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CAROLINE FIGUEIRA PEREIRA

INTERPERSONAL THEORY OF NURSING TO ANXIETY MANAGEMENT IN PEOPLE WITH SUBSTANCE USE DISORDERS (ITASUD)

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Tese apresentada ao Programa de Pós-Graduação em Enfermagem da Escola de Enfermagem da Universidade de São Paulo para obtenção do título de Doutora em Ciências.

Área de concentração: Cuidados em Saúde

Orientador:

Prof. Dr. Divane de Vargas

Supervisora do Doutorado Sanduíche:

Prof. Dr. Linda Beeber

SÃO PAULO

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DEDICATION

To my beloved Family, who have always supported me, encouraged me, and believed in my dreams. Without you it would be impossible to fly so high. Thank you for being with me during all my journey and always loving me unconditionally.

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Pereira CF. Interpersonal theory of nursing to anxiety management in people with substance use disorder (ITASUD) [thesis]. São Paulo: Nursing School, University of São Paulo; 2019.

ABSTRACT

Introduction: The comorbidity of anxiety and substance use disorders has been shown to have a strong association. High levels of anxiety are critical to the increased risk of substance use disorders, relapse and withdrawal of related treatment. While it is broadly accepted that addressing anxiety is a potential factor in helping this population continue with their treatment, there has been no protocol for the same, as well as feasibility studies targeting anxiety in cocaine users. **Objectives:** 1) To describe the extension and application of the Peplau's Interpersonal Theory of Nursing (ITN) to the design of an anxiety management intervention for people with substance use disorders; 2) To verify the feasibility of the anxiety management' intervention for cocaine users. **Method:** The research was based in two moments. The first one was the development of the intervention (objective 1) and the second one was to check the feasibility (objective 2). For the first moment of the research we used two methods, Fawcett's model and Intervention Mapping to develop the intervention; and the second moment we evaluate feasibility outcomes of demand, acceptability, implementation, practicality, adaptation, and safety. **Results:** The intervention targeted behavioral (to manage cocaine use; and to improve sleep, eating and physical activity) and environmental outcomes (to manage social isolation and to reengage in society) that contribute to increase of anxiety, based on determinants of anxiety (knowledge, triggers, relief behaviors, self-efficacy and relations). Preliminary evidence supports the feasibility of the trial with some changes. The number of participants that completed the intervention was low (5.88%), however more than a half (64.10%) attendee until the second appointment. The anxiety measure was acceptable and appeared sensitive to change, decreasing in 38 points in average after the intervention. **Conclusion:** The combination of Fawcett and Intervention Mapping approach provide clarity about the process used in the research based in a nursing model, facilitating the creation of theory and evaluation of theories. By providing a detailed description about the process of construction of the Peplau theoretical framework applied to anxiety in cocaine users, with broad view of all factors that affect the problem, and facilitates replication through transparency of the determinants, methods, and applications used. Besides this, the results of the feasibility trial suggest that Interpersonal Relationship nurse-client have potential as an inexpensive and feasible intervention. A larger trial, following the changes pointed in the implemented protocol, is necessary to fully test the effectiveness of ITASUD.

Keywords: Nursing, Anxiety, Peplau`s Theory, Substance Use Disorders, Intervention Mapping.

Pereira CF. Teoria Interpessoal de enfermagem para manejamento de ansiedade em pessoas com transtornos de uso de substâncias (ITASUD). [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2019.

RESUMO

Introdução: Há evidências de que a comorbidade ansiedade e abuso de substâncias tem demonstrado ter uma forte associação. Altos níveis de ansiedade são críticos para o aumento do risco de abuso de substância, recaída e abandono do tratamento. Enquanto é amplamente aceito que a ansiedade é um dos principais fatores que ajudam na continuação do tratamento. Não há protocolo, e estudos de exequibilidade agindo na ansiedade de usuários de cocaína. **Objetivo:** 1) Descrever a extensão e aplicação da Teoria Interpessoal em Enfermagem da Peplau no design de uma intervenção para o manejamento da ansiedade em usuários de álcool e outras drogas; 2) Verificar a exequibilidade da intervenção de manejamento de ansiedade em usuários de cocaína. **Método:** A pesquisa foi baseada em dois momentos. O primeiro foi o desenvolvimento da intervenção (objetivo 1) e o segundo foi a verificação da exequibilidade da intervenção (objetivo 2). No primeiro momento da pesquisa nós utilizamos dois métodos, o modelo da Fawcett e o mapeamento da intervenção para desenvolver a intervenção; e o segundo momento nós avaliamos a exequibilidade da intervenção, por meio da demanda, aceitabilidade, implementação, praticabilidade, adaptação e segurança da intervenção. **Resultados:** A intervenção focou nos desfechos comportamentais (manejamento de cocaína; melhora do sono, alimentação e atividade física) e ambientais (manejamento da isolação social e reinserção social) que contribui no aumento da ansiedade, baseada nos determinantes da ansiedade (conhecimento, gatilhos, comportamentos de alívio, auto-eficácia e relações). Evidências preliminares suportam a exequibilidade da intervenção com algumas mudanças. O número de participantes que completaram a intervenção foi baixo (5.88%), porém mais que a metade (64.10%) foram até a segunda consulta. A mensuração da ansiedade foi aceita e aparentemente sensível a mudança, pois diminuiu 38 pontos em média após a intervenção. **Conclusão:** A combinação da abordagem da Fawcett e do mapeamento da intervenção providenciou clareza sobre o processo usado na pesquisa, facilitando a criação e avaliação da teoria. Pois providenciou uma descrição detalhada sobre o processo de construção do modelo teórico da intervenção, por meio da transparência dos determinantes, métodos, e aplicações utilizados com ampla visão de todos os fatores que afetam o problema, facilitando a replicação da intervenção. Além disso, os resultados do estudo de exequibilidade sugerem que o relacionamento interpessoal enfermeiro-cliente tem potencial como uma intervenção barata e exequível. No entanto, um grande ensaio clínico, seguindo as mudanças apontadas no protocolo implementado, é necessário para testar a efetividade da ITASUD.

Palavras - chave: Enfermagem, Ansiedade, Teoria da Peplau; Transtornos relacionados ao uso de substancias; Mapeamento da Intervenção.

Pereira CF. Teoría Intrapersonal de Enfermería para el manejo de la ansiedad en personas con transtornos de uso por sustancias (ITASUD). [tese]. São Paulo: Escola de Enfermagem, Universidade de São Paulo; 2019.

RESUMEN

Introducción: Existen evidencias de que la comorbilidad ansiedad y el abuso de sustancias ha demostrado tener una fuerte asociación. Altos niveles de ansiedad son críticos para el aumento del riesgo de abuso de sustancias, recaída y abandono del tratamiento. Sin embargo, es ampliamente aceptado que la ansiedad es también uno de los principales factores que ayudan a la continuación del tratamiento. No existe un protocolo, ni estudios de practicabilidad sobre la ansiedad en usuarios de cocaína. **Objetivo:** 1) Describir la extensión de la aplicación de la Teoría Interpersonal de Enfermería de Peplau en el diseño de una intervención para el manejo de la ansiedad en usuarios de álcool e otras drogas; 2) Verificar la practicabilidad de la intervención de manejo de la ansiedad en usuarios de cocaína. **Método:** La investigación fue basada en dos momentos. El primero fue el desarrollo de la intervención (objetivo 1) y el segundo fue la verificación de la practicabilidad de la intervención (objetivo 2). En el primer momento de la investigación utilizamos dos métodos, el modelo de Fawcett y el mapeamiento de la intervención para desarrollar la intervención, y en el segundo momento evaluamos la practicabilidad de la intervención, por medio de la demanda, aceptación, implementación, practicabilidad, adaptación y seguridad de la intervención. **Resultados:** La intervención se enfocó en los resultados comportamentales (manejo de la cocaína, mejora del sueño, alimentación y actividad física) y ambientales (manejo del aislamiento social y reinserción social) que contribuyen al aumento de la ansiedad, basados en los determinantes de la ansiedad (conocimiento, gatillos, comportamientos de alivio, autoeficacia, y relaciones). Evidencias preliminares soportan la practicabilidad de la intervención con algunos cambios. El número de participantes que completaron la intervención fue bajo (5.88%), sin embargo, más de la mitad (64.10%) participaron de la segunda consulta. La medición de la ansiedad fue aceptada y aparentemente sensible al cambio, ya que hubo disminución media de 38 puntos posterior a la intervención. **Conclusión:** La combinación del abordaje de Fawcett y del mapeamiento de la intervención provee claridad sobre el proceso utilizado en la investigación, facilitando la creación y evaluación de la teoría. Ofrece una descripción sobre el proceso de construcción del modelo teórico de la intervención, por medio de la transparencia de los determinantes, métodos, y aplicaciones utilizados con una amplia visión de todos los factores que afectan el problema, facilitando la replicación de la intervención. Adicionalmente los resultados del estudio de practicabilidad indican que la relación interpersonal enfermero-cliente tiene potencial como una intervención barata y practicable. Sin embargo, un gran ensayo clínico, siguiendo los cambios apuntados en el protocolo implementado, será necesario para testar la efectividad de la ITASUD

Palabras clave: Enfermería, Ansiedad, Teoría de Peplau, Transtornos relacionados al uso de sustancias, Mapeamiento de la intervención.

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LIST OF ABREVIATIONS

ASSIST	Alcohol Smoking and Substance Involvement Screening Test
BAI	Beck Anxiety Inventory
CAPS AD	Psychosocial Care Center for Alcohol and other Drugs
CTE	Conceptual – Theoretical – Empirical
GAD	Generalized Anxiety Disorders
GBD	Global Burden of Disease
GSE	General Self-efficacy Scale
IM	Intervention Mapping
ITASUD	Interpersonal Theory of Nursing to Anxiety management in People with Substance Use Disorders
ITN	Interpersonal Theory of Nursing
MOS SSS	Medical Outcome Study
NEPEEA	Núcleo de Estudos e Pesquisas em Enfermagem em Adições - Álcool e Outras Drogas
PHQ	Patient Health Questionnaire
PSS	Perceived Stress Scale
PTS	Therapeutic Singular Project
RCT	Randomized Clinical Trial
RedCap	Research Electronic Data Capture
SUD	Substance Use Disorders
WHO	World Health Organization

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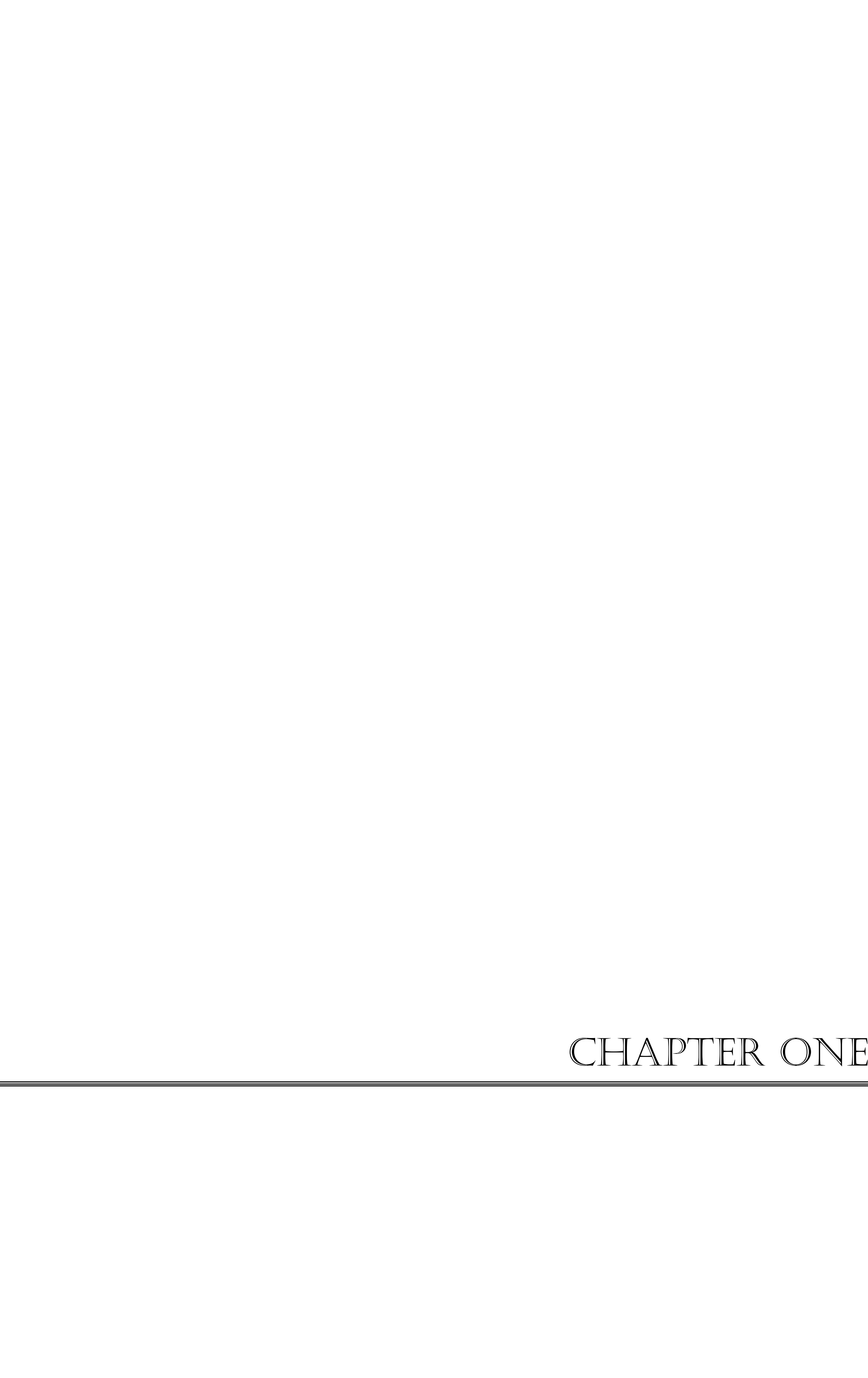


CHAPTER ONE

CHAPTER ONE

1 INTRODUCTION

1.1 PROBLEM – ANXIETY IN BRAZILIAN COCAINE USERS

Brazil is one of the emerging nations in which the use of cocaine, has been increasing. While the consumption of cocaine has been gradually decreasing in countries such as The United States of America and Europe, in Brazil its abuse has raised (UNODC, 2012). Cocaine is the most used stimulant in Brazil, due to its price – it is considered the cheapest rate in the world (Vos et al., 2017). One of the explanations is that Brazil is the biggest market of the substance in South America, because of its geographic position, neighboring the world`s largest cocaine producers such as Peru, Colombia and Bolivia (UNODC, 2012).A study (Abdalla et al., 2014) indicated that approximately 2 million Brazilians have used cocaine at least once in their lifetime, and the prevalence of cocaine users in the country represents roughly 3.2 million of people.

This high prevalence of cocaine use has led to an increase in the number of cocaine users who require emergency treatment, which overloads the health system. An epidemiological study conducted in 2014 revealed that Brazilian cocaine users tend to require emergency care at a rate three times higher than that in cocaine users worldwide. (The Global Drug Survey, 2015). This high demand in emergency care highlights the need to reframe the specialized health service provided to the treatment of alcohol and other drugs, to prevent people from ending up in an emergency room. Such measure will decrease the health care costs with this population once this population stops visiting the emergency room frequently owing to cocaine abuse.

The specialized outpatient health facility for alcohol and other drugs has a high level of clients' drop-out during treatment (Miguel et al., 2016), which is considered a critical issue in the health scenario. One of the major challenges to keeping cocaine users in the specialized treatment is the high level of anxiety in clients, once it is the main cause for relapse and withdrawal of treatment (Shanmugam & Winslow, 2013). One of the possibilities to help this population carry on with their treatment is to address their anxiety. If the cocaine users became aware of their anxiety issue, they can identify, modify and replace the problematic relief behavior (cocaine use) for healthier relief behaviors. Health care providers need to have a

deeper understanding of what anxiety is, so they can apply such knowledge in their analysis of their clients to identify the nature of anxiety in their clients' lives.

1.2 UNDERSTANDING ANXIETY

Anxiety is one of the most prevalent health problems worldwide. In this study, anxiety is defined as a tension that provides energy transformation(Sullivan, 1953)(Peplau, 1991). Such energy can be experienced by the general population in three modes: prototaxic - totally unaware of anxiety; parataxic - aware of anxiety; and syntaxic - aware of anxiety and able to do the connection among expectations that happen before the anxiety and relief behaviors used to decrease anxiety.

The energy of anxiety is transformed in physiological reactions - increase of heart rate, sweating, trembling, irritability, vertigo, foreboding, uncertainty about what might happen, anticipation of loss of control and inability to cope or to survive - and in behavioral responses - security operations developed by the self-system to reduce, relieve, and prevent escalation of anxiety.

Security operations are composed by behavioral responses, such as relief behaviors, relief patterns and self-transformation that are used to decrease or avoid the anxiety(Sullivan, 1953). Behavioral responses due to anxiety can have implications in the quality of life. These consequences are: a) inefficient and rigid performances during interpersonal relation; b) social isolation and loneliness; c) inability to work; d) inability to do activities of daily living; and f) development of complicated relief behaviors, such as drug use.(O'Toole & Welt, 1994). Additionally, there are other implications related to the individual's environment such as limited access to employment opportunities; hospitalization; and medical and social costs.

Anxiety generates a series of diseases, and implications associated with untreated illness that affect health, economy and social sectors (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017). Untreated anxiety has been associated with significant personal and societal costs, frequent primary and acute care visits, decreased work productivity, unemployment, and impaired social relationships (Simpson, 2010). The Global Burden of Disease (GBD) (Whiteford et al., 2013) study estimated that anxiety disorders contributed to 26.8 million disability adjusted life years in 2010, and according to World Health Organization (WHO) (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017) the consequences of anxiety disorders occupied the 6th position as the contributor to global disability.

The estimated number of people living with anxiety disorders in the world is 264 million. It reflects an increase of 14.9% since 2005(Vos et al., 2016a) , as a result of population growth and ageing; and 21% of the estimated number of people living with anxiety are in the Region of Americas (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017). In Brazil the prevalence of anxiety disorders is 9.3% of the population and 8,3% of total years lived with anxiety disorders(*Depression and Other Common Mental Disorders Global Health Estimates*, 2017).

Clinical reviews(Remes, Brayne, van der Linde, & Lafortune, 2016) have shown that the presence of an anxiety disorder is a risk factor for the development of mood disorders, substance abuse; and this presence is highly comorbid with other mental disorders. The comorbidity of anxiety disorders with substance use disorders has been investigated by several researchers, which revealed a strong association. Such combination complicates treatment prognosis, increase services attendance and health care costs, which generates a major issue worldwide.

2. STRUCTURE OF STUDY

This thesis is presented in eight chapters which are detailed in this section. The first chapter are composed by the background.

The second chapter presents the objectives and the theoretical-methodologic approach.

The third chapter presents the methods used across studies, including: 1) theory-generating research, Fawcett's model, to describe the extension and application of the ITN to the design of an anxiety management intervention for people with substance use disorders; 2) intervention mapping approach to develop the intervention structure; 3) feasibility trial to verify if the ITASUD is feasible in the real context. We also present a detail description of the sample, measures and data analysis.

The next four chapters (chapter 4, 5, 6 and 7) present the articles and manual of intervention developed in each step of the study, according the specific aim of the thesis.

Ultimately, the thesis is concluded in chapter eight by a summary of the results of the study as a whole, and suggestions for further studies.

CHAPTER TWO

CHAPTER TWO

3 OBJECTIVES

1) To describe the extension and application of the ITN to the design of an anxiety management intervention for people with substance use disorders

2) To verify the feasibility of the ITN extension intervention developed, ITASUD, to anxiety management in cocaine users.

4. THEORETICAL- METHODOLOGICAL APPROACH

4.1 PEPLAU'S THEORY

Psychotherapeutic nursing started with Hildegard Peplau in 1952 when she introduced a middle-range theory guiding the use of interpersonal processes in nursing practice (Peplau, 1991). The concepts chosen by Peplau came from systematic observations from clinical work with patients with psychiatric disorders and the synthesis of behavioral and social science writings that were emerging at that time. Peplau developed the initial theory to fit all fields of nursing work(Peplau, 1991), eventually specifying the theory with applications to psychiatric mental health nursing(O'Toole, Welt, 1994) . The Interpersonal Theory of Nursing (ITN) provides the concepts and propositions that guide the nurse in establishing and strategically communicating with the client by using an observational, experiential and reflexive approach in structured and unstructured interactions.

A central driver of the interpersonal process is anxiety which if strategically approached, can be a key to client's health problems. Both nurse and client experience anxiety during their interactions, and while providing the energy for change, anxiety can also block productive use of the interpersonal relation to achieve growth. The main way to work with the tension of anxiety is to learn how to be aware of it and enact strategies that keep the level of anxiety in the mild to moderate range that allows it to power productive growth.

4.1.2 FACTORS THAT CONTRIBUTE TO THE PROBLEM – ANXIETY

The factors that contribute to anxiety are the experience of anxiety and the security operations developed that create relief behaviors, relief patterns and sometimes changes on the

self-system. Environmental factors may also influence the level of the individual's anxiety directly and indirectly.

Anxiety starts at infancy during interpersonal relationships between the baby and the mother (or the person that represents the mother's function). When the mother exhibits anxiety, she induces tension in the baby. This happens because the baby can feel the mother's tension and, consequently, exhibits anxiety as well (empathy linkage).

In addition to maternal relationship, the baby interacts with its family group components that plays an important role in anxiety transmission. Therefore, the infant, through interaction with them, starts to evolve from the prototaxic to the parataxic experience and then integrates situations to avoid or minimize anxiety. Simultaneously, the infant starts to identify forbidding gestures, such as speech modifications and facial expressions. Consequently, it becomes alert to its maternal attitudes, which results in high levels of tension. Further, the infant starts to develop security operations(Sullivan, 1953) to decrease or avoid anxiety.

Security operations generate both positive and problematic behavioral responses to decrease anxiety. One example of a positive relief behavior is physical activity, whereas that of a problematic relief behavior is the use of psychoactive substances. The problem is not the use of psychoactive substances to decrease anxiety, once people have always had this practice. The main issue is when such use interferes in the interpersonal relations of the individual, as it acts directly in the development of self-view, self-worth, and self-esteem. Drug abuse tends to generate social isolation, which undermines self-esteem and decreases opportunities for fortunate experiences in life that, in turn, may affect drug use directly. Moreover, the use of stimulants as a relief behavior generates strong episodes of anxiety, which results in social isolation, inability to perform activities of daily living, stigma, marginalization, and high medical costs.

Environmental factors are composed by interpersonal, organizational and community level. At the interpersonal level, family, friendship and peer support, and social networks play an important role in decrease social isolation and loneliness. At the organizational level, the following factors are crucial to engagement in treatment: rules in the health and social services; geographical boundaries, particularly the street; limited health counseling from health care providers on anxiety; limited harm reduction health counseling from health care providers; and few policies on addiction management. At the community level, social factors results in high levels of anxiety: low income, homeless situation leading to living in dangerous places, limited

linkage to social support networks, withdrawal from society, and lack of policies on minors' access to mental health services.

The main determinants that directly affect the intensity of, duration of, and reaction to this tension (anxiety) are awareness/knowledge, relationships, stress (triggers), relief behaviors, and self-efficacy. The main factor that plays an important role in anxiety is interpersonal relationships, as anxiety is a tension that is transmitted among people during their lifetime since infancy (Sullivan, 1953). Individuals need to keep in contact with other people; without this contact, they experience loneliness, which results in the increase of stress (triggers) and high level of anxiety and intensified relief behaviors, such as increase in drug abuse (cocaine use).

The use of cocaine affects the success of an individual in life. To improve this scenario, it is important to decrease stress (triggers) and anxiety, thereby leading to less relief behaviors (less drug use = less *cocaine use*) and better self-efficacy. Improved self-efficacy will lead to better strategies for stress management, which will decrease stress (triggers), anxiety, and relief behaviors (less use of drug). One way to achieve these outcomes is through interpersonal relationships between the nurse and the client that is designed to lead to decreased stress (triggers), anxiety, and relief behavior, and increased self-efficacy.

4.1.3 THEORETICAL SIGNIFICANCE

The Interpersonal Theory in Nursing (ITN) described by Peplau (Peplau, 1991) identifies anxiety as a universal phenomenon: everyone experiences the discomfort of anxiety to some degree at some time throughout life. Interventions to decrease anxiety are mainly characterized by raising awareness on the feeling; that is, by naming it as anxiety. This process is achieved by means of empathic linkage that fosters syntax, awareness, identification, elaboration, reckoning, and alignment toward the proper management of anxiety.

Empathic linkage, frequently called "bond", is the most important tool in the interpersonal relationship between the nurse and the client, because it decreases anxiety and triggers the collaborative process of changing problematic security operations in the client, such as cocaine use as relief behavior. After the empathic linkage is established, the first step is to transform the parataxic mode of anxiety into a syntaxic mode (the transformation of an unpleasant feeling into words, ideally in the client's own words and mental images), process that is followed by awareness of anxiety.

When the clients are aware of their anxiety, they need to identify their expectations (assumptions, wishes, wants, beliefs, goals, self-views), elaborate the meaning of their expectations, and identify the relief behaviors to be used when the expectations are not achieved (O'Toole, Welt, 1994).Only after these steps should nurses promote the reckoning process toward deliberate changing of relief behavior (cocaine use) in an interpersonal context, and replace it with new patterns of relief behavior (alignment) (Peplau, 1991).

4.2 FAWCETT'S MODEL FOR THEORY GENERATING RESEARCH

A conceptual model is defined as a set of abstract and general concepts and the propositions that state something about the concepts (Fawcett, 1992). Conceptual models on nursing practice are important because inform and transform nursing practice by informing and transforming the ways in which practice is experienced and understood (Speedy, 1989). According Fawcett the understanding of the nature and structure of nursing knowledge is guided by a nursing conceptual model that should be the beginning point of reference for nursing practice and development of nursing interventions evidence-based theory (Butts, 2011; Butts, 2012).

Fawcett's model was used to extend the ITN to the population of people who have substance use disorders through the construction of a conceptual model. The model articulates concepts of nurse-client interaction based on concepts of anxiety management in the ITN applied to people who have patterns of substance use disorders and provides clarity about the process used in a research based nursing model, facilitating the creation and evaluation of theories.

The Fawcett model requires that the phenomena that are being studied are specified, the purposes to be fulfilled by the analysis are stated; and the Conceptual – Theoretical – Empirical (CTE) structure be used. (Figure 1)

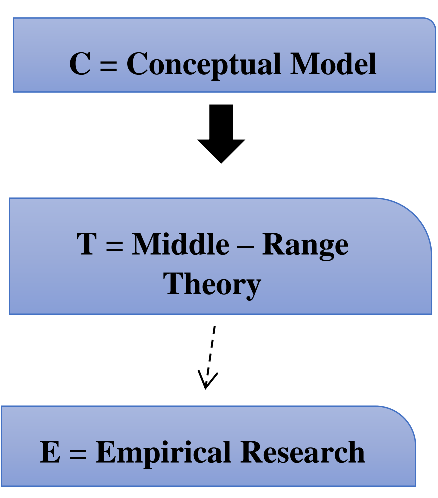


Figure 1- Conceptual – theoretical – empirical structure for theory- testing research: From conceptual model to middle-range theory to empirical research methods. From Fawcett, J.(1999)

The components of CTE are organized hierarchically according the levels of abstraction. The most abstract level is a conceptual model, in which the research is based (C); within the intermediate level is the middle range theory (T) that is generated; and the concrete level is the empirical research methods (E) that are used to conduct the research. (Fawcett & Garity, 2009).

The next step of the development of the intervention will be integrate the conceptual model developed, by Fawcett's model (CTE) based on Peplau's theory, and an ecological approach that considers environmental influences on behavior and develops methods and strategies to address them (Bartholomew, Parcel, Kok, 1998) that will be detailed above.

4.3 INTERVENTION MAPPING APPROACH

The increasing global recognition of many common disease conditions, as the comorbidity anxiety and substance use disorders, requires that the interventions developed considers environmental influences in the disease conditions and propose methods and applications adapted to the current context. To develop the intervention program, we used the conceptual model based on Peplau's theory develop by Fawcett's model and integrate it with the Intervention Mapping protocol that describes the iterative path from problem identification to problem solving (Bartholomew et al.,2016).

Intervention Mapping (IM) is a framework consistent with Medical Research Council (Craig et al., 2008) guidance on developing complex interventions and it has been used to develop intervention programs for many health behaviors (Bartholomew et al.,2016; Fernández et al., 2005; Hurley et al., 2015; Munir et al., 2013; Van Empelen et al.,2015).

IM is very useful because specifies processes for integrating theoretical constructs and evidence-based literature for purposeful of the intervention through description of a logical planning process. IM is a six-step process structured and sequenced as follows: (1) needs assessment (logical model of the problem); (2) creating matrices of performance objective (logic model of change); (3) selecting theory-based methods and practical strategies (program design); (4) program development; (5) adoption and implementation, and (6) evaluation (figure

2). The completion of all the steps serve as a blueprint for designing, implementing and evaluating an intervention based on a foundation of theoretical, empirical and practical information (Bartholomew et al.,2016). The detailed description of each step will be presented in the methods section.

