruz.br/handle/icict/10019
10. Damas FB. Comunidades Terapêuticas no Brasil: expansão, institucionalização e relevância social. Rev Saúde Pública Santa Catarina. 2013;6(1):50-65
11. Fracasso L. Características da comunidade terapêutica. In: Guerra A,. et al. (Org.). Curso nacional de aprendizado à distância: aspectos básicos no tratamento da dependência química. Brasília: SENAD. 2002. p. 88-99.
12. American Psychiatric Associaion APA (2002). Manual diagnóstico e estatístico de transtornos mentais: texto revisado. DSM-IV-TR. Porto Alegre (RS): Artmed; 2002.
13. Bertolucci PH., Brucki S, Campacci SR, Juliano, Y. O mini-exame do estado mental em uma população geral: impacto da escolaridade. Arq. Neuropsiquiatr. 1994; 52(1):1-7.
14. Wright FD. Craving Belief Questionnaire and Relapse Prediction Scale. In: Beck AT, Wright FD, Newman CF, Liese BS. Cognitive Therapy of Substance Abuse. New York (NY): Guilford Press; 1993.
15. Oliveira LGD, Nappo SA. Caracterização da cultura de crack na cidade de São Paulo: padrão de uso controlado. Rev Saúde Pública. 2008;42(4):664-71.
16. Oliveira GP. (2011). Crack e Recaída: os principais motivos que levam os usuários de crack a recaírem após tratamento para dependência química [Internet]. Porto Alegre (RS): Universidade Federal do Rio Grande do Sul; 2011 [Acesso 13 ago 2016]. Disponível em: http://www.lume.ufrgs.br/bitstream/handle/10183/34045/000789984.pdf?sequence=1
17. Santos AMCC. Articular saúde mental e relações de gênero: dar voz aos sujeitos silenciados. Ciência Saúde Coletiva. 2009;14(4):1177-82
18. Bzuneck JA. As crenças de autoeficácia e o seu papel na motivação do aluno. In: E. Boruchovith E, Bzuneck JÁ, (Orgs.). A Motivação do Aluno: Contribuições da Psicologia Contemporânea. Petrópolis (RJ): Editora Vozes; 2001. p. 116-33.
19. Freire SD, Oliveira MDS. Auto-eficácia para Abstinência e Tentação para Uso de Drogas Ilícitas: Uma Revisão Sistemática revisão sistemática. Psicologia: Teoria e Pesquisa. 2011; 27(4):527-36.
20. Longshore D, Anglin MD, Conner BT. Are religiosity and spirituality useful constructs in drug treatment research?. J Behav Health Serv Res. 2009;36(2):177-88.
21. Kumpfer KL, Alvarado R, Whiteside HO. Family-based interventions for substance use and misuse prevention. Substance Use Misuse. 2003;38(11-13):1759-87.
22. Larson DB, Swyers JP, McCullough ME. (Eds.). Scientific research on spirituality and health: A consensus report. Rockville (MD): National Institute for Healthcare Research; 1998

23. Longshore D, Anglin MD, Conner BT. Are religiosity and spirituality useful constructs in drug treatment research?. J Behav Health Serv Res. 2009;36(2):177-188.
24. Almeida RB, Caldas MT. As dificuldades e Sucessos no tratamento do Usuário de crack. Neurobiologia. 2011;74(2): 99-112.
25. Pinho PH, Oliveira, MAD, Almeida MMD. A reabilitação psicossocial na atenção aos transtornos associados ao consumo de álcool e outras drogas: uma estratégia possível?. Rev Psiquiatr Clín. 2008;35(suppl 1):82-8.
26. Lappann NC, Machado JSDA, Tameirão FV, Benjamim MLN. Craving pelo crack nos usuários em tratamento no centro de atenção psicossocial. SMAD. Rev Eletrônica Saúde Mental Álcool e Drogas. 2015;11(1):19-24.

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