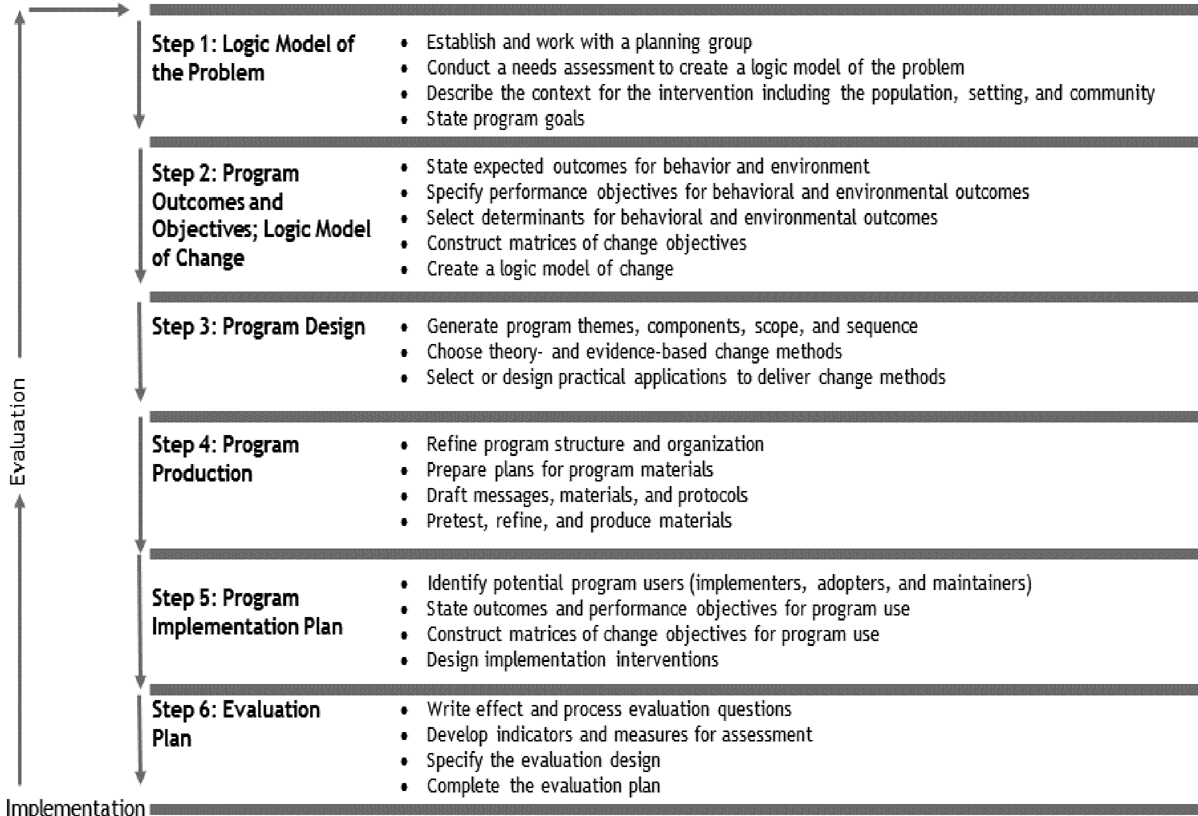


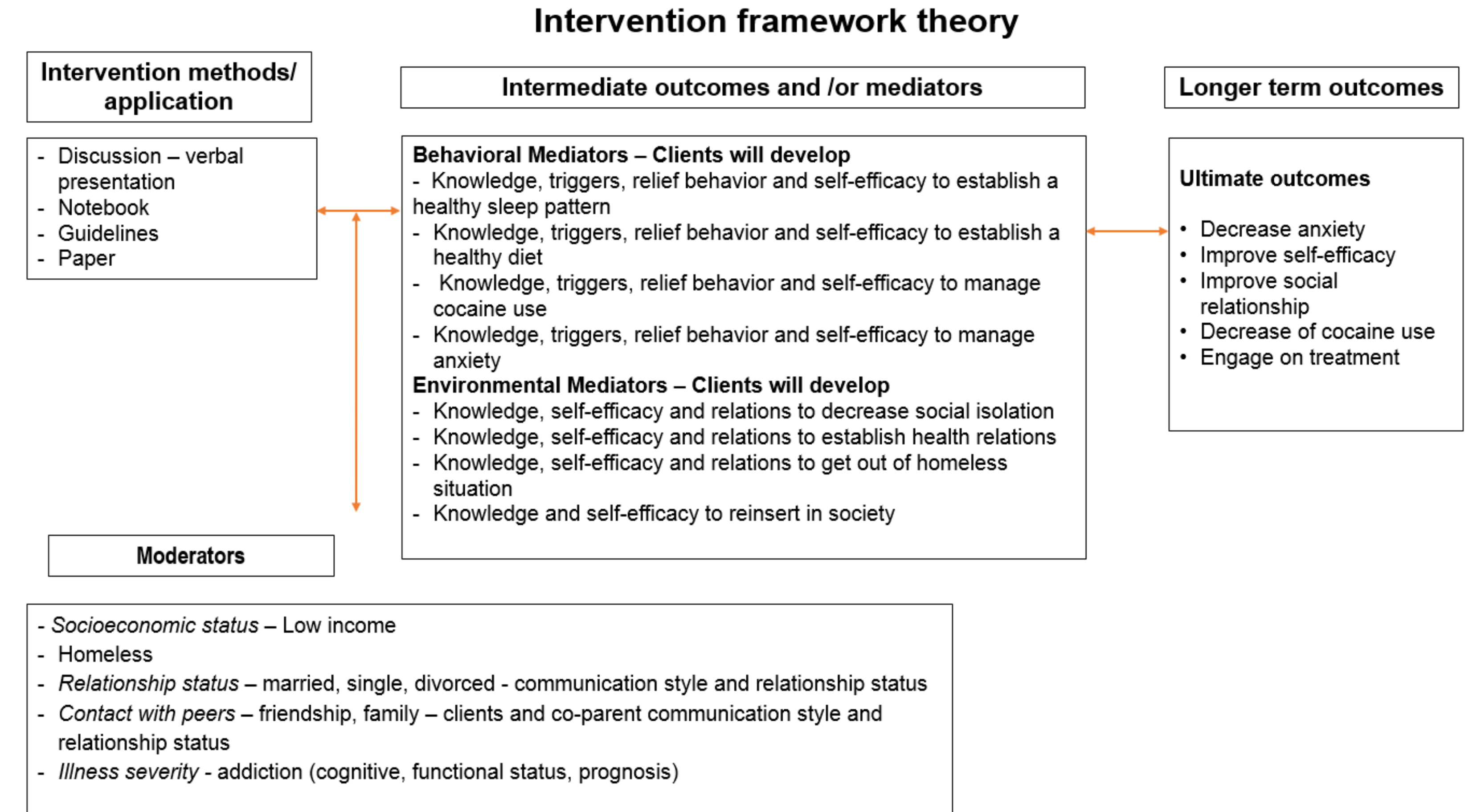
Figure 2: The six steps of intervention mapping. In: Eldredge, L. K. B., Markham, C. M., Ruiter, R. A., Kok, G., Fernandez, M. E., & Parcel, G. S. (2016). *Planning health promotion programs: an intervention mapping approach*. John Wiley & Sons.

4.4 INTERVENTION FRAMEWORK

The intervention framework (frame 1 and 2) was constructed based on the integration of the Fawcett's and IM approach to clarify the structure of the ITASUD intervention. During the development of the anxiety management strategies for people who have substance use disorders we considered behavioral and environmental outcomes, and moderators that contribute to decreasing the level of anxiety. The behavioral outcomes that the clients may achieve are an improvement on sleep patterns and healthy eating habits, and the ability to manage cocaine use. Regarding environmental outcomes, nurses must provide tools for the clients to decrease social

isolation, establish healthy relationships (with friends, peers and family), to reverse homelessness situation and be reinserted in society.

There are six moderators to be taken in consideration in this intervention: 1) *sex*, as women are almost twice as likely as men to experience anxiety because of the differences in brain chemistry and hormonal fluctuations, and the different way that they tend to lead with stress (Remes et al., 2016); 2) *socioeconomic status*, as individuals with lower social status have higher symptoms and sensitivity for anxiety (Reitzel et al., 2017); 3) *homelessness*, which is a trigger to unhealthy relief behaviors (use of cocaine) and is responsible for stressful life events that increase the level of anxiety (Tyler, Schmitz, Ray, 2017); 4) *relationship status* (married, single, unmarried, or divorced), as unmarried women have a demonstrably higher tendency to develop anxiety compared with married women (Stein et al., 2017); 5) c*onflict with peers and contact with anxious peers* (friendship, family, spouse) that may play a role as a trigger to increasing anxiety and consequently increases relief behaviors (cocaine use); and 6) *illness severity*, which produces changes in the brain and neurobiological pathways. (Crunelle et al., 2014).



Frame 1- Intervention framework theory 1

Intervention framework theory

Structure

Client characteristics

- Cocaine users
- High anxiety levels

Healthcare professional characteristics

- Nurses
- Lack of knowledge
- Lack of skills
- Lack of time to communicate with clients (20 Min)

Context characteristics

- Low income
- Homeless
- Few health friendship

Process

Dose: The frequency of intervention will be everyday during one week, total of 5 appointment. The 1st appointment – 30 min , and the others (2,3,4,5) – 20 min

Intervention components

- *Discussion – verbal presentation*
  - Questions that address anxiety awareness
  - Questions that address expectations
  - Question that address relief behaviors
  - Instruct the individual to avoid situations that can generate problematic triggers to anxiety, sleep and eating
  - Discussion about the challenges to achieve a good pattern of sleep and eating
  - Discuss about the importance of physical activity to good sleep and to decrease anxiety
  - Discuss about healthy and unhealthy relationships
  - Discuss about the possibility to sleep in shelter houses
  - Planning coping response to reduce barriers to communication with parents, peers and friends
- *Notebook*
  - List of relief behaviors used to decrease anxiety
  - List of triggers, operative expectations and relief behaviors involved in the anxiety
  - List by identification in a picture what part of the body they feel the discomfort
  - Do notes about pattern of sleep, eating and physical activity
- *Paper*
  - Show the matrix of anxiety`s problem
  - Show the matrix of logic model of change
  - Provide a list of safer places that the client can sleep
  - Provide a list of different places that the client can go
  - Provide a list of different healthy places to practice physical activities
- *Guidelines*
  - Deep breathing
  - Sleeping healthy
  - Eating health
  - Physical activity

Outcomes

Client reactions

- Acceptability
- Show up interest

Client enactment and adherence to treatment

- Remember about what were talk in the last appointment
- Use of skills developed during appointment in your daily life (enactment)
- Keep going in the appointment (adherence)

Intermediate outcomes

Behavioral – Individual Level

- Increase of Knowledge/awareness; identification of triggers and relief behavior; and self-efficacy to establish a healthy sleep pattern
- Increase of Knowledge; identification of triggers and relief behavior; and self-efficacy to establish a healthy diet
- Increase of Knowledge; identification of triggers and relief behavior; and self-efficacy to manage cocaine use
- Increase of Knowledge; identification of triggers and relief behavior; and self-efficacy to manage anxiety

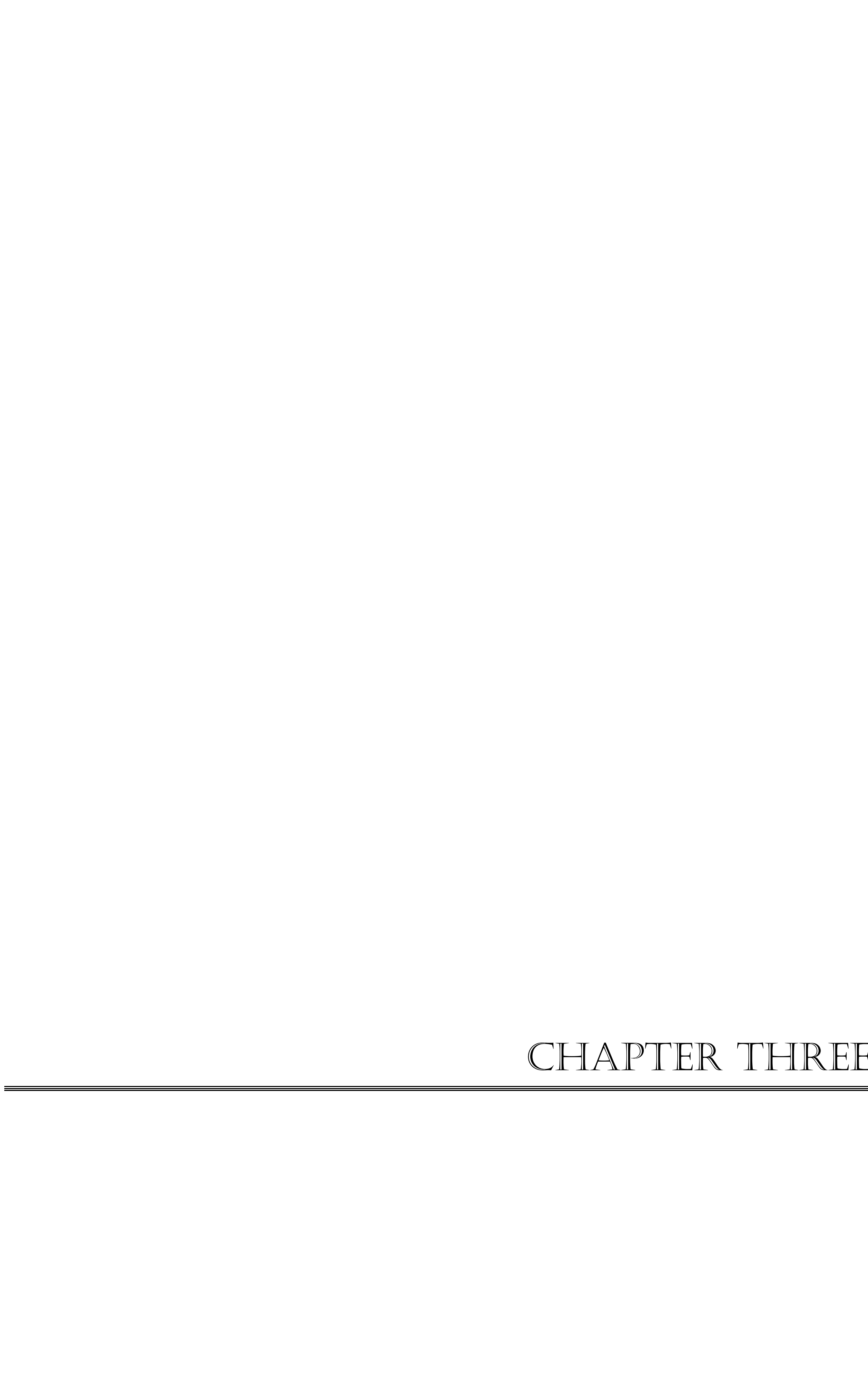
Environmental - Individual Level

- Improve of Knowledge, self-efficacy and relations to help the clients to decrease social isolation / improve social relationship
- Improve of Knowledge, self-efficacy and relations to help the clients to establish health relations
- Improve of Knowledge, self-efficacy and relations to help the clients to find a safe environmental to sleep (perhaps they can get out of homeless situation)
- Improve of Knowledge and self-efficacy to reinsert the clients in society

Ultimate outcomes

- Decrease of cocaine use
- Engage on treatment
- Get out of homeless situation
- Decrease of anxiety
- Increase quality of life

Frame 2: Intervention framework theory 2



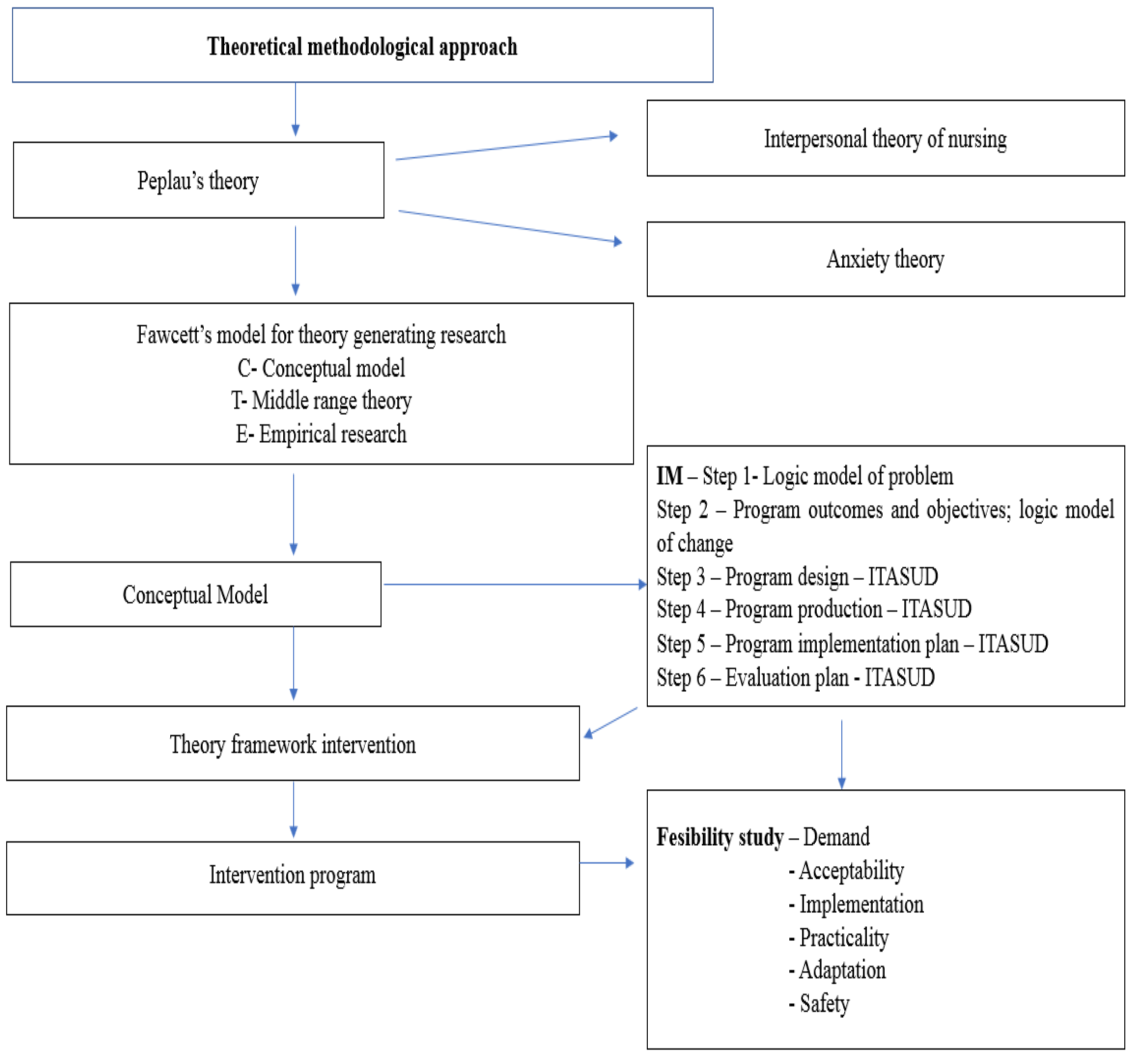
CHAPTER THREE

CHAPTER THREE

5 METHODS

The research was based in two moments. The first one was the development of the intervention (objective 1) and the second one was to check the feasibility (objective 2). For the first moment of the research we used two methods, Fawcett's model and Intervention Mapping to develop the intervention; and the second one we evaluate feasibility outcomes of demand, acceptability, implementation, practicality, adaptation, and safety. As you can see in the frame below (frame 3)

Frame 3: Theoretical methodological approach



In order to achieve the first aim, the methodology used to develop the intervention was the Fawcett's model (Fawcett, Garity, 2009) and the systematic Intervention Mapping (IM) (Bartholomew et al., 2016) development process described below.

5.1 FAWCETT'S MODEL FOR THEORY-GENERATING RESEARCH

The Fawcett's model was used for theory-generating research (Fawcett , Garity, 2009) to extend the Interpersonal Theory in Nursing (ITN) to the population of people who have substance use disorders . It requires that the phenomena that are being studied be specified, the purposes to be fulfilled by the analysis be stated; and the Conceptual – Theoretical – Empirical (CTE) structure be used. The components of CTE are organized hierarchically according to the levels of abstraction.

There are four steps in Fawcett's model for theory-generation. The first step is to describe the phenomena of study, correlating with the main concepts of the conceptual model used (ITN by Peplau); the second step is to develop a theoretical model of the phenomena of study (anxiety in substance abusers) , identifying the nature, manifestation, severity, determinants and consequences of anxiety; the third step is to develop relational propositions to connect the conceptual model (Peplau`s theory) with the theoretical framework of anxiety; the fourth step is to develop the empirical structure to evaluate the intervention theory through instruments.

The results of the development of the conceptual model of the intervention are described in the chapter 3, as an article.

5.2 INTERVENTION MAPPING APPROACH

The other method used to the development of the intervention was the Intervention Mapping(Bartholomew Eldredge, n.d.). IM is a six-step process structured and sequential as follows: (1) needs assessment (logical model of the problem); (2) creating matrices of performance objective (logic model of change); (3) selecting methods and practical strategies (program design); (4) program development; (5) adoption and implementation, and (6) evaluation.

Step 1: Needs assessment

The aim of step 1 was to develop the logic model of the problem to program goals for the intervention related to health and quality of life. This logic model was based on the

combination of comprehensive understanding about the problem through Peplau`s theory, empirical data about the factors that contribute to the problem, and experiential information about the problem. Besides this, this step focuses on the description of intervention context (population, setting and community).

Step 2: Creating matrices of performance objective

Step 2 of IM is followed by: 1) a statement of expected outcomes for behavior and environment and develop performance objectives for behavioral and environmental outcomes;2) selected determinants for behavioral and environmental outcomes; 3) the construction of matrices of change objectives and create the logic model of change.

The main aim of this step is the development of the logic model of change, which represents pathways of the intervention that acts in behavioral and environmental perspective, through the connection between determinants and change objectives, performance objectives, desired outcomes and the improvement of quality of life in relation to the health problem that is anxiety.

Step 3: Selecting theory-based methods and practical strategies

Step 3 is to generate program themes, components, scope and sequence. To accomplish this aim we chose Peplau`s theory as a conceptual model and method, and evidence-based selected methods to reach change objectives. We also used published guidance on intervention mapping approach (Bartholomew et al.,2016) to choose some methods, according the definition and parameter of each one.

Step 4: program development

The team guided by matrices started to refine program structure and organization, prepare plans for program materials, develop specific messages, materials and protocols. The change objectives were converted into practical applications using a range of evidence-based research. In the end of this step the definitive intervention content and materials were created based on relevant additions made through the team discussion.

Step 5: adoption and implementation

The aim of the program implementation plan was to find out the balance between what was planned and what can be implemented in the real world, through the identification of potential users (adopters, implementers and maintainers) and the context that they are inserted,

resulting in a better design for implementation. Additionally, the manual of intervention was adapted to increase the chances of adoption, implementation and sustainability.

Step 6: evaluation

After the step 5, plan for program adoption and implementation, there was the evaluation of this program through operational definitions of feasibility, such as acceptability, demand, practicality, and adaptation.

The IM approach address some part of the definition of feasibility. During the IM approach was used the definition of feasibility that address *acceptability, demand, practicality and adaptation* with nurses that working in the health facility.

We invited nurses of the outpatient treatment for addictions (CAPS AD Centro) in Sao Paulo into focus group and collect data about the nurse`s perception of the acceptability, demand, practicality and adaptation of the interpersonal relationship as an intervention to equip cocaine users to manage anxiety, to explore the feasibility of delivering the intervention prototype, and the barriers and enablers to be addressed to support intervention implementation and uptake by participants . The evaluation about the intervention were conducted by semi structure interviews used during focus group, and the operational definitions and the respective question used to evaluate feasibility by nurses are presented below (table 1).

Table 1 – Feasibility components for nurses evaluate

Feasibility – Area of focus	Operational definition	Questions
Acceptability	Nurses consider the intervention acceptable and appropriate with their service context	The process is attractive to program deliverers? If not, what is the suggestions to improve the program? How can we do more attractive?
Demand	Nurses recognize the demand of delivering the intervention (demand of recruiting)	How many demand is likely to exist?

Practicality	Variations in equipment, staffs and facilities to deliver the intervention	Fit with organizational culture (time of appointment, location of appointment, enough nurses to apply the intervention)? If not, what are the suggestions to improve the fit?
Adaptation	The content and delivery of intervention will need to be modified to enhance acceptability and implementation on feasibility trial	The manual of intervention is clear enough to understanding? The applications reach the patients? Is it an easy format? If not, what are the suggestions to improve the intervention?

Qualitative data were consisting in open questions in which the nurses proposed changes to the intervention prototype or made reflections about the intervention and the population addressed. So, the nurse`s perceptions of this intervention (acceptability, demand, practicality and adaptation) were summarized.

The results of the development of the evidence-based intervention focusing on the management of anxiety in cocaine users are presented in the chapter 4, as an article. Besides this we developed the intervention program and it will be presented in the chapter 5.

5.3 FEASIBILITY STUDY

In order to evaluate the feasibility of the intervention (ITASUD), we conducted the feasibility trial. The main question of feasibility study is: Can this study be done? If not, why not and how should it be changed? They are used to estimate important parameters that are needed to design the main study/trial (RCT)(Eldridge et al., 2016). In order to inform the design of an adequately powered trial which could test the effect of the ITASUD. For instance it was evaluate: 1)Demand – a)willingness of participants to be randomized, b)number of eligible

patients; 2)Acceptability – a)follow -up rates, response rates to questionnaire, adherence/compliance rates, and attrition; 3)Implementation – a)complexity, b)design quality and packaging; 4) Practicality – a) ability of participants carry out the tools/skills presented during intervention to manage anxiety, b) characteristics of the proposed outcome measure (anxiety level); 5)Adaptation- a) availability of data needed or the usefulness and limitations of a particular database, b)time needed to collect, c) refine outcome measures, d)monitor for contamination and cointervention; 6)Safety a) evaluate suicide (PHQ 9 – the last question address suicide) and depression (PHQ 9), b) assessment about drug overdose and alcohol intoxication, c) assessment about serious injuries, d) assessment about the increase of anxiety during the appointment, that could be generate panic because the awareness about anxiety.

Data were analyzed for each component of feasibility. They are presented below (table 2)

Table 2 – Feasibility components of study

Feasibility – Area of focus	**Outcomes of interest**	**Approach/Questions**
Demand	1)Willingness of participants to participate 2)Number of eligible participants	1)How many participants accepted to participate of study? And How many deny to participate the study? 2) a) The criteria inclusion is a lot of specific? How many patients couldn`t participate because the criteria inclusion? b) The eligibility criteria are specific enough to reduce the potential for confounding? What is the potential for confounding that appear? c) The inclusion criteria allow the generalizability of results?
Acceptability	1)Follow-up rates, response rates to questionnaire	1) How many missing on the data?

	Assess feasibility of follow-up assessment and end-points – Help to determine the scheduling (time and how to approach the patient to do the follow -up) of follow-up assessments and the feasibility of measuring different endpoints. 2) Attrition can help estimate the likelihood of being able to collect data at scheduled time points, as well as the extent to which there may be missing data (Hagen et al., 2011) . Furthermore, it may be possible to obtain realistic estimates of participant prognosis for determining participant eligibility (Hudson, Aranda, McMurray, 2001)	How many participants did the follow-up? 2) How many people didn`t answer the call to do follow-up? How many people attend the call, but didn`t appear on the follow-up day? How many sessions the participant used to go? How many participants die, are sick, inpatient unit and/or disappear?
Implementation	1)*Complexity and design* – a) Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, intricacy and number of steps require to implement (Damschroder et al.,2009; Greenhalgh et al.,2004; Grol et al., 2007); b) Degree of execution.(Damschroder et al., 2009)	1)a) The participant demonstrates restlessness during the appointment, asking all the time when the appointment will finish? The participant understands all the strategy provided for him? What kind of terminology (terms used by participants routinely) was incorporate? How many terminologies were incorporate? Are the numbers of steps and content of intervention long?

		b) What phase of the intervention nurses get to achieve? Success or Failure of execution? Why failure, hypothesize an explanation. Amount, type of resources needed to implement? (notebook, paper of information – healthy sleep pattern, healthy eating pattern) What are the factors that affect the implementation (noise, change of room that occur the appointment)? How long is the duration of the intervention? When the intervention is fast (less than 20 minutes) the quality of the intervention is good?
Practicality	1) Ability of participants carry out the tools presented during intervention to manage anxiety. 2) Characteristics of the proposed outcome measure (anxiety level) and in some cases feasibility studies might involve designing a suitable outcome measure; anxiety level will be measured by Beck Anxiety Inventory (BAI)	1) What the participants answer when you do the question what do you remember about the last time (appointment)? What do you were able to do to decrease anxiety? 2) Test if the scales Beck used to measure anxiety works well?
Adaptation	1)Availability of data needed or the usefulness and limitations of a particular database	1)The questions are enough to address all moderators of intervention?

	2)Time needed to collect and analyze data 3)Refine outcome measures (evaluate scales used, thinking about the acceptance of the participant to answer the scales); 4)Monitor for contamination and cointervention.	Are there some questions not necessary? Is it better take off? 2) The time of screening works? The time of application of intervention is enough? The days and time of appointment works? The time of follow -up works? 3)Evaluate the answer in the questionnaires and in the scales applied. 4) The heterogeneity of sample affect the results.
Safety	1)Powerful enough to hurt or to misunderstanding symptoms.	1) a) evaluate depression and suicide through PHQ-9 b) assessment about alcohol intoxication and possible overdose c) assessment about serious injuries d) assessment about the increase of anxiety during the appointment, that could be generate panic because the awareness about anxiety.

The results of the feasibility trial will be presented in the chapter 7, as an article.

5.3.1 SAMPLE SIZE

A sample of 39 participants were the target as this is considered enough for a feasibility study (Lancaster, Dodd, Williamson,2004); we recruited over a set period (October to December 2018) at the specialized outpatient health facility in alcohol and other drugs in the Center of São Paulo.

5.3.2 INCLUSION CRITERIA

1- Users of Cocaine/ crack as the main substance

2- Age 18 years or older

3- Man (sex)

4– Portuguese speaker as their first language

5- Ability to give consent

6- A positive screen for anxiety symptom severity measured by GAD-7, defined as a score of 5 – mild anxiety, 10- moderate anxiety, 15- severe levels of anxiety.

7 – To be on the period of the construction of the singular therapeutic plan, it means that the client is not having treatment with other kind of health professional, only with the researcher.

5.3.3 EXCLUSION CRITERIA

1 - Client that present pathologies that it is necessary inpatient treatment

5.3.4 DATA COLLECTION AND PROCEDURES

Nurse contacted potential participants to explain the study. All data collection took place over face-to-face ranging in length from 60 to 90 min. Nurse directly entered quantitative data into RedCap (Research Electronic Data Capture), a secure online data collection system.

After consent was obtained, nurse collected demographic, clinic and behavioral data; and baseline measures (GSE, MOS SSS, PSS, ASSIST, GAD 7, BAI, and PHQ 9) from all participants. The baseline measures are to evaluate the mediators of the intervention self-efficacy, relation, stress, psychoactive substance use, and anxiety. Self-reported self-efficacy was assessed via the GSE, relation was assessed via MOS SSS, Stress via PSS, Psychoactive substance use via ASSIST, and level of anxiety via GAD 7 in the screening and BAI in the start and end of all appointments. PHQ 9 was used to evaluate the safety of the intervention. Questionnaires were completed prior the intervention, and in the last appointment. Anxiety outcomes, through BAI scale, will be measured in the start and in the end of the appointment.

5.3.5 MEASURES

Demographic, Clinical and Behavioral form

The demographic, clinical and behavioral form were developed by researcher, and completed by all participants at baseline. Demographic information collected included age, color of skin, number of sons, marital status, employment status, ethnicity, religion, and level of education; clinical included comorbidities, medication and disease; behavioral included information about the first contact with cocaine, place that use cocaine, family member with drug's problem and physical activities

General Self-Efficacy Scale

The GSE is a validate scale for Portuguese (Leme et al., 2013) with 10-item, 4-point scale with a Cronbach's alpha coefficient of reliability ranging from 0.76 to 0.90. The scale assesses a person's perceived self-efficacy or their belief that they can complete novel or difficult tasks or cope with diversity. Total scores range from 10 to 40 with higher scores indicating a greater level of self-efficacy.

Medical Outcome Study Scale

The MOS SSS is a validate scale for Portuguese (Zanini, Peixoto, 2016) with 19 -item, 5-point scale with a Cronbach's alpha coefficient of reliability ranging from 0.76 to 0.95. The scale assesses the extent to which the person has the support of others to cope with stressful life situations. Total scores range from 0 to 76 with high scores indicating a greater perceived support.

Perceived Stress Scale

The PSS is a validate scale for Portuguese (Luft et al., 2007) with 14-item, 5-point scale with a Cronbach's alpha coefficient of 0.77 to 0.87. The scale assesses the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. Total scores ranging from 0 to 56 points with high scores indicating a greater level of stress.

Alcohol Smoking and Substance Involvement Screening Test

The ASSIST is a validate scale for Portuguese (Henrique et al., 2004) with 8 item. Each item was evaluate according the kind of psychoactive substance (tobacco, alcohol, cannabis, cocaine, amphetamine (including ecstasy), inhalants, sedatives, hallucinogens, opioids, and "other drugs"), 4-point scale with a kappa coefficient ranged between 0.58 to 0.90. The scale evaluates the frequency of the psychoactive substance use, during the life and in the last three months. Related problems with the use, concerns about the use, unsuccessful attempts to stop or reduce use, compulsive feeling, and use through injectable via. Total scores ranging from 0

to 20 points. Score from 0-3 is an occasional use, 4-15 is abuse, and 16 and above as a suggestive dependence.

General Anxiety Disorder Scale

The GAD-7 is designed to measure anxiety severity. It is a validate scale for Portuguese (Sousa et al., 2015) and it consists in 7 items, 4-point scale with a Cronbach's alfa coefficients of 0.88. Total scores ranging from 0 to 21. Score from 0- 5 is mild anxiety, 6-10 is a moderate anxiety, and 15 and above is severe anxiety.

Beck Anxiety Inventory Scale

The BAI is a validate scale for Portuguese (Quintão, Delgado,Prieto, 2013) with 21-item, 4-point scale with a Cronbach's alpha coefficient of reliability ranging from 0.75 to 0.90. The scale measures the level of anxiety that the person presents in life' situations. Total scores range from 0 to 63. Score of 0-21 is low anxiety, 22-35 is moderate anxiety, 36 and above is potentially concerning levels of anxiety.

Patient Health Questionnaire Scale

The PHQ 9 is a validate scale for Portuguese (Santos et al., 2013) with 9 – item, 4-point scale with a Cronbach's alpha coefficient of reliability of 0.85. The scale assesses the level of depression severity. Total score ranges from 0 to 27. Score of 0 – 4 is none depression, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe, 20 – 27 severe depression.

Qualitative interviews

The qualitative interview guide developed by the research team consists of eight open-ended questions to evaluate and improve the intervention. Questions included : - What do you think about the intervention?; Does the intervention work for you, providing strategies to manage anxiety?; What strategy that you liked more?; What strategy do you think that you are able to use for a long time?; What strategy is not useful at all for you?; Are there some others strategies that you used to manage anxiety? Why did you come back? Anything else you would like to add?

5.3.6 DATA ANALYSIS

We used the Kaplan-Meier model estimator to assess the survival proportion with the aim to re-organize the manual of the intervention, and to reallocate the main content of the intervention in the appointments that we had more participants.

Data were analyzed to meet the study's objectives of evaluating the intervention to equip cocaine users to decrease anxiety for each component of feasibility: demand, acceptability, implementation, practicality, adaptation and safety. Qualitative data were analyzed using a thematic analysis described by Braun (Braun, Clarke, 2006).

Quantitative data were analyzed using the R program. Descriptive statistics were used to report participants' demographic, clinic and behavioral characteristics, and responses from the intervention. To determine preliminary effectiveness, we used the Linear mixed-effects model to assess the changes in the level of anxiety after the intervention. We couldn't assess the mediators of the intervention, since the number of participants that completed the intervention until the last appointment was low.

5.3.7 SCENARIO

The scenario in this health facility is singular because is located in downtown São Paulo, one of the most crowded regions in Brazil, with high levels of homelessness and a vast number of psychoactive substance available, mainly alcohol and crack. The CAPS AD attends people that seek treatment for alcohol and other drugs during the week in the period of 7 am until 7pm. During the weekends and after 7pm, there are reduced health professionals that attend only inpatient people. The CAPS AD has 8 dormitories that present eligible criteria to be occupied, such as the clients' agreement to receive inpatient treatment and the health professionals' team need to understand that the eligible' client is in vulnerable situation and the inpatient treatment is the best choice.

All individuals that seeking treatment during week in the CAPS AD, they are attending by the health professional without scheduling appointment. During this attending, clients answer demographic, clinical and behavioral questionnaire, and they are scheduling to the group appointment on Monday, or Wednesday or Friday. The appointment in group explains how the CAPS AD works, and the types of activities that the client can participate. Moreover, the CAPS AD gives breakfast, lunch and dinner for clients that participate of activities in the CAPS AD all day.

5.3.8 ETHICAL CONSIDERATION

This study was approved by the institutional review board at the Nursing School, University of São Paulo (CAEE number: 86848418.4.0000.5392) (ANNEX 3) and the

Municipal Health Secretary of São Paulo (CAEE number: 86848418.4.3001.0086) (ANNEX 4).

CHAPTER FOUR

CHAPTER FOUR

6. FIRST ARTICLE

Applying Peplau's Interpersonal Theory of Nursing to Anxiety Management in People with Substance Use Disorders

Abstract

Introduction: Peplau introduced the first middle-range nursing theory guiding the use of core interpersonal competencies in psychiatric mental health nursing. Peplau`s Interpersonal Theory of Nursing (ITN) guides the nurse to establish a mutually-invested nurse-client therapeutic relationship in which the anxiety perceived and managed by nurse and client is central to the process. **Aim:** To describe the extension and application of the ITN to the design of an anxiety management intervention for people with substance use disorders. **Methods:** Fawcett's theoretical and empirical theory development structure guided the application of the theory to the intervention components. In Step 1, we identified and described the key phenomena addressed in the conceptual mode; in Step 2, a theoretical model of the phenomena of study was developed; in Step 3, relational propositions to connect conceptual model with theoretical framework were developed; and in Step 4, the empirical structure to evaluate the intervention theory was completed. **Results:** This study provides a detailed description of the conceptual model, theoretical framework and empirical methods used during the development of an intervention theory to manage anxiety in people with substance use disorders through the translation of abstract concepts into concrete relational propositions among anxiety, self-efficacy, relief behaviors, triggers and relations from Peplau`s interpersonal theory. **Conclusion:** The Fawcett approach provides clarity about the process used in a research based nursing model, facilitating the creation and evaluation of theories. By providing a detailed description about the process of construction of the Peplau theoretical framework applied to

anxiety in substance abusers' population, replication or extension to other phenomena can be accomplished.

Keywords: Nursing; Peplau; Mental Health; Substance Use Disorders.

Introduction

Psychotherapeutic nursing started with Hildegard Peplau in 1952 when she introduced a middle-range theory guiding the use of interpersonal processes in nursing practice (Peplau, 1991). The concepts chosen by Peplau came from systematic observations from clinical work with patients with psychiatric disorders and the synthesis of behavioral and social science writings that were emerging at that time. Peplau developed the initial theory to fit all fields of nursing work(Peplau, 1991), eventually specifying the theory with applications to psychiatric mental health nursing(O'Toole & Welt, 1994) . The Interpersonal Theory of Nursing (ITN) provides the concepts and propositions that guide the nurse in establishing and strategically communicating with the client by using an observational, experiential and reflexive approach in structured and unstructured interactions. The purpose of this paper is to describe how the concepts and propositions of the ITN were used to the develop anxiety management interventions for use with people who have substance use disorders. Peplau identified the therapeutic use of the interpersonal relationship as a foundational set of core competencies for nurses through which the nurse can help the client solve health problems preventing the client`s growth and full actualization (Peplau, 1991). Disease treatment and technologies directed at physical aspects of health have dominated healthcare. Recently, however, as the prevalence of chronic conditions aggravated by health habits has increased, the central role of effective communication with and engagement of clients has been recognized by providers(Baker, Black, & Beeber, 2018). Communication is the key for accomplishing good results in all types of health treatment. The construction of a holistic health plan for clients must be based on a comprehensive assessment of the client`s problems and integration of pathophysiological,

psychological and social data into the plan. To accomplish a whole health approach to mental health issues, a dynamic analysis of the nature, determinants, factors, manifestations and consequences of the client's behaviors is helpful. "Dynamic analysis" as used here refers to the data collected by the nurse directly from the client and consensually validated with the client. According Peplau`s theory (Peplau, 1991), such a dynamic analysis occurs within an interpersonal relation between nurse and client and is powered by their interactions. These deliberate interpersonal relations in which real-time interpersonal data are made available to the client are some of the most powerful tools with which to help clients change the thoughts, feelings, behaviors and interpersonal patterns that restrict growth and are associated with recurring life problems.

A central driver of the interpersonal process is anxiety which if strategically approached, can be a key to client's health problems. Both nurse and client experience anxiety during their interactions, and while providing the energy for change, anxiety can also block productive use of the interpersonal relation to achieve growth. The main way to work with the tension of anxiety is to learn how to be aware of it and enact strategies that keep the level of anxiety in the mild to moderate range that allows it to power productive growth. The first step that nurses need to know is the nature of anxiety, how it works in their life and in the client's life to reach a meaningful therapeutic plan with clients that is theoretically informed. The aim of this article is to present the results of a theory-generating analysis that resulted in an extension of the ITN. The goal of the analysis was to bridge the gap between theory and practice through the construction of a conceptual model. The model articulates concepts of nurse-client interaction based on concepts of anxiety management in the ITN applied to people who have patterns of substance use disorders.

Methodology

The analysis used Fawcett`s model for theory-generating research (Fawcett & Garity, 2009) to extend the ITN to the population of people who have substance use disorders. The Fawcett model requires that the phenomena that are being studied are specified, the purposes to be fulfilled by the analysis are stated; and the Conceptual – Theoretical – Empirical (CTE) structure be used. (Figure 1)

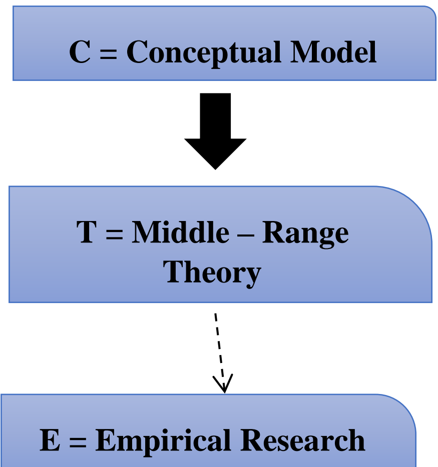


Figure 1- Conceptual – theoretical – empirical structure for theory- testing research: From conceptual model to middle-range theory to empirical research methods. From Fawcett, J.(1999)

The components of CTE are organized hierarchically according the levels of abstraction. The most abstract level is a conceptual model, in which the research is based (C); within the intermediate level is the middle range theory (T) that is generated; and the concrete level is the empirical research methods (E) that are used to conduct the research. (Fawcett & Garity, 2009)

There are four steps in the model for theory-generation. The first step is to describe the phenomena that correlate with the main concepts of the conceptual model used. In this present study, the conceptual model was the Interpersonal Relations in Nursing(Peplau, 1991); the second step is to develop a theoretical model of the phenomena of study (anxiety in substance abusers) , identifying the nature, manifestation, severity, determinants and consequences of

anxiety; the third step is to develop relational propositions to connect concepts in the conceptual model (Peplau) with a theoretical framework of anxiety; the fourth step is to develop the empirical structure for developing the intervention through the propositions linking between concepts of the conceptual model (Peplau`s theory), concepts of theory developed (theoretical model of anxiety for substance abusers) and empirical methods to evaluate the intervention theory.

Results

Phenomena of study - understanding the comorbidity of anxiety and substance use disorders

The comorbidity of anxiety and substance use disorders has been investigated by several researchers(Remes et al., 2016) and a strong association has been shown. Epidemiological and clinical studies (Kosten, Fontana, Sernyak, & Rosenheck, 2000; Kushner, Abrams, & Borchardt, 2000) have demonstrated that high levels of anxiety are associated with an increased risk of substance use disorders. Epidemiological data (Regier, Rae, Narrow, Kaelber, & Schatzberg, 1998; Wittchen, Kessler, Pfister, & Lieb, 2000) suggest that onset of anxiety is primary to onset of substance use disorders and is associated with higher rates of impairment, health care cost, and decreased work productivity (Simpson, 2010).

Studies (Cowley, 1992; Martinez-Cano, Gauna, Vela-Bueno, & Wittchen, 1999) have shown an association between specific types of psychoactive substance and anxiety levels. These include an association between cocaine use and increased risk of panic attack; alcohol and cannabis and increased of anxiety levels; and the use of opioids and sedatives as an attempt to self-medicate anxiety symptoms. These associations demonstrated that the search for relief behaviors by use of psychoactive substance can generate stronger episodes of anxiety retroactively.

According the ITN, anxiety is a tension that provide that people experience along a perceptual continuum consisting of the syntaxic perceptual mode (mild levels), parataxic perceptual mode (moderate levels) and prototaxic perceptual mode (severe levels) (Sullivan, 1953). In the syntaxic mode, mild anxiety can be beneficial because it generates focus attention and action, through energy transformations in physiological, perceptual, cognitive and behavioral functions. An example would be preparing for a presentation. In the parataxic mode, the anxiety is moderate. Linkages are present, but incomplete, broken, and reassembled in strange ways. In the prototaxic mode, anxiety is severe and the perceptual, cognitive and behavioral functions are disintegrated. Reason and words are missing, generating panic.

The energy of anxiety fluctuates in response to the degree of mobilization of energy and the person's efforts to minimize it. Efforts to minimize anxiety can be interpersonal and involve more than the person alone. The energy are transformed in physiological reaction (increase of heart rate, sweating, trembling, irritability, vertigo, foreboding, uncertainty about what might happen, anticipation of loss of control and inability to cope or to survive) and in behavioral responses (security operations development by self-system to reduce, relieve, and to prevent escalation of anxiety), that can generate consequences in the quality of life, such as inefficient and rigid performances during interpersonal relation; social isolation and loneliness; development of complicated security operations, such as use of substances. Relief behaviors such as substance use generate deterioration of one`s self-esteem (O'Toole & Welt, 1994); lead to inability to work, reduced job options and inability to do activities of daily living (Drug Intelligence Center, 2011; Whiteford et al., 2013) ; hospitalizations; memory and concentration problems; and medical and social costs (Gryczynski et al., 2016; Mark et al., 2013; McLellan & Woodworth, 2014).

Factors that contribute to anxiety

The factors that contribute to anxiety are the interpersonal relations, perceived stress, and the security operations developed to manage anxiety that affect self-esteem, self-efficacy, and health. One of the ways to reestablish mental health is through a therapeutic interpersonal relationship developed by the psychiatric nurse with the client with the objective to provide strategies to manage anxiety.

Sullivan proposed that anxiety and the early security operations originate during infancy in the interpersonal relation between the baby and mother (or the person that represent the mother function) (Sullivan, 1953). If mother exhibits anxiety, her tension induces anxiety in the baby through their connection or empathic linkage. In addition to the interpersonal relation with the mother, the baby interacts with its family members who also play an important role in the transmission of anxiety. Through interactions with these significant others, the infant evolves from prototaxic experience to parataxic experience as he develops the security operations necessary for avoiding or minimizing anxiety and securing satisfaction. Simultaneously, the infant learns to identify the forbidding gestures (modification of speech and facial posture), and becomes alert to those miscarriages of things which bring anxiety (Sullivan, 1953).

Security operations are composed of relief behaviors, relief patterns and self-transformations that are used to decrease or minimizing anxiety (Sullivan, 1953). Some security operations are problematic because their use generates isolation, loneliness and changes in the dimension of the self (Sullivan, 1953). One example of this type of problematic relief behavior, commonly used in our current society, is the use of psychoactive substances. The problem is not the use of psychoactive substances to decrease anxiety but rather in the use of substances interfering with the interpersonal relations of the individual. Disrupted interpersonal relations disturbs the self-view, self-worth, and self-esteem, and generates social isolation. In addition, environmental factors such as availability, patterns of peer group, family patterns and financial issues play an important role on substance use disorders and choice of the type of psychoactive substance. All

these issues involved in the substance use generate more anxiety resulting in social isolation, inability to do activities of daily living, stigma, marginalization, and high medical and social costs.

Stress is the subjective and objective response to a threatening stimulus (Brosschot, Verkuil, & Thayer, 2018) in the environment of the individual that acts as a trigger for anxiety. Self-efficacy is one of the dimensions of the self that is very important to the successful management of anxiety. Self-efficacy is the perception of knowledge, skills and energy to maintain safety, control and facilitate valued goals. Increased self-efficacy can decrease anxiety by improved stress management, thus decreasing stress (triggers), and the use of relief behaviors. One way to achieve these outcomes is through a therapeutic interpersonal relation between the nurse and client that will help the client reestablish health, support forward movement of the self, perceptions of wholeness, integrity, and return to function.

The theoretical framework of anxiety (Frame 4) includes the nature, manifestation, severity, determinants and consequences that define this tension. The model will guide relational propositions among these concepts.

Frame 4: Theoretical framework of anxiety

Theoretical model of anxiety	
Nature	Anxiety is a tension that is experienced in three modes of experience (prototaxic, parataxic and syntaxic). The anxiety can be in awareness (apprehension, felt discomfort and physiological reactions) or out of awareness (inability to formulate and verbalizes the precise nature of the triggering cognitive input) (Sullivan, 1953).

Manifestation	The energy of anxiety is transformed in physiological reaction (increased heart rate, sweating, trembling, irritability, restless, vertigo, foreboding, uncertainty about what might happen, anticipation of loss of control and inability to cope or to survive) and in behavioral responses (security operations, or self-system security operations to reduce, relieve, and to prevent escalation of anxiety; (O'Toole & Welt, 1994).
Severity	Anxiety is operationalized in terms of three modes of experience, prototaxic (severe and panic), parataxic (moderate) and syntaxic (mild; (O'Toole & Welt, 1994). These experiences are conceptualized according to the effects on perceptual field, the ability to focus attention, and on observable behaviors. In the mild anxiety the perceptual fields widens slightly , and the person is able to observe more than before and to see relations; the observable behaviors are heightened awareness, alertness, seeing, hearing and grasping more than before, and recognizing anxiety (O'Toole & Welt, 1994). In moderate anxiety the perceptual fields narrows slightly and there is a selective inattention; the person can be observed to see, hear, and grasp less than previously, sustain attention on a particular focus, and usually say "I am anxious now" (O'Toole & Welt, 1994). In the severe anxiety the perceptual field is greatly reduced, there is dissociation (not noticing what is going on outside), and decreased attention; the observable behaviors are seeing, hearing, and grasping far less than previously, relief behaviors are used, the inferences drawn may be distorted, and the person may be unaware of and unable to name anxiety (O'Toole & Welt, 1994). In panic, the perceptual field

	decreases, the focus is on scattered details, there is a massive dissociation especially in self-system, and the person feels enormous threat to survival; the observable behaviors are what the person says “I`m in million pieces”, “I`m gone”, “what`s happening to me?”, flight of ideas, confusion, repeats a detail, many relief behaviors and fear (O’Toole & Welt, 1994).
Determinants	The determinants for anxiety are the interpersonal relations during the person’s development – infancy (mother), childhood (parents and family), juvenile era (peers) (Sullivan, 1953). The construction of self-system, and the security operations developed in the self-system perpetuate relief behaviors, relief patterns and self- transformation. People use these strategies in an attempt to deal with anxiety, but they serve to fuel or maintain the anxiety, and sometimes anxiety appears stronger retroactively.
Consequences	The anxiety shapes the interpersonal relationships (Sullivan, 1953). Consequences of higher anxiety include inadequate, inefficient and rigid performances during interpersonal relation; social isolation and loneliness through disturbance of self-esteem; development of complicated security operations, as use of psychoactive substances which generate deterioration of one`s self-esteem (Sullivan, 1953).

Relational propositions

The relational propositions generated through the Peplau`s theory were: 1) Loneliness (social isolation) develops from lack of relation, what result in increase of stress (triggers), great anxiety and great relief behaviors, such as increase of substance abuse. 2) Stress (triggers) leads to greater anxiety and more complicated relief behaviors, such as substance use. 3) Decreased stress (triggers) leads less anxiety, fewer relief behaviors, and consequently less substance use. 4)More success (accomplishments) in your life, decreased stress (triggers), decreased anxiety generates less use of relief behaviors (less substance use), and lead to greater self-efficacy. 5) Greater self-efficacy will lead to fewer relief behaviors and decreased stress (triggers), anxiety and relief behaviors (less use of substances). 6) The therapeutic interpersonal relation (nurse and client) can be used to decrease stress (triggers), anxiety, relief behavior and increased self-efficacy.

Management of anxiety

Nursing intervention described by Peplau (Peplau, 1991)(O'Toole & Welt, 1994) is a particular form of pattern integration that is deliberate, systematic, phasic and collaborative (nurse and client agreements and mutual investment). Psychiatric mental health nursing intervention is a process whereby the security operations of the client that interfere with health are identified, observed, and changed using selected modalities within the context of the mutual nurse-client relationship. The interpersonal relation is composed by 3 phases: orientation (the phase in which the client determines what help is needed, why it is needed, from whom it will come, what will be done; working is the phase of intervention which nurse and client use the modalities described below to enact systematic change; and termination is the phase of intervention when nurse and client end the relationship.

Anxiety is a universal phenomenon because everyone experiences the discomfort of anxiety in some degree at some time throughout life. The main characteristic of intervention to decrease

anxiety is to position the client to become aware of and name anxiety through empathic linkage, syntax, awareness, identification, elaboration, reckoning and alignment to reach a good manage of anxiety (phases of the therapeutic intervention).

Empathic linkage is important in the interpersonal relationship between nurse and client, because during the interaction, an exchange of energy occurs (usually in the form of anxiety) and the formation of pattern integration, which is frequently called the "bond" between nurse and client. Without empathic linkage it is impossible to decrease anxiety and to start the collaborative process of changing problematic security operations in the client. After the empathic linkage is established, the first step is to transform the parataxic mode of anxiety into syntaxic mode, through the transformation of unpleasant feeling into words, ideally by the client using their own words and mental images. This process is followed by awareness of anxiety.

When the client is aware of anxiety he needs to identify the expectations (assumptions, wishes, wants, beliefs, goals, self-views), elaborate the meaning of expectations and identify the relief behaviors used when the expectations is not achieved (O'Toole & Welt, 1994). Only after these steps nurses will use "reckoning," a process of deliberate changing of security operations in an interpersonal context, and fitting a new security operation with other patterns and pattern integrations (alignment) (L S Beeber & Bourbonniere, 1998; Linda S Beeber, Canuso, & Emory, 2004).

Conceptual- Theoretical- Empirical (CTE) structure

To understand the phenomenon of anxiety and how nurses can work with a specific population who used psychoactive substances as a relief behavior, we articulated this data in a CTE structure. The conceptual model used was Peplau`s Interpersonal Relationship in Nursing; the intervention theory that will be tested is the brief interpersonal relationship to equip substance abusers to manage anxiety: and finally, the empirical research methods are the general self-

efficacy scale (GSE) to evaluate the self-efficacy, medical outcome study scale (MOS- SSS) to evaluate relation, perceived stress scale (PSS) to evaluate triggers, generalized anxiety disorders (GAD-7) to evaluate anxiety, and the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) to evaluate substance use disorder . The frame below describes the CTE structure (Frame 5)

Frame 5 – Conceptual-theoretical-empirical structure

Peplau`s Adaptation Model – **C**	Self	Relation	Stress	Anxiety	Security Operations
Concepts of interpersonal theory of nursing to anxiety management in people who substance use disorders- **T**	Self-efficacy	Relation	Triggers	Level of anxiety	Relief behaviors
Empirical Research - **E**	GSE (General self-efficacy scale)	MOS SSS – (Medical Outcome Study - Social Support Scale)	PSS (Perceived Stress Scale)	GAD – 7 (Generalized Anxiety Disorders) BAI (Beck Anxiety Inventory)	ASSIST (Alcohol, Smoking and Substance Involvement Screening Test)

The propositions linking between conceptual model and theoretical model were: The self-mode was represented by self-efficacy, the relation mode was represented by relation, the stress mode was represented by triggers, the anxiety mode was represented by anxiety level, the security operations were represented by relief behaviors as a substance abuse.

Discussion

This study describes and interconnects the main concepts of the interpersonal theory of psychiatry (Sullivan, 1953) and the application of these concepts in psychiatric nursing practice proposed by Peplau and extended by Beeber (Peplau, 1991), through the translation from the abstract conceptual model of Peplau`s theory to a theoretical framework. The theory is concise and applicable in daily routine of psychiatric nurses.

The development of the theoretical framework of the brief interpersonal relationship in nursing to manage anxiety in substance users according CTE will help to develop a strong intervention connected by a conceptual model, theoretical and empirical structures, and evaluated using a clear connection among the CTE components. Additionally, the CTE structure is useful to be applied as a model in the research, learning and practical scenarios.

Although many studies of anxiety have been conducted, mainly focusing on the efficacy and effectiveness of psychotherapy and pharmacotherapeutic treatments (Cuijpers et al., 2013), few studies have demonstrated the theoretical framework on which the intervention is based. This study specified the determinants of intervention; replication; and evaluation of intervention through criteria of internal consistency, and empirical and pragmatic adequacy.

The majority of studies focusing on the efficacy of psychotherapies and therapies provided by nurses (Hosseinzadeh Asl & Barahmand, 2014; Hyun, Chung, De Gagne, & Kang, 2014) lacked clarification of conceptual model based in theories of nursing.

Conclusion

This study provides a detailed description of concepts and applications from Peplau`s interpersonal theory in nursing to nowadays nursing context. Additionally, the study provided tools to guide future researchers during the development of intervention theory, through the translation of theories in nursing into empirical research methods.

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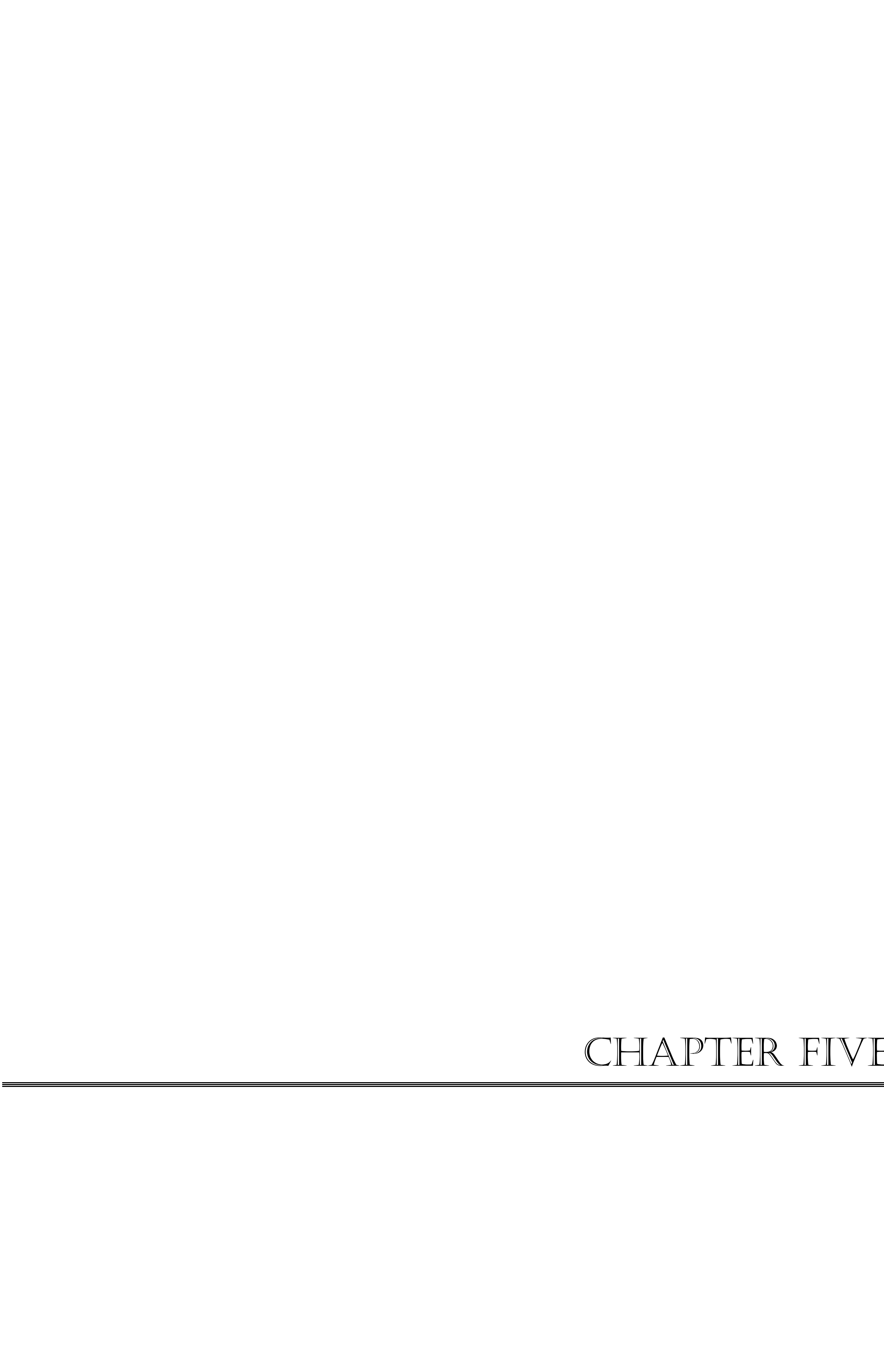


CHAPTER FIVE

CHAPTER FIVE

7. SECOND ARTICLE

An anxiety management intervention for Brazilian cocaine users: an intervention mapping approach based on Peplau`s theory

Abstract

Background: The comorbidity of anxiety and drug use disorders complicates treatment prognosis and one of the greatest challenges is to address the environmental and behavioral factors involved. The aim of this study was to describe the uses of intervention mapping in the design of a theory and evidence-based complex intervention, to develop skills around the management of anxiety for Brazilian cocaine users in outpatient addiction treatment in Sao Paulo city. **Methods:** The study used the six steps of the intervention mapping approach, which are needs assessment; creating matrices of performance objective; selecting methods and practical strategies; program development; adoption and implementation; and evaluation. The theory used to conceptual model was Interpersonal Relations Theory by Peplau and we selected some methods of other theories to achieve certain outcomes of intervention. All the theory-based methods and practical applications were developed at the individual level, acting in behavioral, interpersonal, organizational and community environment. **Results:** The intervention mapping provided a broad overview of the problem and outcomes expectations, through the development of model of problem and model of change consecutively. A list of plans was created to target behavioral (to manage cocaine use; and to improve sleep, eating and physical activity) and environmental outcomes (to manage social isolation and to reengage in society) that contribute to increase of anxiety, based on determinants of anxiety (knowledge, triggers, relief behaviors, self-efficacy and relations). **Conclusions:** The Intervention mapping approach increases the effectiveness of the intervention because the matrices provide a broad view of all factors that affect the problem, and facilitates replication through transparency of the determinants, methods, and applications used.

Keyword: Intervention Mapping, Anxiety, Peplau`s Theory, Cocaine

Introduction

The comorbidity of anxiety with drug use disorders has been investigated by several researchers(Remes et al., 2016) and a strong association has been shown. This association complicates treatment prognosis, increases services utilization and health care costs generating

a global issue. The main challenges are to address both anxiety and drug use disorders by identifying the relation between them and the environmental and behavioral factors involved.

Anxiety is one of the most prevalent health problems worldwide generating health care costs, a high burden of disease, and implications associated with untreated illness that affect health, economy and social sectors(*Depression and Other Common Mental Disorders Global Health Estimates*, 2017). According to the World Health Organization (WHO) (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017) the consequences of anxiety disorders occupied 6th position in the ranks of contributors to global disability. Clinical reviews have shown that the presence of an anxiety disorder is a risk factor for the development of mood disorders and substance abuse (Remes et al., 2016) and is highly comorbid with other mental disorders.

Research has shown that there was an increase of 14.9% of people living with anxiety since 2005 (Vos et al., 2016) and 21% of that estimated number are in the Region of Americas (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017). In Brazil the prevalence of anxiety disorders is 9.3% (*Depression and Other Common Mental Disorders Global Health Estimates*, 2017) of the population and another factor that has been shown to be related to this prevalence is the increase of cocaine users in the country. Due this increase, Brazil has been identified as one of the emerging nations where the use of cocaine has been increased when compared with other regions where it has been gradually decreasing, such as United States of America and Europe(UNODC, 2012). Nowadays cocaine is the most used stimulant in Brazil, one explanation being that Brazil is the largest cocaine market in South America because of its geographic position (neighboring the world`s largest cocaine producers – Peru, Colombia and Bolivia) (UNODC, 2012); and because it has the cheapest cocaine in the world (Vos et al., 2016). Previous study (Abdalla et al., 2014) showed that the prevalence of cocaine users in the country represents roughly 3.2 million of people. This high prevalence occasioned an increase of cocaine users arriving in emergency care, resulting in three times more Brazilian cocaine users arriving in emergency care when compared with cocaine users worldwide (“The Global Drug Survey 2015 findings | Global Drug Survey,” 2015). The fact of this high demand in emergency care demonstrates that it is necessary to work hard in specialized facility to treat person with substance disorder to avoid this high demand in emergency care.

The major challenge of this population is keeping them in the specialized treatment, as long as the high level of anxiety is the mainly cause for relapse and withdrawal of treatment. The key for keeping this population in treatment is to treat the anxiety experienced by cocaine users.

Then, this article presents the development of a theory and an evidence-based intervention to the researchers in early intervention focusing on the management of anxiety in cocaine users, in which the focus was on the steps of Intervention Mapping (IM) approach.

Method

The methodology used to develop the intervention was the systematic Intervention Mapping (IM)(Bartholomew et al.,2016) development process. IM is a framework consistent with Medical Research Council (Craig et al., 2008) guidance on developing complex interventions and it has been used to develop intervention programs for many health behaviors (Bartholomew et al., 1998; Fernández et al., 2005; Hurley et al., 2015; Munir et al., 2013; Van Empelen et al., 2003), because it employs an ecological approach that considers environmental influences on behavior and develops methods and strategies to address them (Bartholomew et al., 1998).

IM is very useful because it specifies processes for integrating theoretical constructs and evidence-based literature for purposeful of the intervention through description of a logical planning process. IM is a six-step process structured and sequenced as follows: (1) needs assessment (logical model of the problem); (2) creating matrices of performance objective (logic model of change); (3) selecting theory-based methods and practical strategies (program design); (4) program development; (5) adoption and implementation, and (6) evaluation.

Step 1: Needs assessment

The aim of step 1 was to develop the logic model of the problem to program goals for the intervention related to health and quality of life. This logic model was based on the combination of comprehensive understanding about the problem through Peplau`s theory, empirical data about the factors that contribute to the problem, and experiential information about the problem. Besides this, this step focuses on the description of intervention context (population, setting and community).

Step 2: Creating matrices of performance objective

Step 2 of IM is followed by: 1) a statement of expected outcomes for behavior and environment and develop performance objectives for behavioral and environmental outcomes;2) selected determinants for behavioral and environmental outcomes; 3) the construction of matrices of change objectives and create the logic model of change.

The main aim of this step is the development of the logic model of change, which represents pathways of the intervention that acts in behavioral and environmental perspective, through the connection between determinants and change objectives, performance objectives, desired outcomes and the improvement of quality of life in relation to the health problem that is anxiety.

Step 3: Selecting theory-based methods and practical strategies

Step 3 is to generate program themes, components, scope and sequence. To accomplish this aim we chose Peplau`s theory as a conceptual model and method, and evidence-based selected methods to reach change objectives. We also used published guidance on intervention mapping approach (Bartholomew et al., 2016) to choose some methods, according the definition and parameter of each one.

Step 4: program development

The team guided by matrices started to refine program structure and organization, prepare plans for program materials, develop specific messages, materials and protocols. The change objectives were converted into practical applications using a range of evidence-based research. In the end of this step the definitive intervention content and materials were created based on relevant additions made through the team discussion.

Step 5: adoption and implementation

The aim of the program implementation plan was to find out the balance between what was planned and what can be implemented in the real world, through the identification of potential users (adopters, implementers and maintainers) and the context that they are inserted, resulting in a better design for implementation. Additionally, the manual of intervention was adapted to increase the chances of adoption, implementation and sustainability.

Step 6: evaluation

After the step 5, plan for program adoption and implementation, there was the evaluation of this program through operational definitions of feasibility, such as acceptability, demand, practicality, and adaptation.

And the feasibility study to evaluate the program of intervention is not in the scope in the current paper, they will only briefly be discussed in the results and discussion section.

Theoretical approach

According to IM it is important to use a theory and evidence to specify determinants, behavioral and environmental factors that are related with the health problem that the intervention intend to address. The present intervention used the Peplau’s Interpersonal Theory of Nursing (ITN) (Peplau, 1991) to conceptual model and we selected some methods of other theories to achieve certain outcomes of intervention based on empirical findings. The ITN is a middle range theory used for nursing in psychotherapeutic intervention, and we used some concepts of that theory as a determinant of anxiety.

Results

Intervention development

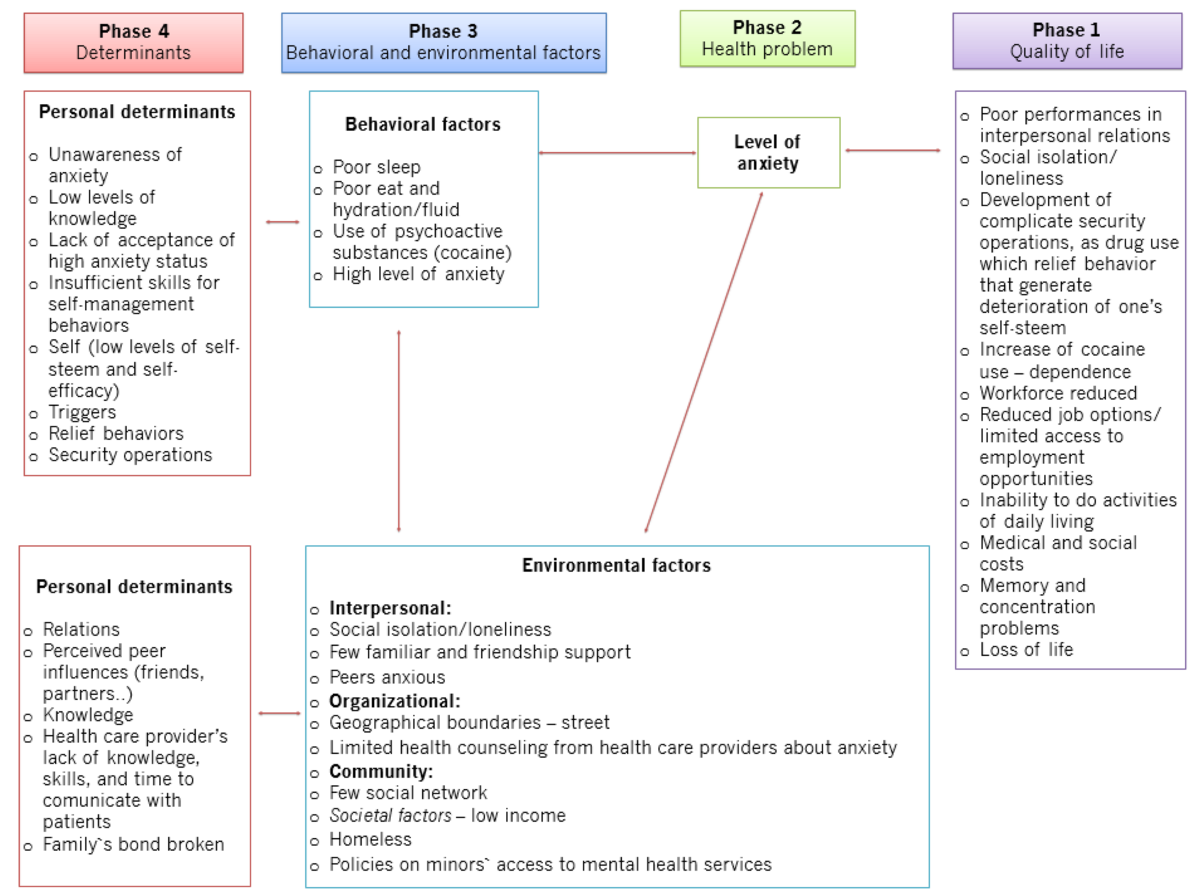
Step 1: Needs assessment

The priority population was adult male cocaine user (age > 18 years) with anxiety resident in Brazil. We focus in male cocaine user, due the higher prevalence of crack use by adults, especially among young males(Horta, Horta, Rosset, & Horta, 2011; Linhares Garcia, Grasel Zacharias, & Sontag, 2012; Smart, 1991), and because we understanding that there are differences between the sexes in brain chemistry, physiology and the way that they tend to lead with stress and anxiety (Remes et al., 2016). In Brazil cocaine user has been identified as a major health and social problem, owing to the increase of users presenting at health facilities and increase in illegal activities affecting urban security (Toledo, Cano, Bastos, Bertoni, & Bastos, 2017).

According to the theoretical explanation by Peplau`s theory, cocaine use is a kind of relief behavior used to decrease anxiety, and it can be transformed into a pattern of behavior that changes the self-system. Therefore, to treat cocaine user it is necessary to treat the anxiety felt by cocaine users, because is the anxiety that generates the start of cocaine use and it is anxiety that plays an important role on relapse and to keep patients in treatment.

We developed a logic model of problem to connect all behavior and environmental factors that play an important role in anxiety, the determinants and the consequences on quality of life (figure 3).

Figure 3: Logic model of problem



Step 2: Matrices

To achieve the first step of the Step 2 we worked from the needs assessment and integrated theoretical framework to specify behaviors and environmental conditions that the program would promote, using the logic model of the problem (figure 3) as a guide to develop desired behavioral and environmental outcomes and after create performance objectives for each behavioral and environmental outcome (table 3).

Table 3: Expected outcomes for behavioral and environmental outcomes

Desired behavioral outcomes and performance objectives (P.O) of the intervention
Behavioral outcome 1: Establish a healthy sleep pattern P.O 1 Selects pattern of sleep relevant to lifestyle P.O 2 Selects physical activities relevant to lifestyle

P.O 3 Monitors progress in increasing sleep P.O 4 Copes with the challenges encountered with engaging in selected pattern of sleep
Behavioral outcome 2: Establish a healthy eating P.O 1 Selects pattern of food relevant to lifestyle P.O 2 Monitors food intake P.O 3 Copes with the challenges encountered with engaging in selected pattern of food
Behavioral outcome 3: Manage cocaine use P.O1 Monitors Cocaine use P.O 2 Copes with the challenges encountered with engaging in less cocaine use
Behavioral outcome 4: Manage anxiety P.O 1 to become aware of and name anxiety P.O2 to become aware of and state the connection between the named anxiety and the behavior used to relieve it P.O 3 Formulate operative expectations P.O 4 Formulation and recognition of the connection between expectations held and what happened instead P.O 5 Consider which factors in the sequence are amenable to control
Desired environmental outcomes and performance objectives (P.O) of the intervention
Interpersonal Environmental
Environmental outcome 1: Social isolation/loneliness – *Decrease social isolation and loneliness* P.O 1 to meet different places P.O 2 to try contact with his family P.O 3 to establish network with other people P.O 4 to have contact with persons who can help him in the field of work collaboratively and live productively with them P.O 5 to be more physically active
Environmental outcome 2: Have relationships healthy with friends, peers and family P.O 1 to evaluate past, current, and potential relationships P.O 2 to avoid relationships with friends, peers and parents that are not healthy
Organizational Environmental
Environmental outcome 3: *to get out of homeless situation*

P.O 1 to find a "shelter houses" P.O 2 to keep contact with his family and maybe came back to his family`s house
Community Environmental
Environmental outcome 4: to be reinserted in society P.O 1 to avoid dangerous places or places that reminder his pattern behavior P.O 2 to find social support to homeless people P.O 3 to know policies to homeless people and addictive persons

The determinants were developed by adaptation of Peplau`s concepts. The first step of this adaptation was to choose some Peplau`s concepts that are related with anxiety and drug abuser, and after to develop relational propositions among them. The determinants of anxiety were knowledge, triggers, relief behaviors, self-efficacy and relations developed in a behavioral and environmental perspective (table 4).

Table 4: Determinants for behavioral and environmental outcomes

Work on behavior' determinants in individual level	
Preliminary List	**Final List**
Unawareness of anxiety	Awareness
Lack of acceptance of high anxiety status	Awareness
Low levels of knowledge about anxiety	Knowledge
Insufficient skills needed for self-management behaviors	Skills
Confidence about avoiding situations that make it hard to say no to inputs that increase anxiety	Self = self-efficacy and self-esteem (effective communication and refusal)
Ability to refuse cocaine	Skills (effective communication and refusal) – relief behaviors
Situations which could lead to increase of anxiety	Triggers
Low self-efficacy	Self = self-efficacy and self-esteem (effective communication and refusal)
Use of psychoactive substance	Security operations

Work on environmental' determinants in individual level	
Preliminary List	**Final List**
Perceived peer influences (friends, partner, family)	Relations
Relations	Relations
Health care provider`s lack of knowledge, skills, and time to communicate with patients, train them in self-management skills, and reinforce self-management	Skills/ self-efficacy + knowledge
Family`s bond broken – family breakdown	Relations
Community`s misguided beliefs about the comorbidity (anxiety and cocaine use), lack of knowledge and lack of policies	Skills/ self-efficacy + knowledge
Policy makers` beliefs about addiction health (abstinence)	Skills/self-efficacy + knowledge
knowledge	knowledge

The last step of step 2 was to integrate the behavioral and environmental outcome with performance objectives and determinants. The first thing that we developed was the logic model of change (figure 4) and through this model we constructed the matrices of change objectives based in each behavioral and environmental outcome (table 5). For example, the behavioral outcome "stablish a healthy sleep pattern" has four determinants (knowledge, triggers, relieve behaviors and self-efficacy), and for each determinant we wrote a performance outcome (specific outcome) that it will be expected to occur as a result of the intervention. In the determinant triggers, one of the performance objectives created was "analyze the triggers that are present in his lifestyle that interfere in the sleep".

Table 5: Construct matrices of change objectives

Behavior: Establish a healthy sleep pattern				
Performance Objectives	Knowledge	Triggers	Relief Behaviors	Self-efficacy/ Self-esteem and Skills
P.O 1 Selects pattern of sleep	K.1 Knowledge about the most	T.1 Analyze the triggers	RB.1 Create new security	SES. 1 Express confidence in ability to

relevant to lifestyle	common pattern of sleep	that are present in his lifestyle that interfere in the sleep	operations to achieve sleep	adequate pattern of sleep in his lifestyle
P.O 2 Selects physical activities relevant to lifestyle	K.2 Knowledge of the benefits of physical activities to improve the sleep	T. 2 Identify the triggers that interfere to not do physical activity	RB.2 Identify physical activity as a relief behavior	SES. 2 Express confidence in ability to do physical activity
P.O 3 Monitors progress in increasing sleep	K.3 Knowledge about your habitual pattern of sleep	T.3 Evaluate the triggers that are still present in the sleep	RB.3 Distinguish the security operations that difficult the sleep from that help a good sleep	SES. 3 Express confidence in ability to change pattern of sleep
P.O 4 Copes with the challenges encountered with engaging in selected pattern of sleep	K.4 Knowledge of the challenges to achieve a good pattern of sleep in your reality and possible safer places to sleep	T.4 Modify the triggers that interfere in the pattern of sleep	RB.4 Modify the relief behaviors that is used to achieve the sleep	SES. 4 Express confidence in ability to face the challenges encountered toward pattern of sleep
Behavior: Establish a healthy diet				
P.O 1 Selects pattern of eating relevant to lifestyle	K.1 Knowledge about the possible pattern of eating in his lifestyle	T.1 Analyze the triggers that are present in his lifestyle that interfere in his diet	RB.1 Create new security operations to achieve a good eating in his lifestyle	SES. 1 Express confidence in ability to adequate pattern of eating in his lifestyle
P.O 2 Monitors food intake	K.2 Knowledge about the right pattern of eating	T.2 Evaluate the triggers that are still present in the diet	RB.2 Distinguish the security operations that difficult the healthy diet from	SES. 2 Express confidence in ability to monitor one`s own food intake

			that help a good diet	
P.O 3 Copes with the challenges encountered with engaging in selected pattern of eating	K.3 Knowledge about the places to eat a healthy food	T.3 Modify the triggers that interfere in the healthy food	RB.3 Modify the relief behaviors that is used to achieve the healthy diet	SES. 3 Express confidence in ability to face the challenges encountered toward pattern of eating
Behavior: Manage cocaine use				
P.O1 Monitors Cocaine use	K.1 List characteristics about the habitual consumption of cocaine	T.1 Analyze the triggers that are present in his lifestyle that interfere direct or indirect to cocaine use	RB.1 Create new security operations his lifestyle	SES.1 Express confidence in ability to monitor one`s own cocaine use
P.O 2 Copes with the challenges encountered with engaging in less cocaine use	K.2 Describe the possible challenges with engaging in less cocaine use	T.2 Modify the triggers that interfere in the cocaine use	RB.2 Modify the relief behaviors	SES.2 Express confidence in ability to generate coping strategies to deal with the challenges
Behavior: Manage anxiety				
P.O 1 to become aware of and name anxiety	K.1 Knowledge about what mean anxiety	T.1 Identify the triggers for anxiety	RB.1 Identify the security operations used during anxiety	SES. 1 Express confidence to recognize anxiety
P.O2 to become aware of and state the connection between the named anxiety and the	K.2 State characteristics of behaviors used to relieve anxiety	T.2 Define the connection between triggers and anxiety	RB.2 Analyze the security operations used	SES.2 Demonstrate the ability to stablish connection between behaviors that is used to relieve anxiety

behavior used to relieve it				
P.O 3 Identify the operative expectations formulated	K.3 Knowledge about the influence of expectations	T.3 Analyze the triggers involved in the operative expectations	RB.3 -----------	SES. 3 Express confidence to recognize expectations
P.O 4 Formulate and recognition of the connection between expectations held and what happened instead	K.4 Knowledge about the connection of expectations and what happened instead	T.4 Appraise the connection among triggers, expectations and what happened instead	RB. 4 Identify if the relief behavior are connected with the expectations	SES. 4 Demonstrate the ability to stablish connection between expectations held and what happened instead
P.O 5 Consider which factors in the sequence are amenable to control	K.5 Knowledge about the connection between the factors and anxiety that could be control	T.5 Categorize the factors in possible triggers for anxiety	RB.5 Modify the security operations that it is possible change	SES. 5 Express confidence to change some expectations and factors to break the cycle

Interpersonal Environmental: Decrease social isolation and loneliness			
Performance Objectives *Clients will:*	Knowledge	Relations	Self-efficacy and Skills
P.O 1 Identify different places	K. 1 Knowledge about different places near of the place that he lives	R.1 Prepare to interpersonal bonds in news places	SES. 1 Recognize barriers to know different places
P.O 2 Contact his family	K.2 L Knowledge about his family history	R.2 Propose to reestablish relational bonds	SES.2 Express confidence to establish contact with his family
P.O 3 Establish network with other people	K. 3 Diffuse knowledge about the importance of healthy network	R.3 Establish interpersonal bonds in news places	SES. 3 Express confidence in your ability to establish

			healthy networks for patient
P.O 4 Establish contact with people who can help him in the field of work	K.4 Diffuse knowledge about the importance of network that can help with his field of work	R.4 Find healthy networks with other people	SES. 4 Express confidence to contact people who can help him in the field of work
P.O 5 To be more physically active	k. 5 Knowledge about physical activities programs in different places near of the place that the client lives	R.5 Establish relational ties to support physical activity	SES. 5 Express confidence to practice physical activity
Interpersonal Environmental: Have relationships healthy with friends, peers and family			
P.O 1 Evaluate past, current, and potential relationships	K.1 Knowledge about the past, present and future relationships	R. 1 Deep understanding about his interpersonal relations that are significant (relational bonds and relational ties)	SES. 1 Recognize the relationships
P.O 2 Avoid relationships with friends, peers and parents that are not healthy	K.2 Knowledge and strategies about how to avoid unhealthy relationships	R.2 Recognize unhealthy relational bonds and relational ties	SES. 2 Express confidence in ability to change/ finish problematic relationships
Organizational Environment: support patients to get out of homelessness situation			
P.O 1 Find a “shelter houses”	K.1 Knowledge about the shelter houses available in his environmental scenario and the shelter’ rules	R.1 Consider “shelter houses” as a relational tie	SES. 1 Express confidence to find a best shelter house for his reality
P.O 2 Keep contact with his family	K.2 Knowledge about the importance of family	R.2 Synthesize the dynamic of family`s bond	SES. 2 Express confidence to keep contact with his family
Community Environment: support patients to be reinserted in society			

P.O 1 Avoid dangerous places or places that reminder his pattern behavior	K.1 Knowledge about the advantages to avoid dangerous places or places that reminder his pattern behavior	R.1 Deep understanding about the relations in dangerous place	SES. 1 Express confidence to deal with environmental cues
P.O 2 Know about social support to homeless people	K.2 Knowledge about the social support available in his city	R.2 Establish relational ties to achieve social support	SES. 2 Express confidence to know social support in his region
P.O 3 Know policies to homeless and addictive people	K. 3 Knowledge about the specific policies to homeless and addictive people available in his city	R.3 ------------------	SES. 3 Express confidence to search some important policies

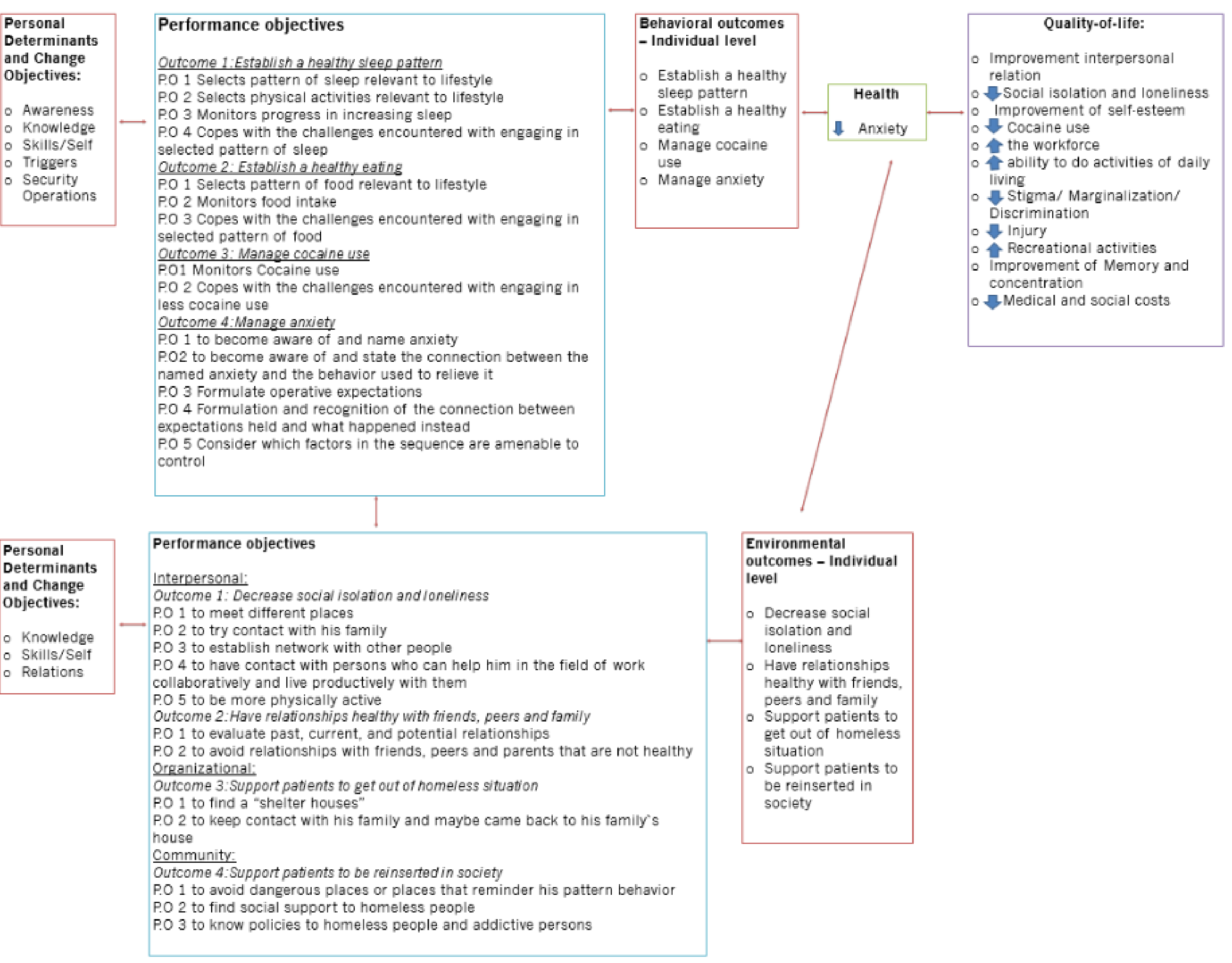


Figure 4 – Logic model of change

Step 3: Selecting theory-based methods and practical strategies

The first task was to organize all the change objectives created on step 2 together with the performance objectives in one column, according with determinants that they were associated. The second task was to match change objectives with specific determinant and methods selected. And the fourth task the team start to think about applications, that is strategies to operationalize the delivery of these methods, for each change objectives (table 6). For example, the determinant "relief behavior" along with the performance objective "monitors progress in increasing sleeping" was linked to change objective "distinguish the relief behaviors that difficult the sleep from that help a good sleep". The method used to achieve this objective was active learning, which was translated into practice application through the statement: "to develop a table with 2 columns which one column will be to relief behaviors that help sleep and the other it will be to relief behaviors that is bad to sleep".

Table 6: Determinants, change objectives (PO + change objective), methods and application

Determinant: Knowledge - *Individual level – Behavior* *Behavioral outcome 1*: Establish a healthy sleep pattern		
Change objectives	**Methods**	**Application**
P.O 1 Selects pattern of sleep relevant to lifestyle K.1 Knowledge the most common pattern of sleep (1.1-1.2)	1.1 Consciousness raising 1.2Using imagery	1.1 Guideline about the common pattern of sleep 1.2 Image with the time of sleep and the mood relation (tired, very tired, well)
P.O 2 Selects physical activities relevant to lifestyle A.2 Knowledge of the benefits of physical activities to improve the sleep (1.3-1.5)	1.3 Consciousness raising 1.4 Using imagery 1.5 Belief selection	1.3 Guideline about the beneficious of physical activity (paper or media) 1.4 Image about the function of physical activities on the body (paper or media) 1.5 Videos/newsletter about the relation between physical activities and improve of sleep

P.O 3 Monitors progress in increasing sleep K.3 Knowledge about the habitual pattern of sleep (1.6)	1.6 Self-monitoring of behavior	1.6 Diary to do notes about your pattern of sleep (notebook)
P.O 4 Copes with the challenges encountered with engaging in selected pattern of sleep A.4 Knowledge of the challenges to achieve a good pattern of sleep in your reality and possible safer places to sleep (1.7-1.11)	1.7 Consciousness raising 1.8 Active learning 1.9 Consciousness raising 1.10 Mobilizing social support 1.11 Reinforcement	1.7 Discussion about the challenges to achieve a good pattern of sleep 1.8 Development of an individual list (paper) pointed the individual`s challenges 1.9;1.10 Provide a list (with localization and contact) with safer places that the client can go to sleep 1.11 Provide information about how safer place contribute to stablish a healthy sleep pattern
Behavioral outcome 2: Establish a healthy Diet		
Change objectives	**Methods**	**Applications**
P.O 1 Identify the most common pattern of eating K.1 Knowledge about the most common pattern of eating (1.1-1.2)	1.1 Consciousness raising 1.2Using imagery	1.1 Guideline about the common pattern of eating 1.2 Image with the foods that the individual can eat per day
P. O 2 Identify your habitual pattern of eating K.2 Knowledge about your habitual pattern of eating (1.3 -1.4)	1.3 Self- monitoring of behavior 1.4 Feedback	1.3 Diary of food intake 1.4 Feedback about the match between the hope health habit of eating and the current individual habit
P.O 3 Identify the places to eat healthy food	1.5 Consciousness raising 1.6 Feedback	1.5 List about the places to eat

K.3 Knowledge about the places to eat healthy food (1.5 -1.6)		1.6 Feedback about the places to eat and the good food for eat
P.O 4 Selects pattern of eating relevant to lifestyle K. 4 Knowledge about the challenges to achieve a good pattern of eating in your reality (1.7 -1.8)	1.7 Consciousness raising 1.8 Active learning	1.7 List with some triggers to bad consumption of food 1.7 Discussion about the challenges to achieve a good pattern of eating 1.8Development of an individual list pointed the individual`s challenges
Behavior outcome 3: Decrease cocaine use		
Change objectives	**Methods**	**Applications**
P.O1 Monitors Cocaine use K.1 Knowledge about the habitual consumption of cocaine and the characteristics of his habitual consumption (1.1 -1.3)	1.1 Consciousness raising 1.2 Self-monitoring of behavior 1.3 Using Imagery	1.1; 1.2 Diary of cocaine use and other substance psychoactive normally used together 1.3 Image with a measure of cocaine (one rock, 250 grams) 1.3 Image with measure of other substance abuse (alcohol) 1.1; 1.3 Knowledge about the pathways of cocaine by figure and video 1.1; 1.3Knowledge about the pathways of cocaine and other substance abuse by figure and video
P.O 2 Copes with the challenges encountered with engaging in less cocaine use A. 2 Knowledge about the challenges to decrease consumption of cocaine (1.4- 1.6)	1.4 Consciousness raising 1.5 Active learning 1.6 Self-monitoring of behavior	1.4List with some triggers to consumption of cocaine 1.4;1.5 Discussion about the challenges to achieve less consumption of cocaine 1.4; 1.5Development of an individual list pointed

		the individual`s challenges 1.4 ;1.6 Diary of cocaine use with description of place, time, and people that the individual used to do consumption
Behavior Outcome 4: Decrease anxiety		
Change objectives	**Methods**	**Applications**
P.O 1 to become *aware* of anxiety, name of anxiety and *knowledge* of anxiety K.1.Knowledge about anxiety and what mean anxiety (1.1 – 1,3)	1.1 Consciousness raising about anxiety 1.2 To be awareness of anxiety - Peplau`s theory – Nursing Verbal Interventions 1.3 Providing cues	1.1 Give some neurophysiological effects of anxiety related with body reactions through images or videos 1.2Do some questions to the individual: - “Are you anxious?”; “Are you nervous?”; “Are you nervous now?”; “Are you upset?”; “Are you tense now?” 1.3 If the person says he is not anxious, you should apply some fiction case about a person with anxiety, adequate this case by reality of individual, because the individual can compare you with this person described in fiction case. If the person says “yes” for the questions above, you should follow for the questions bellow
P.O2 to become aware of and state the connection between the anxiety and the behavior used to relieve it	1.4 Syntax - Peplau`s theory – Nursing Verbal Interventions	After he said “yes” for the questions above. Do some questions to the individual for he realized the connection – “What are you doing now to

K.2 Knowledge about the connection between the anxiety and behaviors (1.4)		relieve being nervous?"; " What are you doing now to relieve it?" If the client says : - "nothing", the nurse may ask: "What do you usually do to get comfortable?"; "When upset in the past, what did you do then?"
P.O 3 Identify behaviors used to relieve anxiety K.3 State (knowledge) characteristics of behaviors used to relieve anxiety (1.5 -1.7)	1.5 Consciousness raising- 1.6 Self-reevaluation 1.7 Environmental reevaluation	1.5,1.6 List the characteristics of behavior and name behaviors 1.7 Encourage the patients to describe how their family members (or peers, friends) feel about these behaviors
P.O 4 Identify the expectations K.4 Knowledge of the expectations (wish, desire, goal...) (1.8)	1.8 Identification - Peplau`s theory – Nursing Verbal Interventions	1.8After the patient is clearly aware of the relation between anxiety and behaviors, then a nurse ask: - "What were you thinking about before you felt upset?"
P.O 5 Identify the operative expectations formulated K.5 Knowledge about the influence of expectations (1.9)	1.9 Elaboration - Peplau`s theory – Nursing Verbal Interventions	1.9 When the expectations are held, up front in mind the patients need to elaborate the meaning of expectations; - "What expectations?"; "Origins?"; "How long held?"; "how important?" "Can they be changed or given up?"; "Was the expectation reasonable – capable of fulfillment?" Identify the discomfort felt, experienced in : "what part of body?"; "what degree?"; "what was noticed by patient?"

P.O6 Formulate and recognition of the connection between expectations held and what happened instead K.6 Deep knowledge about the expectations and stuffs that happen after expectations (1.10)	1.10 Consciousness raising	1.10 List the expectations and stuffs
P.O 7 Formulate and recognition of the connection between expectations held and what happened instead K.7 Knowledge about the connection of expectations and what happened instead (1.11 – 1.12)	1.11 Syntax 1.12 Identification	1.11 When the patient has clearly formulated an expectation, then ask: - "What happened instead?" When the expectations held are not met, the patients need to think about: - "What interfered in the achieve of expectations?"; "what happened instead of expectations?"; "who was to meet the expectation, when, how, what the evidence?" And identify the relief behaviors used when the expectation is not achieved: - "what behavioral act or acts related to what pattern?" 1.12 And identify the relief behaviors used when the expectation is not achieved: - "what behavioral act or acts related to what pattern?"
P.O 8 Consider which factors in the sequence are amenable to control K.8 Knowledge of the factors involved in what happened instead of	1.13 Consciousness raising 1.14 Reckoning	1.13 List factors that can be amenable 1.14 Revise the expectation in relation to what is possible

expectations that can be amenable (1.13 – 1.14)		
P.O 9 Consider which factors in the sequence are amenable to control K.9 Knowledge about the connection between the factors and anxiety that could be control (1.15-1.16)	1.15 Active learning 1.16 Environmental reevaluation	1.15 Discuss about what change might be possible, after you identify and control some factors in the situation that happened instead of expectations, through this questions: " What do you think you will feel when the expectations doesn`t occur? What happened instead? 1.16 List the discomfort felt, and relief behaviors used

Determinant: knowledge – *Interpersonal level – Environmental* *Interpersonal outcome:* Decrease social isolation and loneliness		
Change objectives	**Methods**	**Applications**
P.O 1 To meet different places K. 1 Knowledge about different places near of the place that client live (1.1 – 1.3)	1.1 Consciousness raising 1.2 Pros and cons 1.3 Tailoring	1.1 List different healthy places 1.2 Advise the person to list and compare the advantages and disadvantages about each place presented 1.3 Provide maps about the localization of places and routes to arrive in the place
P.O 2 To try contact with his family K.2 Knowledge about his family history (1.4 -1.5)	1.4 Empathic linkage 1.5 Feedback	1.4 Listen carefully about his family history 1.5 Give feedback about the main points of his family history
P.O 3 To establish network with other people	1.6 Elaboration	1.6 Develop a link about the connection of unhealthy network with

K. 3 Knowledge about the importance of healthy network (1.6)		increase of anxiety, and maintenance of bad relief behaviors
P.O 4 To have contact with persons who can help him in the field of work collaboratively and live productively with them K.4 Knowledge about the importance of person in his friendship network that can help with his field of work (1.7 -1.8)	1.7 Elaboration 1.8 Social skills training	1.7 Knowledge about the importance of a healthy friendship to achieve opportunities of work 1.8 Teach effective social interaction in specific situations (e.g: job interviews) by techniques of behavior rehearsal . Develop a fiction situation to client try to think how react to the situation.
P.O 5 To be more physically active k. 5 Knowledge about different places (recreation centers) near of the place that the client lives that there are physical activities programs (1.9 – 1.10)	1.9 Elaboration 1.10 Pros and cons	1.9 List different healthy places to practice physical activities 1.10 Discuss with the client the pros and cons about each place presented
Interpersonal outcome 2: Establish relationships healthy with friends, peers and family		
Change objectives	**Methods**	**Applications**
P.O 1 To evaluate past, current, and potential relationships K.1 Knowledge about the relationships that the patient had, have and could have in the future (1.1- 1.4)	1.1 Elaboration 1.2 Providing cues 1.3 Environmental reevaluation 1.4Restructuring the social environment	1.1 Discuss about the relationships developed and your mechanism to exist 1.2 Develop comparison between characteristics of relations on past and current 1.3Encourage patients to describe how their family members (or peers, friends) feel about their older relational bonds that they used to hang out before the increase of anxiety. How their family

		members (or peers, friends) feel about their actual relational bonds. And discuss about the reaction of your friends, peers and family in relation a relationship developed 1.4Prompt the patient to identify barriers preventing them from starting a new friendship.
P.O2 To avoid relationships with friends, peers and parents that are not healthy K.2 Knowledge about how to avoid unhealthy relationships (1.5)	1.5 Elaboration	1.5 Construct some strategies together with patient about possible actions to avoid unhealthy relationship
Determinant: knowledge – *Organizational level – Environmental* *Organizational outcome:* to get out of homelessness situation		
Change objectives	**Methods**	**Applications**
P.O 1 To find a “shelter house” K.1 Knowledge about the shelter houses available in your city and the rules (1.1 – 1.3)	1.1 Elaboration 1.2 Pros and cons 1.3 Using imagery	1.1 List different shelter houses near of your common environment 1.2 Discuss with the patient the pros and cons about shelter houses presented 1.3 Provide maps about the localization of places and routes to arrive in that places listed
P.O 2 To keep contact with his family and maybe came back to his family`s house K.2 Knowledge about the importance of family (1.4)	1.4 Elaboration	1.4 Linking of the lack of family`s contact with homeless situation
Determinant: knowledge – *Community level – Environmental*		

Community Outcome: to be reinserted in society		
Change objectives	**Methods**	**Applications**
P.O 1 To avoid dangerous places or places that reminder his pattern behavior K.1 Knowledge through state of advantages to avoid dangerous places or places that reminder his pattern behavior (1.1- 1.4)	1.1 Elaboration 1.2 Providing cues 1.3 Tailoring 1.4 Reinforcement	1.1 Link of dangerous place with increase of anxiety and marginalization 1.2 Link dangerous places with bad relief behaviors 1.3; 1.4 Show documentaries about the relation of dangerous place and increase of marginalization
P.O 2 Give a social support to homeless people K.2 Knowledge about the social support available in your city(1.5 – 1.7)	1.5 List contact with social support to homeless people 1.6; 1.7 Encourage patient to enter in contact with this service	1.4 Written presentation: Distribute on paper a list with contact of social support 1.5 Verbal presentation
P.O 3 Policies to homeless people and addictive persons K. 3 Knowledge about the specific policies to homeless people and addictive people available in your city (1.8 – 1.9)	1.8 Using imagery 1.9 Mobilizing social support	1.8; 1.9 Provide information about specific policies to homeless people by newsletter and images that provide a fast understanding

Determinant: Triggers - *Individual level – Behavior* *Behavioral outcome 1*: Establish a healthy sleep pattern		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of sleep relevant to lifestyle T.1 Analyze the triggers that are present in his lifestyle that interfere in the sleep (2.1 - 2.3)	2.1 Consciousness raising 2.2 Active learning 2.3 Elaboration	2.1;2.2Provide a list with some triggers that interfere in the sleep 2.3 Identify together with client your triggers that interfere in the sleep, and

		provide alternatives for inhibit these triggers (menu of options).
P.O 2 Selects physical activities relevant to lifestyle T. 2 Identify the triggers that interfere to not do physical activity (2.4 – 2.5)	2.4 Consciousness raising 2.5 Restructuring the physical environment	2.4 Link the triggers (frequency and probability) with absence of physical activity 2.5 Prompt the client to identify barriers for start a new exercise regime (e.g., lack of motivation, and discuss ways in which they could help overcome them – e.g., going to the park to do exercise with a friend)
P.O 4 Copes with the challenges encountered with engaging in selected pattern of sleep T.4 Modify the triggers that interfere in the pattern of sleep (2.6 – 2.8)	2.6 Planning coping response 2.7Mobilizing social support 2.8 Feedback	2.6; 2.7 Offer some social support to face this trigger 2.8 Give a positive reinforcement to change of pattern of sleep
Behavioral outcome 2: Establish a healthy Diet		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of eating relevant to lifestyle T.1 Analyze the triggers that are present in his lifestyle that interfere in his diet (2.1 – 2.2)	2.1 Consciousness raising 2.2 Active learning	2.1 Provide a list of possible triggers that interfere in the health diet 2.2 Adapt a list for your reality
P.O 3 Cope with the challenges encountered with engaging in selected pattern of eating T.3 Modify the triggers that interfere in the healthy food (2.3)	2.3 Reinforcement	2.3 Give a positive reinforcement to face the triggers that interfere in the healthy food
Behavior outcome 3: Decrease cocaine use		
Change objectives	**Methods**	**Applications**

P.O 1 Monitors Cocaine use T.1 Analyze the triggers that are present in his lifestyle that interfere direct or indirect to cocaine use (2.1 – 2.3)	2.1 Consciousness raising 2.2 Personalized risk 2.3 Relapse Prevention	2.1 Identify specific triggers that generate the need to use cocaine 2.2 Analyze all the things involved with the triggers 2.3 Develop strategies to avoid environmental triggers
P.O 2 Copes with the challenges encountered with engaging in less cocaine use T.2 Modify the triggers that interfere in the cocaine use (2.4 – 2.7)	2.4 Planning coping response 2.5 Mobilizing social support 2.6 Avoidance/ reducing exposure to triggers for the cocaine use 2.7 Restructuring the social environment	2.4; 2.5 Provide social support to face the trigger present in the cocaine use 2.6 Avoid the situations that provide triggers to cocaine use 2.7 Change (if possible) your usual social environment
Behavior Outcome 4: Decrease anxiety		
Change objectives	**Methods**	**Applications**
P.O 1 to become aware of and name anxiety T.1 Identify the triggers for anxiety (2.1 – 2.2)	2.1Consciousness raising 2.2 Active learning	2.1 Provide a list of triggers that are related with anxiety 2.2 List triggers that generate anxiety
P.O2 to become aware of and state the connection between the named anxiety and the behavior used to relieve it T.2 Define the connection between triggers and anxiety (2.3 – 2.4)	2.3 Consciousness raising 2.4 Environmental reevaluation	2.3 List the characteristics of the triggers (when, where, who) 2.4 Encourage the patients to describe if their family members (or peers, friends) identify some triggers that precede anxiety
P.O 3 Identify the operative expectations formulated T.3 Identify the triggers involved in the operative expectations (2.5 – 2.7)	2.5 Consciousness raising 2.6;2.7 Active learning	2.5; 2.6 Define triggers together with client after the client identified in the first appointment the expectation and relief behaviors used (it is easy to think about triggers

		when you put expectation, what happened instead and relief behaviors). Make a brainstorm with the patient 2.6 Provide a list of triggers that are related with operative expectations 2.7 List the operative expectations at side of the triggers
P.O 4 Formulate and recognition of the connection between expectations held and what happened instead T.4 Appraise the connection among triggers, expectations and what happened instead (2.8)	2.8 Elaboration	2.8 Do an observation and consensual validation of variants of security operations (relief behaviors used)
P.O 5 Consider which factors in the sequence are amenable to control T.5 Categorize the possible triggers to change (2.9 – 2.10)	2.9 Personalized risk 2.10 Planning coping responses	2.9 Instruct the individual to avoid situations that can generate this problematics triggers 2.10 Formulate together with patient strategies to avoid these situations

Determinant: Relief Behaviors - *Individual level – Behavior* *Behavioral outcome 1:* Establish a healthy sleep pattern		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of sleep relevant to lifestyle RB.1 Create new relief behavior to achieve sleep (3.1 – 3.3)	3.1 Consciousness raising 3.2Active learning	3.1 Reinforcement the importance of Mindful breathing to achieve sleep, but the patient can choose to do only deep breath

	3.3Tailoring	before sleep. He can decide what works better for him. 3.2 Teach the patient to do a deep breath before sleep (Step 3 in the mindful breathing) 3.3 Discussion with the client your environmental situation. Because sometimes the client said that he needs to keep herself awake to be safe in dangerous place. You can teach him that he can adapt the mindful breathing to be awake when he heard some noise that represent danger for him. E.g. Instead of letting go all the thoughts, he needs to keep in your unconsciousness that he will recognize noise that represent danger to be awake and alert in the same moment.
P.O 2 Selects physical activities relevant to lifestyle RB.2 Identify physical activity as a relief behavior (3.4 – 3.5)	3.4 Consciousness raising 3.5 Using imagery	3.4; 3.5 Provide information with the function of physical activity in decrease anxiety (body relaxation) by paper, video, pictures and achieve to sleep
P.O 3 Monitors progress in increasing sleep RB.3 Distinguish the relief behaviors that difficult the sleep from that help a good sleep (3.6)	3.6 Active learning	3.6 Develop a table with 2 columns which one column will be to relief behaviors that help sleep and the other it will be to relief behaviors that is bad to sleep that the client use
P.O 4 Copes with the challenges encountered with engaging in selected pattern of sleep RB.4 Modify the relief behaviors that is used to achieve the sleep (3.7)	3.7 Active learning	3.7 Use the table developed previously to identify the bad and good relief behaviors used, and with the patient try to substitute the bad relief behavior for others.

Behavioral outcome 2: Establish a healthy Diet		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of eating relevant to lifestyle RB.1 Create new relief behavior to achieve a good eating in his lifestyle (3.1 – 3.2)	3.1 Counterconditioning 3.2 Cue altering	3.1; 3.2 Encourage the patient to learn health behaviors that can substitute for this problematic behavior (to schedule a regular time to eat; don`t eat snack before the meal; don`t drink alcohol beverage before the meal)
P.O 2 Monitors food intake RB.2 Distinguish the relief behaviors that difficult the healthy diet from that help a good diet (3.3)	3.3 Active learning	3.3 Develop a table with 2 columns which one column will be to relief behaviors that help healthy eating and the other it will be to relief behaviors that is bad to diet that the client use
P.O 3 Copes with the challenges encountered with engaging in selected pattern of eating RB.3 Modify the relief behavior that is used to achieve the healthy diet (3.4)	3.4 Active learning	3.4 Use the table developed previously to identify the bad and good relief behavior used, and with the patient try to substitute the bad relief behavior for others.
Behavior outcome 3: Decrease cocaine use		
Change objectives	**Methods**	**Applications**
P.O 1 Monitors Cocaine use RB.1 Create new relief behavior in his lifestyle (3.1 - 3.2)	3.1 Counterconditioning 3.2 Consciousness raising	3.1; 3.2 Discuss with the patient about others relief behaviors that give him pleasure similar a cocaine (mindfulness, physical activity, food..)
P.O 2 Copes with the challenges encountered with engaging in less cocaine use	3.3 Counterconditioning	3.3 After figure out others relief behaviors, the patient can try to use this new relief behaviors instead of cocaine

RB.2 Modify the relief behaviors (3.3 – 3.4)	3.4 Environmental reevaluation	3.4 Encouraging the patient to compare the new relief behavior with the big quantity of cocaine use (the patient here, he can keep use cocaine, but at least decrease a little of consumption or use other kind of drug, or other kind of the way of consumption – "crack – cocaine powder")
Behavior Outcome 4: Decrease anxiety		
Change objectives	**Methods**	**Applications**
P.O 1 to become aware of and name anxiety RB.1 Identify the relief behaviors used during anxiety (3.1 – 3.2)	3.1 Consciousness raising 3.2 Elaboration	3.1 Connect the anxiety and relief behavior 3.2 What pattern of behavior is used?
P.O2 to become aware of and state the connection between the named anxiety and the behavior used to relieve it RB.2 Analyze the relief behaviors used (3.3)	3.3 Elaboration	3.3 After identify the relief behaviors used (questions below), the nurse has to follow this question to the patient do an analyze of the relief behaviors: Is there a series of relief behaviors that are used? Does the series recur in the same order in subsequent anxiety- producing behaviors? The amount of anxiety is also inferred from the relief behaviors Identify the place that the discomfort is experienced: "What part of the body do you feel this discomfort?"
P.O 3 Identify the operative expectations formulated ------------------------------- ------------------------------	--------------------------------- --------------------------------- --------------------------------- ---------------------------------	------------------------------- ------------------------------- ------------------------------- -----------------------

P.O 4 Formulate and recognition of the connection between expectations held and what happened instead RB. 4 Identify if the relief behavior is connected with the expectations (3.4)	3.4 Possession	3.4 After analyze the relief behaviors (series, order and amount of the series of behaviors), the patient should be connected the relief behaviors with the wish to decrease or stop the extreme discomfort and internal tension(anxiety) is experienced in your body and your mind.
P.O 5 Consider which factors in the sequence are amenable to control RB.5 Modify the relief behavior that it is possible change (3.5)	3.5 Self-reevaluation	3.5 The person can be to compare his image as a current relief behavior to a possible image as a new relief behavior (e.g.: A person can compare his image as a sedentary person to a possible image of himself as an active person, using the physical activity as a relief behavior instead of cocaine use)

Determinant: Self-efficacy/ Self- esteem and Skills - *Individual level – Behavior* *Behavioral outcome 1*: Establish a healthy sleep pattern		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of sleep relevant to lifestyle SES. 1 Express confidence in ability to adequate pattern of sleep in his lifestyle (4.1 – 4.2)	4.1 Guided practice	4.1 The client firstly show how he is using the techniques to improve your sleep (mindfulness, deep breathing...) and then the nurse asks to patient to do the same several times to analyze the way that he is doing. After this, nurse will give brief comments on the patient`s performances, emphasizing aspects done well. 4.2 Clients keep a diary about your pattern of sleep, and take notes about how

	4.2 Self-monitoring of behavior	the techniques are help to adequate pattern of sleep in his lifestyle
P.O 2 Selects physical activities relevant to lifestyle SES. 2 Express self-efficacy (confidence) in ability to do physical activity (4.3 – 4.6)	4.3 Goal setting 4.4 Self-monitoring of behavior 4.5 Planning coping response 4.6 Flooding	4.3 Client and nurse discuss the goal for the next meeting, deciding on a goal that is acceptable in his lifestyle to improve his physical activity. 4.4 Client keeps a diary about the physical activity done 4.5 Nurses provide a list of potential barriers and ways to overcome these, as example, if the park that the patient used to go to do physical activity is closed, he can other options near this park to do exercise. 4.6 Clients must keep in mind that physical activity is important to reduce anxiety, and consequently achieve sleep
P.O 3 Monitors progress in increasing sleep SES. 3 Express self-efficacy (confidence) in ability to change pattern of sleep (4.7 – 4.8)	4.7 Improving physical and emotional states	4.7 Patient are taught to breathe deeply and relax before to go to sleep, and consequently he will have more chance to sleep well. For patient that live in the street (homeless) nurse have to reaffirm that during this breath the patient have to keep in mind that some noise that can represent dangerous he will wake up fast and alert (unconsciousness message – this is what happen when mom wake up instantly when she heard the cries sound of your son). 4.8 Patient search for a place safer than previous

	4.8 Cue altering	that he used to sleep, in order to avoid disturb in your sleep
Behavioral outcome 2: Establish a healthy Diet		
Change objectives	**Methods**	**Applications**
P.O 1 Selects pattern of eating relevant to lifestyle SES.1 Express self-efficacy (confidence) in ability to adequate pattern of eating in his lifestyle (4.1)	4.1 Reinforcement	4.1 Use positive messages (positive reinforcement) to show that the patient is capable to enhance an adequate pattern of eating
P.O 2 Monitors food intake SES. 2 Express self-efficacy (confidence) in ability to monitor one`s own food intake (4.2)	4.2 Self-monitoring of behavior	4.2 Diary to do notes about your food intake (notebook)
P.O 3 Copes with the challenges encountered with engaging in selected pattern of eating SES. 3 Express self-efficacy (confidence) in ability to face the challenges encountered toward pattern of eating (4.3- 4.5)	4.3 Cue altering 4.4 Mobilizing social support 4.5 Planning coping response	4.3 Client search for a place that can provide more health food, in order to avoid unhealthy food. 4.4 Offer some social support that provide free food or with low cost, and healthy. 4.5 Nurses provide a list of potential barriers and ways to overcome these
Behavior outcome 3 : Decrease cocaine use		
Change objectives	**Methods**	**Applications**
P.O 1 Monitors Cocaine use	4.1 Self-reevaluation	4.1; 4.2 Diary with notes about your cocaine intake

SES.1 Express self-efficacy (confidence) in ability to monitor one`s own cocaine use (4.1 – 4.2)	4.2 Self-monitoring of behavior	and the way used to consumption
P.O 2 Copes with the challenges encountered with engaging in less cocaine use SES.2 Express self-efficacy (confidence) in ability to generate coping strategies to deal with the challenges (4.3 – 4.5)	4.3 Cue altering 4.4 Mobilizing social support 4.5 Flooding 4.6 Planning coping response 4.7 Relapse Prevention	4.3 Patient search for a place that he cannot have a lot of access to cocaine 4.4 Offer some social support that provide others relief behaviors instead of cocaine 4.5 Talk to patient to go to the gym to overcome anxiety, instead to use cocaine 4.6 Nurses provide a list of potential barriers and ways to overcome these. 4.7 Develop strategies to avoid environmental triggers
Behavior Outcome 4: Manage anxiety		
Change objectives	**Methods**	**Applications**
P.O 1 to become aware of and name anxiety SES. 1 Express self-efficacy (confidence) to recognize anxiety (4.1)	4.1 Verbal persuasion	4.1 Use positive messages (positive reinforcement) to show that the patient is capable to recognize anxiety
P.O2 to become aware of and state the connection between the named anxiety and the behavior used to relieve it SES.2 Demonstrate the self-efficacy (ability) to establish connection between behaviors that is used to relieve anxiety (4.2-4.3)	4.2 Self-monitoring behavior 4.3 Alignment	4.2; 4.3 clients keep a diary to do notes about the discomfort (where in the body - the nurse can provide a picture what the body parts for the patient identify what is the part of body that he feels discomfort) that came before the unpleasant sensation (anxiety) and the relieve behavior used to decrease this unpleasant sensation

P.O 3 Identify the operative expectations formulated SES. 3 Express self-efficacy (confidence) to recognize expectations (4.4)	4.4 Verbal persuasion	4.4 Use positive messages (positive reinforcement) to show that the client is capable to recognize expectations
P.O 4 Formulate and recognition of the connection between expectations held and what happened instead SES. 4 Demonstrate the self-efficacy (ability) to identify the connection among expectations held, what happened instead and relief behaviors as soon as possible (4.5)	4.5 Syntax	4.5 Teach for the client how recognize as soon as possible the connection between expectations held, what happened instead, relieve behaviors and anxiety. Because once the client learn identify the cycle, he can break the cycle, or use other kind of relief behaviors.
P.O 5 Consider which factors in the sequence are amenable to control SES. 5 Express self-efficacy (confidence) to change some expectations and factors to break the cycle of unpleasant feelings (4.6)	4.6 Guided practice	4.6 Use all the models to target behavior that constitute anxiety (deep breath; mindfulness; physical activity, diet health; use of less cocaine)
Determinant: Self-efficacy/ Self- esteem and Skills – *Interpersonal level – Environmental* *Interpersonal outcome 1*: Decrease social isolation and loneliness		
Change Objectives	**Methods**	**Applications**
P.O 1 Facilitate patients to know different places SES. 1 Self-efficacy to recognize barriers` to know different places (2.1)	2.1 Changing routine	2.1 Advise on ways of changing routines daily or weekly to limit exposure to behavioral cues, and to create an opportunity to meet other people
P.O 2 Motivate patients to try contact with his family SES.2 Express self-efficacy (confidence) in	2.2 Empathic linkage	2.2 Through empathic linkage is developed "bond" between nurse and client, and nurse can

<table>
<tr><td>your ability to try establishing contact between the patient and his family (2.2)</td><td></td><td>talk/listen more about client`s family and encourage clients to contact their family</td></tr>
<tr><td>P.O 3 Motivate patients to establish network with other people
SES. 3 --</td><td>-----------------------------------

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<tr><td>P.O 4 Motivate patients to have contact with persons who can help him in the field of work collaboratively and live productively with them
SES. 4 ---</td><td>-----------------------------------

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<tr><td>P.O 5 Facilitate patients to be more physically active
SES. 5 Express self-efficacy (confidence) in your ability to motivate patient to practice physical activity (2.4)</td><td>2.3Action planning
2.4 Flooding</td><td>2.3 Prompt planning the performance of a particular physical activity (e.g. running) at a particular time on certain days of week .
2.4Taking client to a gym to overcome anxiety about engaging in physical activity</td></tr>
<tr><td colspan="3"><u>Interpersonal outcome 2</u> : Have relationships healthy with friends, peers and family</td></tr>
<tr><td>Change objectives</td><td>Methods</td><td>Applications</td></tr>
<tr><td>P.O 2 Motivate patients to avoid relationships with friends, peers and parents that are not healthy
SES. 2 Express self-efficacy (confidence) in ability to encourage the patient to change/ finish problematic relationships (2.1 – 2.3)</td><td>2.1 Counterconditioning
2.2 Pros and cons
2.3 Stimulus control</td><td>2.1; 2.2 List in the paper the problematic relationship through a table with pros and cons of the relationship
2.3 To break habits- if the patient knows that he can meet the guy (which he has a problematic relationship) in a specific place, it is important that the patient recognize that it isn't help if he keep going in this place</td></tr>
<tr><td colspan="3">Determinant: Self-efficacy/ Self- esteem and Skills – <u>Organizational level – Environmental</u></td></tr>
</table>

<table>
<tr><td colspan="3"><u>Organizational outcome</u>: to get out of homelessness situation</td></tr>
<tr><td>Change Objectives</td><td>Methods</td><td>Applications</td></tr>
<tr><td>P.O 1 Encourage the clients to find a “shelter houses”
SES. 1 Express self-efficacy (confidence) in ability to know a best shelter house for your reality (2.1 – 2.2)</td><td>2.1 Feedback
2.2 Pros and cons</td><td>2.1 Give a positive reinforcement to find a shelter house
2.2 List pros and cons to each shelter house</td></tr>
<tr><td>P.O 2 To keep contact with his family and maybe came back to his family`s house<br>SES. 2 Express self-efficacy (confidence) to keep contact with his family and maybe back to his family`s house (2.3)</td><td>2.3 Pros and cons</td><td>2.3 List pros and cons to back to his family`s house</td></tr>
<tr><td colspan="3">Determinant: Self-efficacy/ Self- esteem and Skills – <u>Community level – Environmental</u>
<u>Community Outcome</u>: to be reinserted in society</td></tr>
<tr><td>Change Objectives</td><td>Methods</td><td>Applications</td></tr>
<tr><td>P.O 1 Avoid dangerous places or places that reminder his pattern behavior
SES. 1 Express self-efficacy (confidence) to deal with environmental cues (2.1 – 2.2)</td><td>2.1 Stimulus control
2.2 Restructuring the social environment</td><td>2.1 To break habits- Talking with patient about some habits that it is not well view by society
2.2 Identify barriers to the reinsertion in the society</td></tr>
<tr><td>P.O 2 Give a social support to homelessness people
SES. 2 ----------------------
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<tr><td>P.O 3 Show policies to homelessness and addictive people
SES. 3 ----------------------
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Determinant: Relations– *Interpersonal level – Environmental* *Interpersonal outcome1 :* Decrease social isolation and loneliness		
Change objectives	**Methods**	**Applications**
P.O 1 Know different places R.1 Establish interpersonal relations (bonds) in news places (3.1)	3.1 Social skills training	3.1 Teach effective social interaction by techniques of behavior rehearsal. Develop a simulation situation for the client try to think how react to the situation.
P.O 2 To try contact with his family R.2 Reestablish relational bonds (3.2 – 3.3)	3.2 Environmental reevaluation 3.3 Social skills training	3.2 Encourage clients to describe how their family members (or peers, friends) feel about their older relational bonds that they used to hang out before the increase of anxiety 3.3 Teach effective social interaction by techniques of behavior rehearsal. Develop a simulation situation to patient try to think how react to the situation. How reestablish relational bonds (message, Facebook, meet face to face)
P.O 3 Establish network with other people R.3 --	--	---
P.O 4 Establish contact with people who can help him in the field of work R.4 ---	--	---

<table>
<tr><td></td><td>--</td><td>---</td></tr>
<tr><td>P.O 5 To be more physically active
R.5 Establish relational ties to support him to do physical activity (3.4)</td><td>3.4 Restructuring the social environmental</td><td>3.4 Identify barriers to start a new exercise e.g., lack of motivation, and discuss ways in which they could help overcome him e.g., going to the gym with a buddy</td></tr>
<tr><td colspan="3"><u>Interpersonal outcome 2</u> : Have relationships healthy with friends, peers and family</td></tr>
<tr><td>Change Objectives</td><td>Methods</td><td>Applications</td></tr>
<tr><td>P.O 1 Evaluate past, current, and potential relationships
R. 1 Propose a deep understanding about his interpersonal relations that are significant (relational bonds and relational ties) (3.1 – 3.3)</td><td>3.1 Consciousness raising
3.2 Pros and cons
3.3 Environmental reevaluation</td><td>3.1 Provide a conversation about the client' relations.
3.2 Identify pros and cons of relations
3.3 Encourage client to describe how his family members (or peers, friends) feel about his relations</td></tr>
<tr><td>P.O 2 Avoid relationships with friends, peers and parents that are not healthy
R.2 Recognize unhealthy relational bonds and relational ties (3.4 – 3.5)</td><td>3.4 Pros and cons
3.5 Stimulus control</td><td>3.4 Identify pros and cons of unhealthy relational bonds and link with increase of unpleasant feeling (anxiety) and bad relief behaviors
3.5 To break habits- if the client knows that he can meet the guy (which he has a problematic relationship) in a specific place, it is important that the client recognize that it isn't help if he keep going in that place</td></tr>
<tr><td colspan="3">Determinant: Relations – <u>Organizational level – Environmental</u>
<u>Organizational outcome</u> : to get out of homelessness situation</td></tr>
</table>

Change Objectives	**Methods**	**Applications**
P.O 1 To find a "shelter house" R.1 Propose to client a "shelter house" as a relational tie	3.1 Elaboration	3.1 Talk with the client that shelter house can be a place that he can establish relation with other person that share the same reality
P.O 2 Keep contact with his family R.2 -------------------------------- --------------------------------	------------------------------------ ------------------------------------ ------------------------------------ ------------------------------------ ------------------------------------ -----	------------------------- ------------------------- ------------------------- ------------------------- ------------------------- --------------------
Determinant: Relations – <u>*Community level – Environmental*</u> <u>*Community Outcome*</u>: to be reinserted in society		
Change Objectives	**Methods**	**Applications**
P.O Avoid dangerous places or places that remind his pattern behavior R.1 -------------------------------- ------------------------------	------------------------------------ ------------------------------------ ------------------------------------ ------------------------------------ ------------------------------------ -----	------------------------- ------------------------- ------------------------- ------------------------- ------------------------- --------------------
P.O 2 Give a social support to homeless people R.2 -------------------------------- ----------------------------	------------------------------------ ------------------------------------ ------------------------------------ ---	------------------------- ------------------------- ------------------------- ------------
P.O 3 Show policies to homeless and addictive people R.3 -------------------------------- ---------------------------------	------------------------------------ ------------------------------------ ------------------------------------ ------------------------------------ ----	------------------------- ------------------------- ------------------------- ------------------------- ---------------

Step 4 – Program

The selected theories that we used were Behavioral Cognitive Theory (BCT)(Michie et al., 2013), Peplau`s Theory(Peplau, 1991), Social Cognitive Theory (Bandura, 1999), Trans-Theoretical Model (Prochaska & Velicer, 1997) , Goal-Setting Theory (Latham & Locke, 2007) , Theories of Information Processing, Precaution- adoption process Model (Weinstein et al.,

2008), Self-Affirmation Theory (Sherman, 2013), Theories of Automatic, Impulsive and Habitual Behavior (Wood & Neal, 2007), Attribution Theory and Relapse Prevention Theory (Marlatt & Donovan, 2008); Theories of Goal Directed Behavior (Hofmann, Friese, & Wiers, 2008); Theories of Social Networks and Social Support (Glanz, Rimer, & Viswanath, 2015); and Theories of Self-Regulation (Creer, 2000). The consensus about the theory used, methods proposed, and applications was building for final agreement on the adaptations needed to the intervention prototype structure to provide equip for cocaine users to manage anxiety.

The program was designed for individual sessions (nurse-client) based on the phases of interpersonal relationship proposed by Peplau (orientation, work and resolution) during five days of consecutive sessions delivered by a trained nurse using Peplau's concepts of interpersonal relationship. The first session lasts 30 minutes and the subsequent last 20 minutes. We decided this time of duration because in Brazil the nurse needs to attend 3 clients in a period of 60 minutes. Only the first session went longer than others because this session consists in 2 phases of interpersonal relationship (orientation and work).

The prototype of the manual of intervention was guided by the matrices and the ideas about methods and strategies, what help a lot of in the construction of specific messages and overall content of each program component. During the production phase of the manual of intervention, we used the matrices generated, and included the structure of each appointment, thinking about the order of target behavioral and environmental outcomes, time and material used. All material used, such as notebook, guidelines, and images, were designed to be appropriate for individuals with low literacy skills and were produced in English and Portuguese.

Step 5 – Adoption and Implementation

The outcomes of the program were divided in behavioral and environmental outcomes, but all developed at the individual level. During the construction of the outcomes, mainly the environmental outcomes, we thought carefully about the reality of the population (homeless people and cocaine/crack user) and how this reality could affect the program adoption. The behavioral outcomes were: to stablish a healthy sleep pattern, to stablish a healthy eating, to manage anxiety, and to manage cocaine use. And the environmental outcomes were: to decrease social isolation, to have relationships healthy, to get out of homeless situation, and to be reinserted in society. The team structured the session of intervention as a self-content, due the high chance of dropout rate. Then, the client could come to the first session and maybe don't back for the other sessions, thinking in this specific population, the minimal dose will be one appointment and the maximum dose will be 5 appointments.

We also developed the program manual of intervention for nurses in the health facility, and a program curriculum for training nurses with concepts of interpersonal relationship by Peplau. The manual included program goals and objectives, program effectiveness, an overview of the program materials and such resource material as a guideline for the management of anxiety, a staffing plan and budget, and program evaluation tools.

Step 6: Evaluation

We did focus group with nurses that worked in the health facility to deep understanding of their conceptions about the program plan to equip cocaine users to manage anxiety through specific questions that addressed each operational definition of feasibility.

The focus group was composed by 7 nurses. It was generated 12 themes related to feasibility: adaptation (n=5 – different world, environmental factor as the most important, relation between behavior and environmental factor, food and CAPS AD, focus in the anxiety), demand (n= 3 – intoxication level, exclusion criteria, clients who use crack/cocaine), acceptability (n=1 - answer the scale), practicability (n=3 – nurse's worry to apply the intervention, place to the nurse' appointment, adequate the nurse' work day).

The most frequent theme was related to adaptation of the intervention due to the singularity of the population studied (homelessness, illiteracy, vulnerability) and the factors that could be influence the acceptance of the intervention to decrease the rate of treatment' withdrawal. Opinions were mixed about the scale application in the first and in the last appointment, mainly because the amount of scales.

Clients' **acceptability** to answer the amount of scales

"Normally when they agree to participate of the intervention, they stayed until the end of the appointment. I believe that the amount of scale will be easy to apply" N.2

"I think it is a lot of scales, in my opinion you should decrease the number of scales, because they will be restlessness" N5

"I think they will be confused with a lot of scales, maybe you can choose some scales instead to apply all." N.7

All nurses suggested to make an **adaptation**: to approach environmental before than behavioral factors, and don't work sleep and eat pattern deeply, due to the homelessness situation.

"It is really difficult work sleep and eat pattern, due to the social conditions of the clients" N.3

"Clients start to talk about homelessness situation, they don't want to talk about food and sleep first" N.1

"I don't work with my clients about healthy eating. I just talk to them that they must try to eat in a better way possible." N.5

In relation to **practicability** they addressed issues as nurse' work day, time of appointment, and complexity of the manual of intervention, but all nurses agree that 20 minutes to address all the issues related to anxiety in each appointment could be insufficient.

"The nurse' work day is an issue, since nurse works 12 hours and she can't conduct the next appointment, thinking the intervention will length 5 consecutive days (Monday until Friday)" N.4

"I think this manual is so complex, if you asked me to apply this manual, I would say no" N.7

The main theme related to **demand** was about the intoxication status, because the health facility is an outpatient facility and it is difficulty the patients to be abstinent, mainly in the onset of the treatment.

"I should say that 99% of clients that seek treatment here, they are intoxicated" N.3

"I think you have to evaluate the intoxication level, but you cannot use intoxication as an exclusion criteria" N.2

After the focus group, the team made changes in the manual of the intervention to improve the feasibility of the intervention in the singular health scenario. The next step of this work it will be to conduct a feasibility trial to evaluate the feasibility of the program created to decrease anxiety in cocaine users in the specific health facility in São Paulo. The data from feasibility trial will indicate if the program is acceptable or not, and it will help the team to refine and to adapt the materials based on feedback of the patients.

Discussion

This study describes the development of an intervention to equip cocaine users with strategies to manage anxiety through IM approach. There is limited literature about the phases of the development of complex interventions, mainly in this thematic that includes comorbidity (anxiety and cocaine use). One of the explanations for this sparse literature is because the development of complex intervention is a considerable challenge for researchers, mainly

because it is very difficult to identify all factors that play an important role in the health problem of interest and to present all the steps of a new intervention in such a way that the readers can understand all the process to achieve the intervention protocol .

The IM is based on matrices creation to show all the steps of development of the intervention. The process of matrices creation is a very time-consuming but helps all components of team during the brainstorm to see the relation between the determinants, change objectives, performance objectives, behavioral and environmental outcomes that affect the health problem studied. Besides this, all this methodological process assists in the development of intervention framework theory, which is necessary to the identification of mediator and moderators of the intervention that plays an important role in the success and failure of intervention.

The needs assessment produced during this study was fundamental to identify the barriers to accessing cocaine users and services based on the outpatient logical, such as high rates of drop out of the clients, the undocumented status, and environmental factors that directly affect the level of anxiety. IM is a powerful methodological tool that facilitates the comprehensive examination of these environmental factors using an ecological perspective, instead of acting only on behavioral factors. We followed all the steps of IM using a mix of quantitative and qualitative methods to achieve a better manual of intervention that incorporate resources that affected the majority of the barriers identified to accomplish the outcome of intervention.

The overall structure of the program was adapted to the singularity of the clients based on the stakeholders' experiences. The structure of the intervention was adapted from environmental factors in the 5th appointment to the 4th appointment, and it was taken to enhance clients' acceptability as demonstrated in focus group that all nurses said that the environmental factors are the factors that the clients like to talk more, and this affects each individual's level of anxiety. Additionally we took out two behavioral factors, sleeping and eating, that we identified as an important factors in increasing anxiety, but during focus group all nurses identified these factors as difficult topic to broach with the patients, as the majority of them are homelessness. The intervention will be applied during 5 consecutive days, 20 minutes of appointment, taking into consideration the high drop out rates of these clients in the outpatient service.

Conclusion

This study will provide valuable guidance for future researchers, health agencies, and health care professionals who are interested in reproducing this systematic approach to developing a complex intervention. The program has already been implemented in the feasibility study.

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CHAPTER SIX

CHAPTER SIX

8. INTERVENTION PROGRAM

Interpersonal Theory of Nursing to anxiety management in people with substance use disorders (ITASUD)

Training Manual to the interventionist

Orientation and training

Orientation and training
Obtain the consent form
Collect data and scheduling
Pre-appointment – cell phone call and message
The day of data collection
Data 1 – Appointment 1
Data 2 – Appointment 2
Dados 3 – Appointment 3
Dados 4 – Appointment 4
Dados 5 – Appointment 5
Dados 6 – Follow-up

General information

ITASUD is an intervention based on Peplau's Interpersonal Theory in Nursing (ITN). Our main aim with this intervention is to equip cocaine users with anxiety management strategies during 5 appointments. The first appointment will be of 30 minutes and the others 20 minutes. The focuses of ITASUD are to improve knowledge and self-efficacy in relation to anxiety, to recognize triggers and relief behaviors to anxiety, and to improve social relationship.

Dose of Intervention

The frequency of intervention will be every day for one week.

Each session is self-content. The client could come to the first session and maybe don't back for the other sessions, thinking in this specific population, the minimal dose will be one appointment and the maximum dose will be 5 appointments.

Appointment 1 *Orientation + Work*	Appointment 2 *Work*	Appointment 3 *Work*	Appointment 4 *Work*	Appointment 5 *Resolution*
30 min	20 min	20 min	20 min	20 min

<u>The intervention has 4 phases:</u>

Phase 1 – Screening – T0

1) Apply the scales – a) Scale to identify anxiety – GAD-7
   b) Scale to identify cocaine use – ASSIST
2) Invite the client to participate of the intervention (if the client is eligible to the study)
3) Give to the client a paper with the date and hour of the intervention.

Phase 2 – Intervention –T1

1) *First appointment – orientation+ work: The content focus in the anxiety' management*

- *Explain about the intervention*
- *Give the consent form to the clients*
- *Applying scales* – a) Scale to evaluate anxiety - BAI
  b) Scale to identify cocaine use – ASSIST
  c) Scale to identify depression – Patient Health Questionnaire – PHQ-9
  d) Scale to identify triggers - PSS (Perceived Stress Scale)
  e) Scale to identify relations – MOSS SSS – (Medical outcome study)
  f) Scale to identify self-efficacy - GSE (General self- efficacy scale)

2) *Second appointment – work - The content focus in the management of anxiety*

- *Applying scales* – a) Scale to evaluate anxiety – BAI (before and after appointment)

3) *Third appointment – work – The content focus in the environmental factors*
- *Apply the scale* – a) Scale to evaluate anxiety – BAI (before and after appointment)

4) *Fourth appointment – work – The content focus in the behavioral factors*
- *Apply the scale* – a) Scale to evaluate anxiety – BAI (before and after appointment)

Phase 3 – End of intervention – T2

5) *Fifty appointment – Resolution*
- *Applying scales* – a) Scale to evaluate anxiety – BAI (before and after appointment)
  b) Scale to identify cocaine use – ASSIST (after appointment)
  c) Scale to identify depression – Patient Health Questionnaire – PHQ-9 (after appointment)
  d) Scale to identify triggers - PSS (Perceived Stress Scale) (after appointment)
  e) Scale to identify relations – MOSS SSS – (Medical outcome study) (after appointment)
  f) Scale to identify self-efficacy - GSE (General self- efficacy scale) (after appointment)

Fase 4 – Acompanhamento (uma semana)- T3

- *Applying scales* – a) Scale to evaluate anxiety – BAI (before and after appointment)
  b) Scale to identify cocaine use – ASSIST (after appointment)
  c) Scale to identify depression – Patient Health Questionnaire – PHQ-9 (after appointment)
  d) Scale to identify triggers - PSS (Perceived Stress Scale) (after appointment)
  e) Scale to identify relations – MOSS SSS – (Medical outcome study) (after appointment)
  f) Scale to identify self-efficacy - GSE (General self- efficacy scale) (after appointment)

Planning to collect data and scale

Day of study	1	2	3	4	5	6	7	8	9	10	11	12	13
Day of intervention		1	2	3	4	5							
Observation BAI	A0	A1	A2	A3	A4	A5							A 6
Observation	T0	T1				T2							T3
Intervention	01	X1	X2	X3	X4	X5							X6

Constructs, Instruments & Measure

Constructs	Instruments	T1/A1	A2	A3	A4	T2/A5	T3/A6
Anxiety	BAI	X	X	X	X	X	X
Self-efficacy	GSE (General self-efficacy scale)	X				X	X
Relation	MOS SSS – Medical outcome study	X				X	X
Triggers	PSS (Perceived Stress Scale)	X				X	X
Relief behavior	ASSIST	X				X	X
Safety	PHQ-9	X				X	X
Interviews with the participants	Semi-structured interview					X	

A. Initial Session: Orientation + Work Interpersonal Relationship in Nursing (1)

Appointment 1

The first appointment establishes the parameters of the intervention, using assessments that help determine the cocaine users' needs and strengths. We decide in the first appointment put together 2 phases from interpersonal relationship (orientation + work) because the high tax of drop out of this population during treatment.

Step 1: Introduce yourself as therapist

- State first name.
- Identify role as therapist responsible for facilitating the sessions.

Script:

- I would like to welcome you to this first session.
- My name is Maria. I am the nurse who will facilitate the sessions and work with you throughout the sessions of this treatment.

Step 2: Explain the intervention + Orientation about the appointment

- What is the intervention and what is expected to do (goal of intervention).

Script:

- The intervention is based on Peplau`s theory – Interpersonal relationship in Nursing, that are based in the relation between nurse and client with some goal to be achieved. During this treatment our mainly goal will be decrease anxiety during these 5 appointments, the first appointment will have duration of 30 minutes and the others 20 minutes.
- The treatment that you will receive is a non-pharmacological treatment for anxiety problem. This means that it does not involve medication or pills. The interpersonal relation treatment for anxiety focuses on improve your knowledge and self-efficacy in relation to anxiety, recognition of triggers and relief behaviors of anxiety, and how improve health relations in your context.
- Review confidentiality issues, purpose of audiotaping and video record (study fidelity evaluation and analysis of non-verbal).
- We will use a questionnaire about some sociodemographic and personal characteristics.
- We will use some instruments to measure factors that infer in the level of anxiety and two instruments to measure level of anxiety:
    - To measure anxiety, during the screening, we will use the GAD-7 (Generalized Anxiety Disorder-7) an instrument with 7 questions; and BAI (Beck Anxiety Inventory), before and after each appointment, it is an instrument with 21 questions.
    - To measure Self-efficacy, we will use the GSE (General Self-Efficacy Scale) in the first appointment and in the last appointment, it is an instrument with 10 questions that evaluate self-efficacy

- To measure the relations, we will use the MOS- SSS (Medical Outcome Study – Social Support Scale) in the first appointment and in the last appointment, it is an instrument with 19 questions that evaluate your social relations
- To measure stress, we will use the PSS (Perceived Stress Scale) in the first appointment and in the last appointment, it is an instrument with 10 questions that evaluate in which situations in an individual`s life is appraised as stressful
- To measure cocaine use we will use ASSIST

- Remind the clients that there are no right or wrong answers to the questionnaire/instruments
- Explain that the clients take time to complete the questionnaire, and ask for clarification; interventionist can respond, as needed
- Administer the questionnaire/instruments in the selected method
- Get the completed questionnaire/instruments
- Clarify pre-conceptions and expectations of client

Step 3: 1) *Name of intervention*: Working to manage anxiety – Name anxiety

2) Goals of intervention (change objectives + determinants):

- Knowledge about anxiety;

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Knowledge about anxiety and what mean anxiety (1.1 – 1.3)	1.1 Consciousness raising about anxiety 1.2 To be awareness of anxiety 1.3 Providing cues	1.1 Give some neurophysiological effects of anxiety (pathways) related with body reactions 1.2 Do some questions to the individual: - “Are you anxious?”; “Are you nervous?”; “Are you nervous now?”; “Are you upset?”; “Are you tense now?” 1.3 If the person says he is not anxious, you should apply some fiction case about a person with anxiety, adequate this case by reality of individual,	1.1 Show images or videos 1.2 Verbal presentation 1.3 Verbal presentation

		because the individual can compare you with this person described in fiction case. If the person says "yes" for the questions above, you should follow for the questions bellow	
Knowledge about the connection between the anxiety and behaviors (1.4)	1.4 Syntax	1.4 After he said "yes" for the questions above. Do some questions to the individual for he realized the connection between anxiety and behaviors – "What are you doing now to relieve being nervous?"; "What are you doing now to relieve it?" If the patient say: - "nothing", the nurse may ask: "What do you usually do to get comfortable?"; "When upset in the past, what did you do then?"	1.4 verbal presentation
State (knowledge) characteristics of behaviors used to relieve anxiety (1.5 – 1.7)	1.5 Consciousness raising 1.6 Self-reevaluation 1.7 Environmental reevaluation	1.5; 1.6 List the characteristics of behavior and name behaviors 1.7 Encourage the patients to describe how their family members (or peers, friends) feel about these behaviors	1.5 Written presentation – write together with client, in a paper, the behaviors that he says that use to relieve anxiety 1.7 Verbal presentation

Knowledge of the expectations (wish, desire, goal...) (1.8)	1.8 Identification	1.8 After the patient is clearly aware of the relation between anxiety and behaviors, then a nurse asks: - “What were you thinking about before you felt upset?”	1.8 Verbal presentation
Knowledge about the influence of expectations (1.9)	1.9 Elaboration	1.9 When the expectations are held, up front in mind the patients need to elaborate the meaning of expectations; - “What expectations?”; “Is it attainable?”; “Origins?”; “How long held?”; “how important?” “Can they be changed or given up?”; “Was the expectation reasonable – capable of fulfillment?” Identify the discomfort felt, experienced in: “what part of body?”; “what degree?”; “what was noticed by patient?”; “ Was it communicate to the other(s) in the situation?”	1.9 Verbal presentation

Deep knowledge about the expectations and stuffs that happen after expectations (1.10)	1.10 Consciousness raising	1.10 List the expectations and stuffs	1.10 Written -Take notes of the expectations and stuffs
Knowledge about the connection of expectations and what happened instead (1.11 – 1.12)	1.11 Syntax 1.12 Identification	1.11 When the patient has clearly formulated an expectation, then ask: - “What happened instead?” When the expectations held are not met, the patients need to think about: - “What interfered in the achieve of expectations?”; “what happened instead of expectations?”; “who was to meet the expectation, when, how, what the evidence?” 1.12 And identify the relief behaviors used when the expectation is not achieved: - “what behavioral act or acts related to what pattern?”	1.11; 1.12 Verbal presentation
Knowledge of the factors involved in what happened instead of expectations that can be amenable (1.13 – 1.14)	1.13 Consciousness raising 1.14 Reckoning	1.13 List factors that can be amenable 1.14 Revise the expectation in relation to what is possible	1.13 Written -Take notes of the factors 1.14 Verbal presentation
Knowledge about the connection between	1.15 Active learning	1.15 Discuss about what change might be	1.15 Verbal presentation

the factors and anxiety that could be control (connection between anxiety and expectations) (1.15-1.17)	1.16 Environmental reevaluation	possible, after you identify and control some factors in the situation that happened instead of expectations, through these questions: "What do you think you will feel when the expectations doesn`t occur? What happened instead? 1.16 List the discomfort felt, and relief behaviors used	1.16 Written -Take notes of the relief behaviors used

Step 4: Skill to decrease anxiety

- Teach a skill to decrease anxiety

Script:

- Now I will show and apply with you in these last 5 minutes the steps of mindful breathing described in this paper

See on the next page the worksheet with steps to Mindful Breathing

Worksheet – Mindful Breathing for anxiety

Goal: The intention of this deep breathing exercise is allowed thoughts and sensations to come and go, through the connection between mind and body to reach the relief of unpleasant feelings. The key of mindful breathing is to focus your attention on your breath, the inhale and exhale.

Read and apply this entire worksheet following the steps

- Step 1: Find a comfortable place to sit, preferably a place where you won't be disturbed. You can put your feet flat on the ground and try to straighten your posture, always think in an imaginary line get out of your head;
    - Note: It is not necessary put your feet flat on the ground, you can sit in the better position for you
- Step 2: Close your eyes or keep them open, whichever is more comfortable for you. You may find it easier to maintain your focus if you close your eyes, but if you prefer to keep them open, focus on something neutral;
- Step 3: Begin by taking a few deep breaths:
    - A deep inhale through your nostrils (3 seconds), when you inhale, you must riser your shoulder together the movement of inhale;
    - Hold your breath (2 seconds);
    - And a long exhale through your mouth (4 seconds) saying "ahhhh"
- Step 4: After a few deep breaths, begin breathing at a normal rate and rhythm. Allow your breath to find its own natural rhythm. Pay attention to the movements of in-breath the air enters by your nostrils and causes a belly expansion, and during movements of out-breath your belly contracts, the air out by mouth or nostril (chose what is better for you), and notice that your body becoming more settled. Also notice the sound of your breath as you breathe in and out;
- Step 5: When you are distracted by thoughts, sounds, plans, problems or physical sensations, notice the distraction, but do not attach to it. Gently go back to pay attention to your breathing through to practice of letting go of the thoughts;
- Step 6: Continue to focus on your breathing and stay in this relaxed state for as long as you like;
- Step 7: When you are ready, slowly open your eyes and bring your attention back to your surroundings, come back fully alert and awake.
    - Note: Each more you practice, better you will be to achieve mindfulness and consequently decrease anxiety.

Step 4: End of the appointment

- Announcement of the end of appointment

Script:

- Say thank you for the client for came to the appointment
- Say that you are glad for the client stay all appointment work with you
- Say that you hope to see you again in the next appointment
- If the client has a mobile phone say that you will send message to remind about the time of the next appointment

Nurse tasks – During/ after appointment

Complete the data forms:

- Sociodemographic questionnaire
- Assessment of symptoms, issues, support
- Score of the BAI (before and after appointment), GSE, MOS SSS, PSS, ASSIST
- Nurse narrative and field notes
- Prepare for supervision meeting

B. Middle Sessions 2-4: Work (identification + exploitation) Interpersonal Relationship in Nursing
Appointment 2- 4

The middle session focus on implementing strategies address to the behavioral and environmental factors that increase the level of anxiety. But to start to implement strategies the first thing to do in the second appointment is to know if the client remembers what we're working in the last appointment

Appointment 2

Step 1: Focus in client`s feelings

- Start of Each session maintains a present focus in how the client feels.

Script:

- How have you been since we last met?
- Clients typically respond with either a reference to unpleased feelings (tensions - anxiety) or the events in her life during the last day. If the patients provide information about an interpersonal event, the nurse should link the event to the patient`s unpleased feelings during the day reported or vice versa.

Step 2: Remind about the last appointment

- To know what the client absolved about the last appointment

Script:

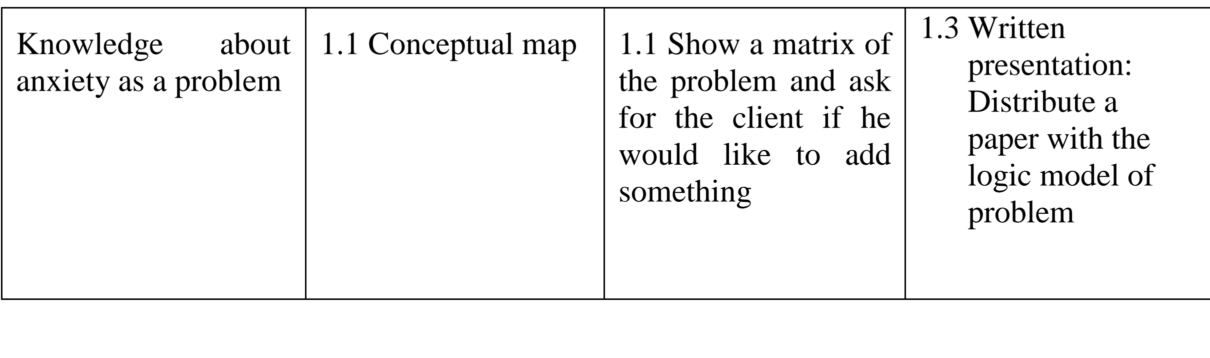
- What do you remember about the last time (appointment)?
    - Note: he needs to name anxiety (use the word anxiety associated a unpleasant feelings), and he can tell about some action that he uses to decrease anxiety.
    - Note: If he doesn't talk at least the two things listed below, the nurse needs to do all the things listed in the first appointment.
- What do you were able to do to decrease anxiety?
    - Note: he might have mentioned the deep breathing, even if he said that he can`t do this. (some possible answers: I didn`t like of this deep breathing. I tried to do this deep breathing, but it is impossible to do with a lot of noise. I can't concentrate in the breathing). He needs to mention that he reminds about deep breathing teaching in the last appointment.

Name of intervention: Logic Model of the problem

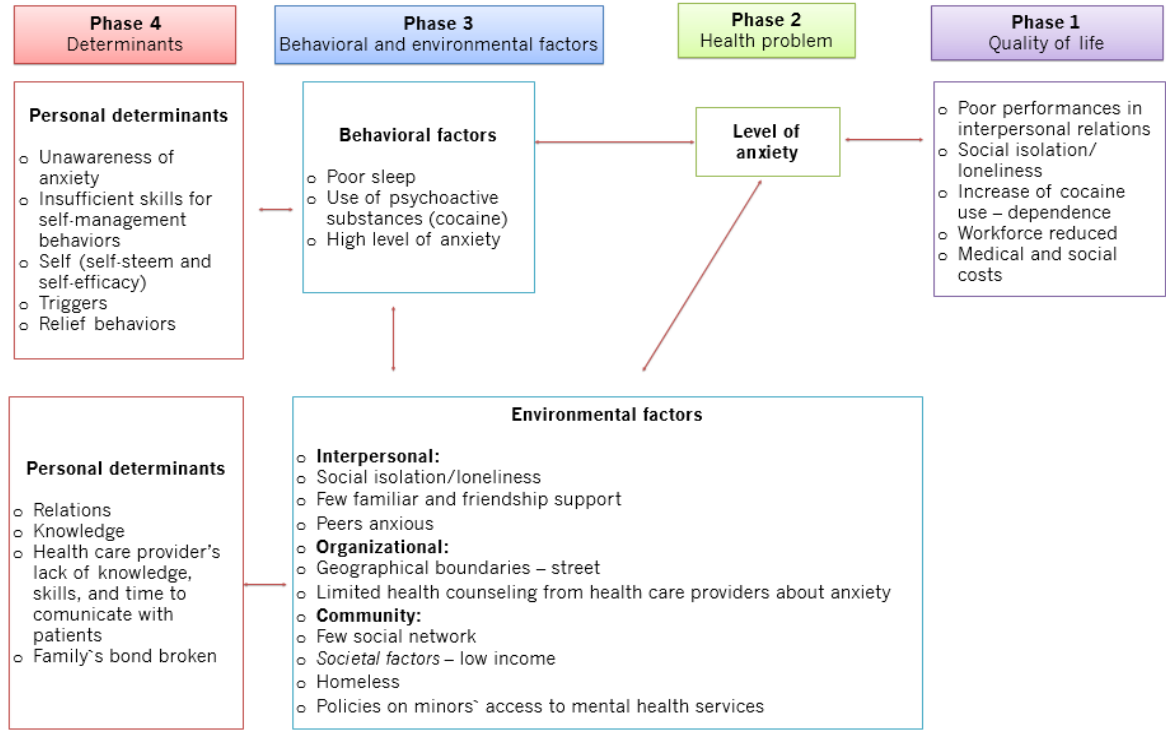
2) Goals of intervention (change objectives + determinants):

- Knowledge about the logical model of the problem (anxiety)

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**



Knowledge about anxiety as a problem	1.1 Conceptual map	1.1 Show a matrix of the problem and ask for the client if he would like to add something	1.3 Written presentation: Distribute a paper with the logic model of problem



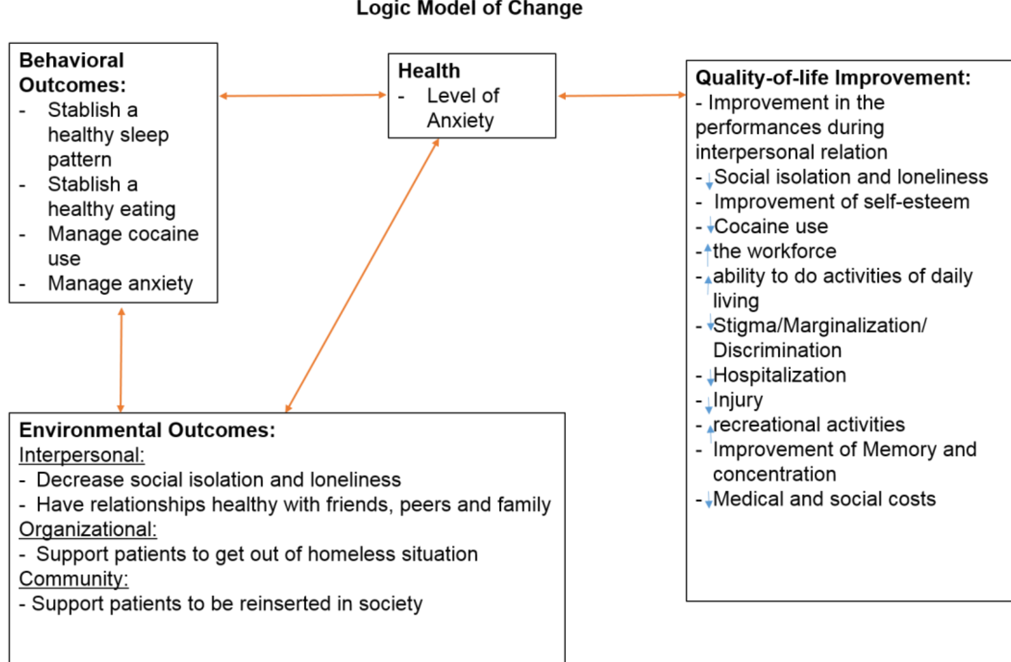
<u>Step 2</u>: Logic model of the problem + logic model of change

- Bring on the table the logic model of the problem and present a logic model of change.
    - Note: If the client adds something in the logic model of the problem, the nurse should readapt the model of the problem and based in this new model of the problem, the nurse should do some adaptations on the logic model of change to present for the client.
- Talk about the interactions among behavioral and environmental outcomes with the anxiety (health problem) and how they can improvement the quality of life.
- Discuss with the patient about the behavioral outcomes, environmental outcomes and how this will be affecting her quality-of -life

Script:

- So, here is the logic model of the problem that we worked together and now I would like to show a logic model of change that represent the transition of behavior and environmental factors in behavioral and environmental outcomes that you can

accomplish in order to decrease this unpleasant feelings (anxiety) that you feel, and to improve your quality of life.



- For each behavioral outcome and environmental outcome, we have some suggestion in how you can achieve these outcomes. I will present these suggestions for you, and we will work together to make this suggestion in the best shape for you

Step 3: 1) *Name of intervention*: Working to manage anxiety – Triggers + relief behaviors + self-efficacy

2) Goals of intervention (change objectives + determinants):

- Recognition of the triggers involved in the anxiety;

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Identify the triggers involved in the operative expectations (2.1 – 2.3)	2.1 Consciousness raising 2.2 Active learning	2.1; 2.2 Define triggers together with client after the client identified in the first appointment the expectation and relief behaviors used (it is easy to think about triggers when you put expectation,	2.1; 2.2 Written - Take notes of the triggers used 2.3 Written -Take notes of the triggers + operative expectations + what happened instead

		what happened instead and relief behaviors). Make a brainstorm with the patient 2.2 Provide a list of triggers that are related with operative expectations 2.3 List the operative expectations at side of the triggers	
Define the triggers (2.3 -2.5)	2.3 Consciousness raising 2.4 Self-reevaluation 2.5 Environmental reevaluation	2.3; 2.4 List the characteristics of the triggers (when, where, who, how) 2.5 Encourage the patients to describe if their family members (or peers, friends) identify some triggers that precede the change of behavior	2.3;2.4 Written - Take notes of the characteristics of the triggers 2.5 Verbal presentation
Appraise the connection among triggers, expectations and what happened instead (2.7)	2.7 Elaboration	2.7 Do an observation and consensual validation of variants of security operations (relief behaviors used)	2.7 Written -Take notes of the triggers + expectations + relief behaviors used
Categorize the possible triggers to change (2.8 – 2.9)	2.8 Personalized risk 2.9 Planning coping responses	2.8 Instruct the individual to avoid situations that can generate this problematics triggers 2.9 Formulate together with patient strategies to avoid these situations	2.8; 2.9 Verbal presentation

- Identification, analyze and connection of the relief behaviors;

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Identify the relief behaviors used during anxiety (3.1-3.2)	3.1 Consciousness raising 3.2 Elaboration	3.1 Connect the anxiety and relief behavior 3.2 What pattern of behavior is used?	3.1; 3.2 Verbal presentation
Analyze the relief behaviors used (3.3)	3.3 Elaboration	3.3 After identify the relief behaviors used (questions below), the nurse has to follow this question to the patient do an analyze of the relief behaviors: Is there a series of relief behaviors that are used? Does the series recur in the same order in subsequent anxiety- producing behaviors? The amount of anxiety is also inferred from the relief behaviors Identify the place that the discomfort is experienced: "What part of the body do you feel this discomfort?"	3.3 Verbal presentation
Connection of the relief behaviors and anxiety (3.4)	3.4 Possession	3.4 After analyze the relief behaviors (series, order and amount of the series of behaviors), the patient should be connected the relief behaviors with the wish to decrease or stop the extreme	3.4 Verbal presentation

		discomfort and internal tension(anxiety) is experienced in your body and your mind.	
Modify the relief behaviors that it is possible change (3.5)	3.5 Self-reevaluation	3.5 The person can be comparing his image as a current relief behavior to a possible image as a new relief behavior (e.g.: A person can compare his image as a sedentary person to a possible image of himself as an active person, using the physical activity as a relief behavior instead of cocaine use)	3.5 Verbal presentation

- Express self-efficacy to face anxiety.

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Express self-efficacy (confidence) to recognize anxiety (4.1)	4.1 Verbal persuasion	4.1 Use positive messages (positive reinforcement) to show that the patient is capable to recognize anxiety	4.1 Verbal presentation
Demonstrate the self-efficacy (ability) to establish connection between behaviors that is used to relieve anxiety (4.2- 4.3)	4.2 Self-monitoring behavior 4.3 Alignment	4.2; 4.3 clients keep a diary to do notes about the discomfort (where in the body - the nurse can provide a picture what the body parts for the patient identify what is the part of body	4.2; 4.3 Written presentation – notebook that it will keep with the nurse – circle the part of the body on notebook

		that he feels discomfort) that came before the unpleasant sensation (anxiety) and the relieve behavior used to decrease this unpleasant sensation	
Express self- efficacy (confidence) to recognize expectations (4.4)	4.4 Verbal persuasion	4.4 Use positive messages (positive reinforcement) to show that the client is capable to recognize expectations	4.4 Verbal presentation
Demonstrate the self-efficacy (ability) to identify the connection among expectations held, what happened instead and relief behaviors as soon as possible (4.5)	4.5 Syntax	4.5 Teach for the client how recognize as soon as possible the connection between expectations held, what happened instead, relieve behaviors and anxiety. Because once the client learns identify the cycle, he can break the cycle, or use other kind of relief behaviors.	4.5 Verbal presentation
Express self- efficacy (confidence) to change some expectations and factors to break the cycle of unpleasant feelings (4.6)	4.6 Guided practice	4.6 Use all the models to target behavior that constitute anxiety (deep breath; mindfulness; physical activity, diet health; use of less cocaine)	4.6 Written presentation: Distribute a paper with the instructions of deep breath – mindfulness; the kinds of physical activities, how long to do, how to do; and diet health)

Step 4: Explanation about the papers and applications

- Explain each paper

Script:

- I have these 2 information papers about the possible relief behaviors that can replace the bad relief behaviors
- I will talk deeper about the others 2 relief behaviors in the next appointment and we will have the opportunity to shape them better for your context
- Now I would like to know if you are using the steps of mindful breathing described in the paper on the last appointment
  - Note: If he said that he isn`t use, the nurse can suggest to apply with him the steps of deep breathing.

Step 5: End of the appointment

- Announcement of the end of appointment

Script:

- Say thank you for the client for came to the appointment
- Say that you are glad for the client stay all appointment work with you
- Say that you hope to see you again in the next appointment
- If the client has a mobile phone say that you will send message to remind about the time of the next appointment

Nurse tasks – During/ after appointment

Complete the data forms:

- Assessment of symptoms, issues, support
- Score of the BAI (before and after appointment)
- Nurse narrative and field notes
- Prepare for supervision meeting

Appointment 3

Step 1: Focus in client`s feelings

- Start of Each session maintains a present focus in how the client feels.

Script:

- How have you been since we last met?
- Clients typically respond with either a reference to unpleased feelings (tensions - anxiety) or the events in her life during the last day. If the patients provide information about an interpersonal event, the nurse should link the event to the patient`s unpleased feelings during the day reported or vice versa.

Step 2: 1) *Name of intervention*: Working to decrease social isolation

2) Goals of intervention (change objectives + determinants):

- Knowledge to decrease social isolation

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Knowledge about different places near of the place that client live (1.1 – 1.3)	1.6 Consciousness raising 1.7 Pros and cons	1.5 List different healthy places 1.6 Advise the person to list and compare the advantages and	1.1 ; 1.3Written presentation: Distribute on paper a list with places and localization

	1.8 Tailoring	disadvantages about each place presented 1.7 Provide maps about the localization of places and routes to arrive in the place	1.2 Verbal presentation
Knowledge about his family history (1.4 - 1.5)	1.4 Empathic linkage 1.5 Feedback	1.8 Listen carefully about his family history 1.9 Give feedback about the main points of his family history	1.9 -1.5 Verbal presentation
Knowledge about the importance of healthy network (1.6)	1.6 Elaboration	1.10 Develop link about the connection of unhealthy network with increase of anxiety, and maintenance of bad relief behaviors	1.6Verbal presentation
Knowledge about the importance of friendship network that can help with his field of work(1.7 - 1.8)	1.7 Elaboration 1.8 Social skills training	1.11 Knowledge about the importance of a healthy friendship to achieve opportunities of work 1.12 Teach effective social interaction in specific situations (e.g: job interviews, eating out) by techniques of behavior rehearsal . Develop a fiction	1.7 Verbal presentation

		situation to client try to think how react to the situation.	
Knowledge about different places (recreation centers) near of the place that the client lives that there are physical activities programs (1.96 – 1.10)	1.9 Elaboration 1.10 Pros and cons	1.9 List different healthy places to practice physical activities 1.10 Discuss with the client the pros and cons about each place presented	1.13 Written presentation: Distribute on paper a list with places and localization 1.14 Verbal presentation

- Self-efficacy to decrease social isolation

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Self-efficacy to recognize barriers` client to know different places (2.1)	2.1 Changing routine	2.1 Advise on ways of changing routines daily or weekly to limit exposure to behavioral cues, and to create an opportunity to meet other people	2.1 Verbal presentation
Express self-efficacy (confidence) to establish contact with his family (2.2)	2.2 Empathic linkage	2.2 Through empathic linkage is developed “bond” between nurse and client, and nurse can talk/listen more about client`s family and encourage clients to contact their family	2.2 Verbal presentation
Express self-efficacy (confidence) to practice physical activity (2.3 – 2.4)	2.3Action planning 2.4 Flooding	2.3 Prompt planning the performance of a particular physical activity (e.g. running) at a particular time on	2.3 Verbal presentation

		certain days of week . 2.4Taking client to a gym to overcome anxiety about engaging in physical activity	

- Improvement in the interpersonal relation

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Prepare clients to interpersonal relations (bonds) in news places (3.1)	3.1 Social skills training	3.1 Teach effective social interaction by techniques of behavior rehearsal. Develop a simulation situation to client try to think how react to the situation.	3.1 Verbal presentation
Reestablish relational bonds (3.2-3.3)	3.2 Environmental reevaluation 3.3 Social skills training	3.2 Describe how family members (or peers, friends) feel about his older relational bonds that he used to hang out 3.3 Teach effective social interaction by techniques of behavior rehearsal. Develop a simulation situation to patient try to think how react to the situation. How reestablish relational bonds (message, Facebook, meet face to face)	3.2; 3.3 Verbal presentation
Establish relational ties to support to do	3.4 Restructuring the social environment	3.4 Identify barriers to start physical activity (e.g., lack of motivation), and	3.4 Verbal presentation

physical activity (3.4)		discuss ways which could help overcome the barriers (e.g., going to the gym with a buddy)	

Step 3: 1) *Name of intervention*: Working to establish relationship healthy

2) Goals of intervention (change objectives + determinants):

- Enhance relationship

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Knowledge about the past, current and future relationships (1.1 – 1.4)	1.1 Elaboration 1.3 Providing cues 1.3 Environmental reevaluation 1.4Restructuring the social environment	1.1 Discuss about the relationships developed and your mechanism to exist 1.2 Develop comparison between characteristics of relations on past and current 1.3Encourage clients to describe how their family members (or peers, friends) feel about their older relational bonds that they used to hang out. How their family members (or peers, friends) feel about their current relational bonds. And discuss about the reaction of your friends, peers and family in relation a relationship developed 1.4Prompt the patient to identify barriers preventing them from starting a new friendship.	3.1 Verbal presentation

Knowledge about how to avoid unhealthy relationships (1.5)	1.5 Elaboration	1.5 Construct some strategies to avoid unhealthy relationship	1.5 Verbal presentation

- Increase of the self-efficacy to enhance relationship

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Express self-efficacy (confidence) in ability to encourage the client to change/ finish problematic relationships (2.1 - 2.3)	2.1 Counterconditioning 2.2 Pros and cons 2.3 Stimulus control	2.1; 2.2 List in the paper the problematic relationship through a table with pros and cons of the relationship 2.3 To break habits- if the patient knows that he can meet the guy (which he has a problematic relationship) in a specific place, it is important that the patient recognize that it isn't help if he keep going in this place	2.1- 2.2 Written presentation: Development the columns with the client on a paper 2.3 Verbal presentation

- Increase of the healthy relations

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Propose to clients a deep understanding about their interpersonal relations that are significant (relational bonds and relational ties) (3.1 – 3.3)	3.1 Consciousness raising 3.2 Pros and cons 3.3 Environmental reevaluation	3.1 Provide a conversation about the relations that the client has. 3.2 Identify pros and cons of his relations 3.3 Encourage client to describe how their	3.1 – 3.3 Verbal presentation

		family members (or peers, friends) feel about his relations	
Prepare cliens to recognize unhealthy relational bonds and relational ties (3.4 – 3.5)	3.4 Pros and cons 3.5 Stimulus control	3.4 Identify pros and cons of the unhealthy relational bonds and link with increase of unpleasant feeling (anxiety) and bad relief behaviors 3.5 To break habits- if the patient knows that he can meet the guy (which he has a problematic relationship) in a specific place, it is important that the patient recognize that it isn't help if he keep to go in this place	3.4 – 3.5 Verbal presentation

Step 4: 1) *Name of intervention*: Working to get out of homeless situation

2) Goals of intervention (change objectives + determinants):

- Knowledge about alternatives to homelessness situation

Change Objectives **(Determinants)**	**Method** **(Active ingredient)**	**Application** **(Component)**	**Mode of Delivery**
Knowledge about the shelter houses available in his city and the rules (1.1 – 1.3)	1.1 Elaboration 1.2 Pros and cons 1.3 Using imagery	1.1 List different shelter houses near of your common environment 1.2 Discuss with the patient the pros and cons about shelter houses presented 1.3 Provide maps about the localization of places and routes to arrive in that places listed	1.1Written presentation: Distribute on paper a list with places and localization 1.2 Verbal presentation

knowledge about the importance of family (1.4)	1.4 Elaboration	1.4 Linking of the lack of family`s contact with homeless situation	1.4 Verbal presentation

- Increase of self-efficacy to get out of homelessness situation

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Express self-efficacy (confidence) to find a best shelter house (2.1-2.2)	2.1 Feedback 2.2 Pros and cons	2.1 Give a positive reinforcement to find a shelter house 2.2 List pros and cons to each shelter house	2.2; 2.2 Verbal presentation
Express self-efficacy (confidence) in ability to help the client to keep contact with his family and maybe back to his family`s house (2.3)	2.3 Pros and cons	2.3 List pros and cons to back to his family`s house	2.3 Verbal presentation

- Establish a relation between get out of homelessness situation and new relations

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Propose to clients a "shelter house" as an opportunity to do relational ties with people (3.1)	3.1 Elaboration	3.1 Talk to the client that Shelter house can be a place that he can establish a relation with other person that share the same reality	3.1 Verbal presentation

Step 5: 1) *Name of intervention*: Working to be reinserted in society

2) Goals of intervention (change objectives + determinants):

- Reinsertion into society

Change Objectives	**Method**	**Application**	**Mode of Delivery**

(Determinants)	(Active ingredient)	(Component)	
Knowledge through state of advantages to avoid dangerous places or places that reminder his pattern behavior (1.1- 1.4)	1.1 Elaboration 1.2 Providing cues 1.3 Tailoring 1.4 Reinforcement	1.1 Link of dangerous place with increase of anxiety and marginalization 1.2 Link dangerous places with bad relief behaviors 1.3; 1.4 Show documentaries about the relation of dangerous place and increase of marginalization	1.1 – 1.2 Verbal presentation 1.3Video
Knowledge about the social support available in his city (1.5 – 1.7)	1.5 Active learning 1.6 Reinforcement 1.7 Mobilizing social support	1.5 List contact with social support to homeless people 1.6; 1.7 Encourage client to enter in contact with this service	1.10 Written presentation: Distribute on paper a list with contact of social support 1.11 Verbal presentation
Knowledge about the specific policies to homeless people and addictive people available in your city (1.8 – 1.9)	1.8 Using imagery 1.9 Mobilizing social support	1.8; 1.9 Provide information about specific policies to homeless people by newsletter and images that provide a fast understanding	1.8;1.9Verbal presentation

- Increase of self-efficacy to be reinsert into society

Change Objectives **(Determinants)**	**Method** **(Active ingredient)**	**Application** **(Component)**	**Mode of Delivery**
Express self-efficacy (confidence) in ability to generate coping strategies to deal with	2.1 Stimulus control 2.2 Restructuring the social environment	2.1 To break habits- Talking with patient about some habits that it is not well view by society	2.1- 2.2 Verbal presentation

environmental cues (2.1 – 2.2)		2.2 Prompt the patient to identify barriers preventing them from starting a reinsertion in the society	

Step 6: End of the appointment

- Announcement of the end of appointment

Script:

- Say thank you for the client for came to the appointment
- Say that you are glad for the client stay all appointment work with you
- Say that you hope to see you again in the next appointment
- If the client has a mobile phone say that you will send message to remind about the time of the next appointment

Nurse tasks – During/ after appointment

Complete the data forms:

- Assessment of symptoms, issues, support
- Score of the BAI (before and after appointment)
- Nurse narrative and field notes
- Prepare for supervision meeting

Appointment 4

Step 1: Focus in client`s feelings

- Start of Each session maintains a present focus in how the client feels.

Script:

- How have you been since we last met?
- Clients typically respond with either a reference to unpleased feelings (tensions - anxiety) or the events in her life during the last day. If the patients provide information about an interpersonal event, the nurse should link the event to the patient`s unpleased feelings during the day reported or vice versa.

Step 2: 1) *Name of intervention*: Working to manage cocaine use

2) Goals of intervention (change objectives + determinants):

- Knowledge about cocaine use

Change Objectives (Determinants)	Method (Active ingredient)	Application (Component)	Mode of Delivery
Knowledge about the habitual consumption of cocaine and the characteristics of his habitual consumption (1.1 - 1.3)	1.1 Consciousness raising 1.2 Self-monitoring of behavior 1.3 Using Imagery	1.1; 1.2 Diary of cocaine use and other substance psychoactive normally used together 1.3 Image with a measure of cocaine (one rock, 250 grams) 1.3 Image with measure of other substance abuse (alcohol) 1.1; 1.3 Knowledge about the pathways of cocaine by figure and video 1.1; 1.3Knowledge about the pathways of cocaine and other substance abuse by figure and video	1.1 -1.3 Written presentation – images 1.2 Written presentation – notebook
Knowledge about the challenges to decrease consumption of cocaine (1.4 -1.6)	1.4 Consciousness raising 1.5 Active learning 1.6 Self-monitoring of behavior	1.4 List with some triggers to consumption of cocaine 1.4; 1.5 Discussion about the challenges to achieve less consumption of cocaine 1.4; 1.5 Development of an individual list pointed the individual`s challenges 1.4 ;1.6Diary of cocaine use with description of place,	1.4 Written presentation: Distribute on paper a list with triggers 1.5 Written presentation – notebook 1.6 Verbal presentation

		time, and people that the individual used to do consumption	

- Recognition of the triggers involved in cocaine use

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Triggers that are present in his lifestyle that interfere direct or indirect to cocaine use (2.1 -2.3)	2.1 Consciousness raising 2.2 Personalized risk 2.3 Relapse Prevention	2.1 Identify specific triggers that generate the need to use cocaine 2.2 Analyze all the things involved with the triggers 2.3 Develop strategies to avoid environmental triggers	2.1 -2.3 Verbal presentation (fill the table)
Modify the triggers that interfere in the cocaine use (2.4-2.7)	2.4 Planning coping response 2.5 Mobilizing social support 2.6 Avoidance/ reducing exposure to triggers for the cocaine use 2.7 Restructuring the social environment	2.4; 2.5 Provide social support to face the trigger present in the cocaine use 2.6 Avoid the situations that provide triggers to cocaine use 2.7 Change (if possible) your usual social environment	2.4-2.7 Verbal presentation

- Identification, analyze and connection of the relief behaviors

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**

Create a new relief behavior in his lifestyle (3.1 -3.2)	3.1 Counterconditioning 3.2 Consciousness raising	3.1; 3.2 Discuss with the patient about others relief behaviors that give him pleasure similar a cocaine (mindfulness, physical activity, health sex , food..)	3.1-3.2 Verbal presentation
Modify the relief behaviors (3.3 – 3.4)	3.3 Counterconditioning 3.4 Environmental reevaluation	3.3 After figure out others relief behaviors, the patient can try to use this new relief behaviors instead of cocaine 3.4 Encouraging the patient to compare the new relief behavior with the big quantity of cocaine use (the patient here, he can keep use cocaine, but at least decrease a little of consumption or use other kind of drug, or other kind of the way of consumption – "crack – cocaine powder")	3.3-3.4 Verbal presentation

- Express self-efficacy to manage cocaine use

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Express self-efficacy (confidence) in ability to monitor one`s own cocaine use (4.1-4.2)	4.1 Self-reevaluation 4.2 Self-monitoring of behavior	4.1; 4.2 Diary with notes about your cocaine intake and the way used to consumption	4.1-4.2 Written presentation – notebook (nurse can decide together with the individual if the

			notebook will stay with her or with the client, because in the next appointment the client should bring the notebook)
Express self-efficacy (confidence) in ability to generate coping strategies to deal with the challenges (4.3 – 4.7)	4.3 Cue altering 4.4 Mobilizing social support 4.5 Flooding 4.6 Planning coping response 4.7 Relapse Prevention	4.3 Patient search for a place that he cannot have a lot of access to cocaine 4.4 Offer some social support that provide others relief behaviors instead of cocaine 4.5 Talk to patient to go to the gym to overcome anxiety, instead to use cocaine 4.6 Nurses provide a list of potential barriers and ways to overcome these. 4.7 Develop strategies to avoid environmental triggers	4.3-4.7 Verbal presentation

- Note: After work with all the strategies to manage the cocaine consume, and the client keep resistant to try these new strategies. The nurse should talk some reinforcement messages: - I can`t compete with drugs, because the drugs give a pleasant sensation so fast, but I and you know that this sensation ends fast. So, all the things that we talked today, I can say that the relieve duration is longer than drugs, but you need to practice each day more to achieve the best sensation.

Step 3: 1) *Name of intervention*: Working to establish a healthy sleep pattern

2) Goals of intervention (change objectives + determinants):

- Knowledge about the most common pattern of sleep

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Knowledge about the most common pattern of sleep (1.1-1.2)	1.1 Consciousness raising 1.2Using imagery	1.1 Guideline about the common pattern of sleep 1.2 Image with the time of sleep and the mood relation (tired, very tired, well)	1.1; 1.2 Written presentation: Distribute a paper with information about pattern of sleep and figure with mood and sleep relation
Knowledge of the benefits of physical activities to improve the sleep (1.5-1.7)	1.5 Consciousness raising 1.6 Using imagery 1.7Belief selection	1.5 Guideline about the beneficious of physical activity (paper or media) 1.6 Image about the function of physical activities on the body (paper or media) 1.7Videos/newsletter about the relation between physical activities and improve of sleep	1.5 -1.7 Written presentation
Knowledge about your habitual pattern of sleep (1.8)	1.8 Self-monitoring of behavior	1.8 Diary to do notes about your pattern of sleep (notebook)	1.8 Written presentation – notebook
Knowledge of the challenges to achieve a good pattern of sleep in your reality and possible safer places to sleep (1.9-1.13)	1.9 Consciousness raising 1.10 Active learning	1.9 Discussion about the challenges to achieve a good pattern of sleep 1.10 Development of an individual list (paper) pointed the individual`s challenges 1.11;1.12 Provide a list (with localization and contact) with	1.9; 1.13 Verbal presentation 1.10- 1.12 Written presentation - Distribute a paper with information

	1.11 Consciousness raising 1.12 Mobilizing social support 1.13 Reinforcement	safer places that the client can go to sleep 1.13 Provide information about how safer place contribute to stablish a healthy sleep pattern	

- Recognition of the triggers involved in the sleep

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Triggers that are present in your lifestyle that interfere in the sleep (2.1-2.3)	2.1 Consciousness raising 2.2 Active learning 2.3 Elaboration	2.1;2.2Provide a list with some triggers that interfere in the sleep 2.3 Identify together with client your triggers that interfere in the sleep, and provide alternatives for inhibit these triggers (menu of options).	2.1- 2.2 Written presentation: Distribute on paper a list with triggers 2.3 Verbal presentation + written presentation (add on the list give for client the new triggers that he identified)
Triggers that interfere to not do physical activity (2.4 -2.5)	2.4 Consciousness raising 2.5 Restructuring the physical environment	2.4 Link the triggers (frequency and probability) with absence of physical activity 2.5 Prompt the client to identify barriers for start a new exercise regime (e.g., lack of motivation, and discuss ways in which they could help overcome them – e.g., going to the park to do exercise with a friend)	2.4; 2.5 Verbal presentation

Modify the triggers that interfere in the pattern of sleep (2.6-2.8)	2.6 Planning coping response 2.7Mobilizing social support 2.8 Feedback	2.6; 2.7 Offer some social support to face this trigger 2.8 Give a positive reinforcement to change of pattern of sleep	2.6 -2.8 Verbal presentation

- Identification, analyze and connection of the relief behaviors;

Change Objectives (Determinants)	Method (Active ingredient)	Application (Component)	Mode of Delivery
Relief behaviors to achieve sleep (3.1-3.3)	3.1 Consciousness raising 3.2Active learning 3.3Tailoring	3.1 Reinforcement the importance of Mindful breathing to achieve sleep, but the patient can choose to do only deep breath before sleep. He can decide what works better for him. 3.2 Teach the patient to do a deep breath before sleep (Step 3 in the mindful breathing) 3.3 Discussion with the client your environmental situation. Because sometimes the client said that he needs to keep herself awake to be safe in dangerous place. You can teach him that he can adapt the mindful breathing to be awake when he heard some noise that represent danger for him. E.g. Instead of letting go all the thoughts, he needs to keep in your	3.1 Verbal presentation 3.2 Practical application 3.3 Verbal presentation

		unconsciousness that he will recognize noise that represent danger to be awake and alert in the same moment.	
Physical activity as a relief behavior (3.4 - 3.5)	3.4 Consciousness raising 3.5 Using imagery	3.4; 3.5 Provide information with the function of physical activity in decrease anxiety (body relaxation) by paper, video, pictures and achieve to sleep	3.4; 3.5 Written presentation
Distinguish the relief behaviors that difficult the sleep from that help a good sleep (3.6)	3.6Active learning	3.6 Develop a table with 2 columns which one column will be to relief behaviors that help sleep and the other it will be to relief behaviors that is bad to sleep that the client use	3.6Written presentation: Development the columns with the client on a paper
Modify the relief behaviors that is used to achieve the sleep (3.7)	3.7 Active learning	3.7 Use the table developed previously to identify the bad and good relief behaviors used, and with the patient try to substitute the bad relief behavior for others.	3.7 Written presentation

- Express self-efficacy to achieve health sleep pattern

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Self-efficacy in ability to adequate pattern of sleep in his lifestyle (4.1 – 4.2)	4.1 Guided practice	4.1 The client firstly show how he is using the techniques to improve your sleep (mindfulness, deep	4.1 Practical application

	4.2 Self-monitoring of behavior	breathing...) and then the nurse asks to patient to do the same a number of times to analyze the way that he is doing. After this, nurse will give brief comments on the patient`s performances, emphasizing aspects done well. 4.2 Clients keep a diary about your pattern of sleep, and take notes about how the techniques are help to adequate pattern of sleep in his lifestyle	4.2 Written presentation – notebook
Express self-efficacy (confidence) in ability to do physical activity (4.3 -4.5)	4.3 Goal setting 4.4 Self-monitoring of behavior 4.5 Planning coping response 4.6 Flooding	4.3 Client and nurse discuss the goal for the next meeting, deciding on a goal that is acceptable in his lifestyle to improve his physical activity. 4.4 Client keeps a diary about the physical activity done 4.5 Nurses provide a list of potential barriers and ways to overcome these, as example, if the park that the patient used to go to do physical activity is closed, he can other options near this park to do exercise. 4.6 Clients must keep in mind that physical activity is important	4.3; 4.5; 4.6 Verbal presentation 4.4 Written presentation – notebook

		to reduce anxiety, and consequently achieve sleep	
Express self-efficacy (confidence) in ability to change pattern of sleep (4.7 – 4.8)	4.7 Improving physical and emotional states 4.8 Cue altering	4.7 Patient are taught to breathe deeply and relax before to go to sleep, and consequently he will have more chance to sleep well. For patient that live in the street (homeless) nurse have to reaffirm that during this breath the patient have to keep in mind that some noise that can represent dangerous he will wake up fast and alert (unconsciousness message – this is what happen when mom wake up instantly when she heard the cries sound of your son). 4.8 Patient search for a place safer than previous that he used to sleep, in order to avoid disturb in your sleep	4.7 Verbal presentation

Step 4: 1) *Name of intervention*: Working to establish a healthy diet

2) Goals of intervention (change objectives + determinants):

- Knowledge about the most common pattern of eating

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**

Knowledge about the most common pattern of eating (1.1-1.2)	1.1 Consciousness raising 1.2Using imagery	1.1 Guideline about the common pattern of eating 1.2 Image with the foods that the individual can eat per day	1.1; 1.2 Written presentation: Distribute a paper with information about pattern of eating and figure with the foods
Knowledge about your habitual pattern of eating (1.3 -1.4)	1.3 Self- monitoring of behavior 1.4 Feedback	1.3 Diary of food intake 1.4 Feedback about the match between the hope health habit of eating and the current individual habit	1.3 Written presentation – notebook 1.4 Verbal presentation
Knowledge about the places to eat healthy food (1.5 -1.6)	1.5 Consciousness raising 1.6 Feedback	1.5 List about the places to eat 1.6 Feedback about the places to eat and the good food for eat	1.5 Written presentation – provide a list on paper 1.6 Verbal presentation
Knowledge about the challenges to achieve a good pattern of eating in your reality (1.7 -1.8)	1.7 Consciousness raising 1.8 Active learning	1.7 List with some triggers to bad consumption of food 1.7 Discussion about the challenges to achieve a good pattern of eating 1.8Development of an individual list pointed the individual`s challenges	1.7 Written presentation – provide a list on paper 1.8 Verbal presentation

- Recognition of the triggers involved in the eating

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**

Triggers that are present in your lifestyle that interfere in your diet (2.1-2.2)	2.1 Consciousness raising 2.2 Active learning	2.1 Provide a list of possible triggers that interfere in the health diet 2.2 Adapt a list for your reality	2.1Written presentation: Distribute on paper a list with triggers 2.2 Verbal presentation + written presentation (add on the list give for client the new triggers that he identified)
Modify the triggers that interfere in the healthy food (2.3)	2.3 Reinforcement	2.3 Give a positive reinforcement to face the triggers that interfere in the healthy food	2.3 Verbal presentation

- Identification, analyze and connection of the relief behaviors

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Create new relief behaviors to achieve a good eating in his lifestyle (3.1 – 3.2)	3.1 Counterconditioning 3.2 Cue altering	3.1; 3.2 Encourage the patient to learn health behaviors that can substitute for this problematic behavior (to schedule a regular time to eat; don`t eat snack before the meal; don`t drink alcohol beverage before the meal)	3.1; 3.2 Verbal presentation
Distinguish the relief behaviors that difficult the healthy diet from that help a good diet (3.3)	3.3 Active learning	3.3Develop a table with 2 columns which one column will be to relief behaviors that help healthy eating and the other it will be to relief behaviors that	3.3 Written presentation: Development the columns with the client on a paper

		is bad to diet that the client use	
Modify the relief behaviors that is used to achieve the healthy diet (3.4)	3.4 Active learning	3.4 Use the table developed previously to identify the bad and good relief behaviors used, and with the patient try to substitute the bad relief behavior for others.	3.4 Written presentation

- Express self-efficacy to achieve healthy diet

Change Objectives (Determinants)	**Method (Active ingredient)**	**Application (Component)**	**Mode of Delivery**
Express self-efficacy (confidence) in ability to adequate pattern of eating in his lifestyle (4.1)	4.1 Reinforcement	4.1 Use positive messages (positive reinforcement) to show that the patient is capable to enhance an adequate pattern of eating	4.1 Verbal presentation
Express self- efficacy (confidence) in ability to monitor one`s own food intake (4.2)	4.2 Self-monitoring of behavior	4.2 Diary to do notes about your food intake (notebook)	4.2 Written presentation – notebook

Express self-efficacy (confidence) in ability to face the challenges encountered toward pattern of eating (4.3-4.5)	4.3 Cue altering 4.4 Mobilizing social support 4.5 Planning coping response	4.3 Client search for a place that can provide more health food, in order to avoid unhealthy food. 4.4 Offer some social support that provide free food or with low cost, and healthy. 4.5 Nurses provide a list of potential barriers and ways to overcome these.	4.3-4.5 Verbal presentation

Step 5: End of the appointment

- Announcement of the end of appointment

Script:

- Say thank you for the client for came to the appointment
- Say that you are glad for the client stay all appointment work with you
- Say that you hope to see you again in the next appointment
- If the client has a mobile phone say that you will send message to remind about the time of the next appointment

Nurse tasks – During/ after appointment

Complete the data forms:

- Assessment of symptoms, issues, support
- Score of the BAI (before and after appointment)
- Nurse narrative and field notes
- Prepare for supervision meeting

C. Termination Session 5: Resolution - Interpersonal Relationship in Nursing
Appointment 5

The goal of termination session is to summarize all the previous sessions, identifying the most important skills that the client developed to achieve the goal (decrease anxiety), development of strategies for the clients maintain the skills in your context daily, and terminate the relationship between nurse and client. This session can be full of feelings, so the nurse must to be prepared to sadness and tears that might happen.

<u>Step 1:</u> Focus in client`s feelings

- Start of Each session maintains a present focus in how the client feels.

Script:

- How have you been since we last met?
- Clients typically respond with either a reference to unpleased feelings (tensions - anxiety) or the events in her life during the last day. If the patients provide information about an interpersonal event, the nurse should link the event to the patient`s unpleased feelings during the day reported or vice versa.

Step 2: Resolution

- Summary the goals

Script:

- During these days we talk about ways to reach a better level of anxiety. The main points to reach this are change your health sleep pattern, your food intake and your cocaine use; and change your relationships and decrease your social isolation.
  - Note: If the patient is homeless, change your situation of homeless is an important factor to be consider in this moment.
- We work together to adapt some strategies to achieve these changes for your reality. Perhaps new situations can appear in your life that demand a new strategy to face them, but you have keep in mind that the main strategies are these, and you can readapt or create others based in these main strategies.
- Review the strategies that the client will use.
- Now you know how to recognize anxiety and the expectations, and when you are in syntax mode of anxiety you can create new relief behavior to face the unpleasant feeling that is anxiety, and you can choose healthy relief behaviors instead of problematic relief behaviors.

<u>Step 3</u>: End of the appointment

- Announcement of the end of appointment

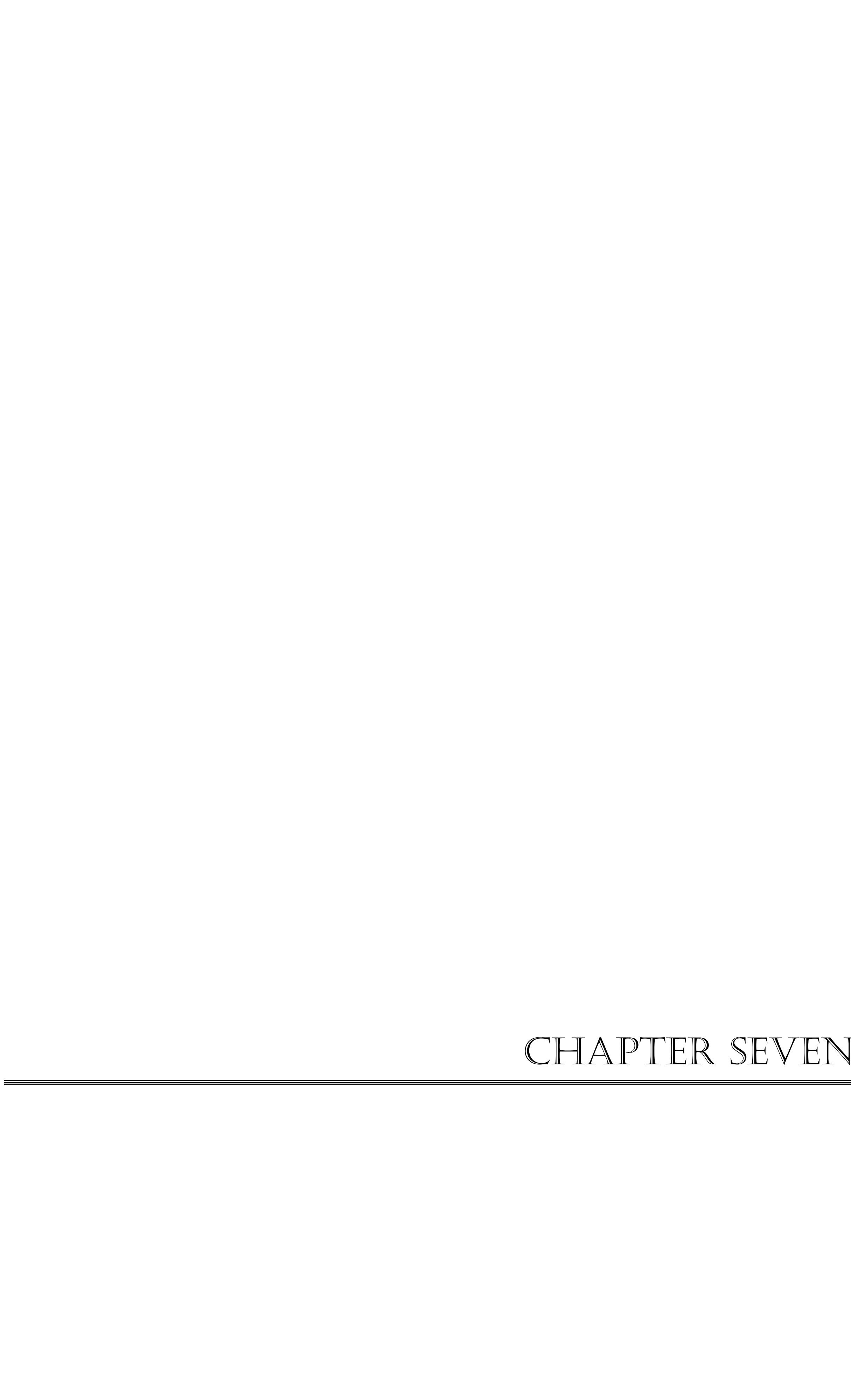
Script:

- Say thank you for the client for came to the appointment.
- Say that you are glad for the client stay all appointment work with you.
- Terminate the relationship between nurse and client but tell for the client that he can always back to specialized service in alcohol and other drugs when he thinks it is necessary in any time and any day to be attending by our health care provider.
- If the client asks if he can be attending for you, you have to clarify that you will not be able to do more appointment with him.
- Allow the nurse and the client to grieve the loss

Nurse tasks – During/ after appointment

Complete the data forms:

- Assessment of symptoms, issues, support
- Score of the BAI, GSE, MOS SSS, PSS, ASSIST
- Nurse narrative and field notes
- Prepare for supervision meeting



CHAPTER SEVEN

CHAPTER SEVEN

9. THIRD ARTICLE

Interpersonal theory of nursing to anxiety management in people with substance use disorder (ITASUD): a feasibility study

Abstract

Background: The comorbidity of anxiety and substance use disorders has been shown to have a strong association. High levels of anxiety are critical to the increased risk of substance use disorders, relapse and withdrawal of related treatment. While it is broadly accepted that a potential factor in helping this population continue with their treatment is to address their anxiety. There has been no protocol, and feasibility studies targeting anxiety in cocaine users. **Methods:** Our aim was to verify the feasibility of the interpersonal relationship between nurse and patient to equip cocaine users with anxiety management strategies. Thirty-nine participants received a complex intervention focused on their anxiety. Feasibility outcomes included: 1) Demand; 2) Acceptability; 3) Implementation; 4) Practicality; 5) Adaptation; and 6) Safety. Besides this, we used General Self- Efficacy Scale (GSE), Medical Outcome Study (MOS SSS), Perceived Stress Scale (PSS), ASSIST (Alcohol Smoking and Substance Involvement Screening Test), Generalized Anxiety Disorders (GAD 7) and Beck Anxiety Inventory (BAI) to measure the mediators of intervention. **Results:** Preliminary evidence support the feasibility of the trial with some changes. The main results demonstrate that it is necessary a synthesis of the intervention program to three days, instead of five, due to the low prevalence of people in the fourth and fifth appointments. The main content of the intervention may appear in the first (100%) and second appointment (64.10%), period that we have more people attending. The anxiety measure was acceptable and appeared sensitive to change, decreasing in 38 points in average after the intervention. **Conclusion:** The results of this feasibility study suggest that Interpersonal Relationship nurse-patient have potential as an inexpensive and feasible intervention. A larger trial, following the changes pointed in this implemented protocol, is necessary to fully test the effectiveness of ITASUD.

Background

The comorbidity of anxiety and substance use disorders has been investigated by several researches (Remes et al., 2016) and a strong association has been shown. Epidemiological and clinical studies (Kosten et al., 2000; Kushner et al., 2000) have demonstrated that high levels of anxiety are associated with an increased risk of substance use disorders. And data (Regier et al., 1998; Wittchen et al., 2000) suggest that onset of anxiety is primary to onset of substance use disorders and is associated with higher rates of impairment, health care cost, and decrease work productivity (Simpson, 2010). The purpose of this paper is to verify the feasibility of a prototype intervention, based on Peplau's theory, to anxiety management for cocaine users.

To date, attempts to intervene in substance use disorders, specifically cocaine use disorders, have focused on cocaine use, and the majority have been realized in the laboratory with mice. These interventions have met with varied levels of efficacy. The limited efficacy may be because interventions address only the psychoactive substance (cocaine). An alternative and novel approach is to conceptualize the anxiety felt by cocaine users as the problem that generates the use of cocaine, in order to consider underlying determinants of anxiety (self-efficacy, relations, triggers, and cocaine) that could be targeted by interventions.

This knowledge is important given the increase of cocaine users in Brazil (UNODC, 2012), and the high demand of cocaine users in emergency room ("The Global Drug Survey 2015 findings ", 2015) which overloads the Health System, and highlights the need to reframe the specialized health service provided to the treatment of alcohol and other drugs, in order to prevent people from ending in an emergency room. Such a measure will decrease the health care costs with this population, once this population will no longer reach the emergency room frequently due to cocaine abuse

The high level of patients' drop out during the treatment in specialized outpatient health facility in alcohol and other drugs is related with patients' high anxiety levels(Shanmugam & Winslow, 2013), and this drop out is considered a critical issue in the health scenario (Miguel et al., 2016). Due to this issue, the overall aim of this study is to assess whether it is possible to design a complex intervention to equip cocaine users in the management of anxiety.

The intervention was developed in earlier phases of the study (using an intervention mapping approach to develop a new intervention which combines environmental and behavioral factors of anxiety as well as focus groups with nurses). We are now conducting a study to assess the feasibility of the intervention, which it is significant since it will estimate

important parameters that are needed to design the main study/trial (RCT). In order to inform the design of an adequately powered trial which could test the effect of the interpersonal relationship between nurse and patient to equip cocaine users with anxiety management strategies.

Methods

Design

The study used a mixed-methods single-arm repeated measures feasibility design and was conducted from October 2018 to December 2018. Thirty-nine cocaine/crack users with anxiety attending in the specialized outpatient health facility in alcohol and other drugs localized in the São Paulo downtown received over a one-week period of the intervention to management of anxiety through the Interpersonal Relationship nurse-client. Participants completed measure of General Self- Efficacy Scale (GSE), Medical Outcome Study (MOS SSS), Perceived Stress Scale (PSS), ASSIST (Alcohol Smoking and Substance Involvement Screening Test), Generalized Anxiety Disorders (GAD 7) and Beck Anxiety Inventory (BAI) at baseline, and in the last appointment. The Beck Anxiety Inventory (BAI) was applied in all 5 appointments in the start and in the end of appointment to evaluate the level of anxiety. There is also a questionnaire about the characteristics (e.g., demographics) of the participants that there is applied only in the first appointment. Qualitative open-ended interviews were conducted with participants at the last appointment.

Ethical consideration

This study was approved by the institutional review board at the Nursing School, University of São Paulo (CAEE number: 86848418.4.0000.5392) and the Municipal Health Secretary of São Paulo (CAEE number: 86848418.4.3001.0086).

Participants

We recruited 42 cocaine/crack users in the specialized outpatient health facility for alcohol and other substances in São Paulo downtown, via advertisement and talk face to face around the health facility. The inclusion criteria were (a) to be a man, (b) age 18 years or over, (c) to use cocaine/crack as a principal drug, (d) to present high level of anxiety, (e) to be during the development of Therapeutic Plan Singular (PTS) – When the patient doesn’t have contact with other health professional, and he is not participating of any group in the health facility. People were excluded if (a) they were experiencing a psychotic episode, had thought-disorder

or who were unable to give consent, (b) they were intoxicated by any psychoactive substance, and (c) they were not fluent in Portuguese.

The Intervention

The intervention is a complex intervention, which used the intervention mapping as a method and Peplau's Interpersonal Theory of Nursing (ITN) as a conceptual model. It was delivered by a nurse researcher that developed the manual of intervention, and she had an extensive training in Peplau's concepts. The intervention to equip cocaine user in the management of anxiety is a client-centered that we address the behavioral (sleep, eat, drug addiction) and environmental (social isolation, familiar and friendship support, low income) main factors of anxiety. However, during the appointment, the client can bring some other factors, and the nurse will work with these new factors during the appointment. The underlying principle of the intervention is based on Peplau's ITN.

Communication is the key for accomplishing good results in all types of health treatment. The construction of a holistic health plan for clients must be based on a comprehensive assessment of the client`s problems and integration of pathophysiological, psychological and social data into the plan to accomplish a whole health approach to mental health issues. All this process is construct with the individual to increase their self-efficacy when approaching and dealing with anxiety.

The clients received up to five 1-hour one-to-one sessions with the same nurse throughout, who use the intervention methods in the interaction. Sessions took place over one-week period in the health service.

Sample size

A sample of 39 participants were the target as this is considered enough for a feasibility study (Lancaster et al., 2004); we recruited over a set period (October to December 2018) at the specialized outpatient health facility for alcohol and other substances in São Paulo downtown.

Data collection and procedures

Nurse contacted potential participants to explain the study. All data collection took place over face-to-face ranging in length from 60 to 90 min. Nurse directly entered quantitative data into RedCap (Research Electronic Data Capture), a secure online data collection system.

After consent was obtained, nurse collected demographic, clinic and behavioral data; and baseline measures (GSE, MOS SSS, PSS, ASSIST, GAD 7, BAI, and PHQ 9) from all

participants. The baseline measures are to evaluate the mediators of the intervention self-efficacy, relation, stress, psychoactive substance use, and anxiety. Self-reported self-efficacy was assessed via the GSE, relation was assessed via MOS SSS, Stress via PSS, Psychoactive substance use via ASSIST, and level of anxiety via GAD 7 in the screening and BAI in the start and end of all appointments. PHQ 9 was used to evaluate the safety of the intervention. Questionnaires were completed prior the intervention, and in the last appointment. Anxiety outcomes, through BAI scale, will be measured in the start and in the end of the appointment.

Measures

Demographic, Clinical and Behavioral form

The demographic, clinical and behavioral form were completed by all participants at baseline. Demographic information collected included age, color of skin, number of sons, marital status, employment status, ethnicity, religion, and level of education; clinical included comorbidities, medication and disease; behavioral included information about the first contact with cocaine, place that use cocaine, family member with substance's problems and physical activities

General Self-Efficacy Scale

The GSE is a 10-item, 4-point scale with a Cronbach's alpha coefficient of reliability ranging from 0.76 to 0.90. The scale assesses a person's perceived self-efficacy or their belief that they can complete novel or difficult tasks or cope with diversity. Total scores range from 10 to 40 with higher scores indicating a greater level of self-efficacy.

Medical Outcome Study

The MOS SSS is a 19 -item, 5-point scale with a Cronbach's alpha coefficient of reliability ranging from 0.76 to 0.95. The scale assesses the extent to which the person has the support of others to cope with stressful life situations. Total scores range from 0 to 76 with high scores indicating a greater perceived support.

Perceived Stress Scale

The PSS is a 14-item, 5-point scale with a Cronbach's alpha coefficient of 0.77 to 0.87. The scale assesses the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. Total scores ranging from 0 to 56 points with high scores indicating a greater level of stress.

Alcohol Smoking and Substance Involvement Screening Test

The ASSIST is a 8 item by the type of psychoactive substance (tobacco, alcohol, cannabis, cocaine, amphetamine – type stimulants (including ecstasy), inhalants, sedatives, hallucinogens, opioids, and “other drugs”), 4-point scale with a kappa coefficient ranged between 0.58 to 0.90. The scale evaluates the frequency of the psychoactive substance use, during the life and in the last three months. Related problems with the use, concerns about the use, unsuccessful attempts to stop or reduce use, compulsive feeling, and use through injectable via. Total scores ranging from 0 to 20 points. Score from 0-3 is an occasional use, 4-15 is abuse, and 16 and above as a suggestive dependence.

General Anxiety Disorder

The GAD-7 is designed to measure anxiety severity. It consists in 7 items, 4-point scale with a Cronbach’s alfa coefficients of 0.88. Total scores ranging from 0 to 21. Score from 0- 5 is mild anxiety, 6-10 is a moderate anxiety, and 15 and above is severe anxiety.

Beck Anxiety Inventory

The BAI is a 21-item, 4-point scale with a Cronbach’s alpha coefficient of reliability ranging from 0.75 to 0.90. The scale measures the level of anxiety that the person presents in life’ situations. Total scores range from 0 to 63. Score of 0-21 is low anxiety, 22-35 is moderate anxiety, 36 and above is potentially concerning levels of anxiety.

Patient Health Questionnaire

The PHQ 9 is a 9–item, 4-point scale with a Cronbach’s alpha coefficient of reliability of 0.85. The scale assesses the level of depression severity. Total score ranges from 0 to 27. Score of 0 – 4 is none depression, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe, 20 – 27 severe depression.

Qualitative interviews

The qualitative interview guide developed by the research team consists of eight open-ended questions to evaluate and improve the intervention. Questions included : - What do you think about the intervention?; Does the intervention work for you, providing strategies to manage anxiety?; What strategy that you liked more?; What strategy do you think that you are able to use for a long time?; What strategy is not useful at all for you?; Are there some others strategies that you used to manage anxiety? Why did you come back? Anything else you would like to add?

Data analysis

We used the Kaplan-Meier model estimator to assess the survival proportion with the aim to re-organize the manual of the intervention, and to reallocate the main content of the intervention in the appointments that we had more participants.

Data were analyzed to meet the study's objectives of evaluating the intervention to equip cocaine users to decrease anxiety for each component of feasibility: demand, acceptability, implementation, practicality, adaptation and safety. Qualitative data were analyzed using a thematic analysis described by Braun (Braun & Clarke, 2006).

Quantitative data were analyzed using the R program. Descriptive statistics were used to report participants' demographic, clinic and behavioral characteristics, and responses from the intervention. To determine preliminary effectiveness, we used the Linear mixed-effects model to assess the changes in the level of anxiety after the intervention. We couldn't assess the mediators of the intervention, since the number of participants that completed the intervention until the last appointment was low.

Results

Specialized Outpatient Health Facility in Alcohol and other Drugs in the Center of São Paulo (CAPS AD)

The scenario in this health facility is singular because is in São Paulo downtown, one of the most crowded regions in Brazil, with high levels of homelessness and a vast number of psychoactive substance available, mainly alcohol and crack. The CAPS AD attends people that seek treatment for alcohol and other substances during the week in the period of 7 am until 7pm. During the weekends and after 7pm, there are reduced health professionals that attend only inpatient people. The CAPS AD has 8 dormitories that present eligible criteria to be occupied, such as the clients' agreement to receive inpatient treatment and the health professionals' team need to understand that the eligible' client is in vulnerable situation and the inpatient treatment is the best choice.

All individuals that seeking treatment during week in the CAPS AD, they are attending by the health professional without scheduling appointment. During this attending, clients answer demographic, clinical and behavioral questionnaire, and they are scheduling to the group appointment on Monday, or Wednesday or Friday. The appointment in group explains how the CAPS AD works, and the types of activities that the client can participate. Moreover, the CAPS AD gives breakfast, lunch and dinner for clients that participate of activities in the CAPS AD all day.

Individuals are inviting to participate of research after the client' first appointment with the health professional. The individuals that agree to participate of the intervention will work during 5 days with the researcher about strategies to manage anxiety, and they will not participate of other activities in the CAPS AD.

Participants

Forty-eight adults were screened for inclusion and exclusion criteria. Among those, 6 were women, and they were excluded of research; 3 were found eligible, but they don't wait to be attending by the researcher, and they don't back to the service in other day to participate of research. The final study sample consisted of 39 men. Participants characteristics were summarized in the table 7.

As shown in the table 7, the majority were single (71. 80%), without religion (58.97%), unemployed (74.36%), homelessness (38.46%), alcohol use (94.87%), and normally use cocaine on the streets (92.31%). The participants present the mean of 40.03 years old.

Table 7: Participants characteristics

Variables	Level	Count	Percent	95%CI.lo	95%CI.hi
Color of skin	White	16	41.03	27.08	56.58
	Brown	9	23.08	12.65	38.34
	Black	14	35.90	22.74	51.58
Marital status	Single	28	71.80	56.22	83.46
	Married	5	12.82	5.60	26.71
	Divorced/Separated	6	15.39	7.25	29.73
Religion	No	23	58.97	43.42	72.92
	Yes	16	41.03	27.08	56.58
State	Alagoas	1	2.56	0.45	13.18
	Bahia	7	17.95	8.98	32.67
	Ceará	1	2.56	0.45	13.18
	Maranhão	2	5.13	1.42	16.89
	Natal	1	2.56	0.45	13.18
	Paraná	1	2.56	0.45	13.18
	Pernambuco	2	5.13	1.42	16.89
	Rio de Janeiro	3	7.69	2.65	20.32

	Santa Catarina	1	2.56	0.45	13.18
	São Paulo	20	51.28	36.20	66.13
Education level	Incomplete high school	14	35.90	22.74	51.58
	Complete high school	9	23.08	12.65	38.34
	Incomplete elementary	7	17.95	8.98	32.67
	Complete elementary	8	20.51	10.78	35.53
	Technical degree	1	2.56	0.45	13.18
Job situation	Self employed	1	2.56	0.45	13.18
	Unemployed	29	74.36	58.92	85.43
	Formal job	4	10.26	4.06	23.58
	Informal job	5	12.82	5.60	26.71
Habitation	Hostel	11	28.21	16.54	43.78
	Renting	1	2.56	0.45	13.18
	Community on the street	4	10.26	4.06	23.58
	Illegal habitation	3	7.69	2.65	20.32
	Other	1	2.56	0.45	13.18
	Shelter	2	5.13	1.42	16.89
	Own home	2	5.13	1.42	16.89
	Homelessness	15	38.46	24.89	54.10
Physical activity	No	39	100.00	91.03	100.00
Health problems	No	25	64.10	48.42	77.26
	Diabetes	1	2.56	0.45	13.18
	Gastritis	1	2.56	0.45	13.18
	Hypertension	12	30.77	18.57	46.42
Alcohol use	No	2	5.13	1.42	16.89
	Yes	37	94.87	83.11	98.58
First cocaine contact	Pub	6	15.39	7.25	29.73
	At home with friends	13	33.33	20.63	49.02
	At home with parents	1	2.56	0.45	13.18
	Party	2	5.13	1.42	16.89
	On the street	17	43.59	29.30	59.02
Cocaine use	At home	2	5.13	1.42	16.89
	On the street	36	92.31	79.68	97.35

	To relax	1	2.56	0.45	13.18
Parents that use cocaine	No	34	87.18	73.29	94.40
	Yes	5	12.82	5.60	26.71
Parents that use other substances	No	18	46.15	31.57	61.43
	Yes	21	53.85	38.57	68.43

Feasibility Assessment

Robust measurements of feasibility, such as demand, acceptability, implementation, practicality, adaptation and safety were assessed (Damschroder et al., 2009; Greenhalgh et al., 2004; Grol et al., 2007; Hagen et al., 2011), through the questions for which measurement as shown in the table 8

Table 8: Feasibility components assessment

Feasibility – Area of focus	**Outcomes of interest**	**Approach/ Questions**	**Answer**
Demand	1)Willingness of participants to participate 2)Number of eligible clients	1)How many participants accepted to participate of study? And How many deny to participate the study? 2)a)The criteria inclusion is a lot of specific? How many clients couldn`t participate because the	1) 42 clients were eligible to the study. 39 accepted to participate of the study (92.85%). 3 participants denied to participate of the study (7.14%) 2) a) The criteria of inclusion are not so specific, because we included the users of multiple substances, but they need to choose cocaine/crack as the main substance, and the ASSIST may indicate cocaine/crack as the most abused substance. 6 (15.38%) women wouldn't participate of the research because the eligibility criteria. b) We had some potential confounding, due to the diversity of substance use, as the use of marijuana, that many participants use to relax, and they arrived more relaxed in the appointment when

		criteria inclusion? b) The eligibility criteria is specific enough to reduce the potential for confounding? What are the potential for confounding that appear? c) The inclusion criteria allow the generalizability of results?	compared with participants that don't use marijuana. c) We can generalize the results for people that lives on the street or in hostel that are using cocaine/crack as the main substance. The diversity of substance allows the generalizability of results and maximize the number of potentially eligible subjects. On the other hand, increase the potential for confounding.
Acceptability	1)Follow-up rates. 2) Attrition	1) How many missing on the data? How many participants did the follow-up? 2) How many people didn`t answer the call to do follow-up? How many people attend the call, but didn`t appear on the follow-up day?	1) 39 (100%) participants answer the questionnaire in the baseline, and during the appointments they answer the BAI in the start and in the end of appointment. 2 (5.88%) participants completed the follow-up. We consider that we didn't have missing data because in this intervention each appointment is self-content. The client could come to the first session and maybe don't back for the other sessions, thinking in this specific population, the minimal dose will be one appointment and the maximum dose will be 5 appointments. 2) The majority of the participants (94.12%) don't have cell phone, so we didn't have how to call for these participants that don't appear in the appointments. 35.90% of participants used to go in 1 appointment, 35.90% in 3

		How many sessions the participant used to go? How many participants die, are sick, inpatient unit and/or disappear.	appointments, 20.51% in 2 appointments, 5.13% in 5 appointments plus the follow-up, 2.56% in 4 appointments. 2 (5.12%) participants went in the first appointment, but after this first appointment they were insert in the inpatient treatment. Then, they were not eligible to keep doing the intervention, due to the bias. 35 (89.74%) participants disappear.
Implementation	1)*Complexity and design* – a) Perceived difficulty of implementati on; b) Degree of execution.	1)a) The participant demonstrate s restlessness during the appointment , asking all the time when the appointment will finish? The participant understands all the strategy provided for him? What kind of terminology (terms used by participants routinely) was incorporate? How many terminologi es was incorporate? Are the numbers of	1) a) The participant didn't ask all the time when the appointment will finish, but they start to ask when the nurse will finish to ask the questionnaires during the first appointment. Moreover, they demonstrate restlessness and some confusion in relation to amount of questions in the questionnaires, and sometimes the nurse had to stop the questions and to change the topic. The participants understand all the strategies provided during the intervention. Participants use a lot of the term "corote". Corote is the brand of a kind of cachaça (alcohol used in Brazil); "baseado" what mean marijuana; "tiro" what mean cocaine; and "pedra" what mean crack; then we inserted these 4 terminologies during the interpersonal relationship. The content of the intervention was long to be apply in the real scenario, thinking that some appointments had duration of 1 hour and 30 minutes. b) All participants achieved the "work phase" of the ITN, thinking that in the first appointment we worked with the anxiety felt for them. The "resolution phase" of

		steps and content of intervention long? b) What phase of the intervention nurses get to achieve? Success or Failure of execution? Why failure, hypothesize an explanation. Amount, type of resources needed to implement (notebook, guidelines)? What are the factors that affect the implementation? How long is the duration of the intervention? When the intervention is fast (less than 20 minutes) the quality of the intervention is good? 2) The appearance of the notebook, guideline	the ITN was achieved by 5.13% of participants. We think that we had success in the intervention, thinking that we worked with a specific population, with high levels of anxiety, and normally they don't stay sit for a long-time paying attention. We completed the appointment with all participants, and they spent a mean of 90 minutes in the first appointment with the researcher. When the participant spent less than 60 minutes in the first session, the quality of the intervention decreases. The noise and change in the appointment' room affected the intervention, since there were some participants that didn't find the researcher, because she was in a different appointment' room with other client. The participants liked the information paper about the good sleep pattern, and physical activities. They said that the information paper is good since there are a lot of pictures and few words.

		are attractive?	
Practicality	1) Ability of participants carry out the tools presented during the intervention to manage anxiety 2) Characteristics of the proposed outcome measure (anxiety level).	1) What the participants answer when you do the question: - - What do you were able to do to decrease anxiety? 2) Test if the scales Beck and GAD 7 used to measure anxiety works well?	1) The majority of participants answer about the breath, but they say that it is difficult to spend a long time breathing, and It doesn't work to get sleep. 2) Beck is a good instrument to apply in clients with anxiety, because it shows all symptoms of anxiety and participants can identify the symptoms as well. On the other hand, Beck is a long instrument to apply during the screening, because this we decided to apply GAD 7 during screening.
Adaptation	1)Availability of data, or the usefulness and limitations of a specific database. 2)Time needed to collect and analyze data 3)Refine outcome measures 4)Monitor for contamination and cointervention.	1)a)The questions are enough to address all moderators of intervention ? b)Are there some question not necessary, that It is better take off? 2)The screening' period works? The application' period of the intervention is enough? The days and time of	1) a)The question is not enough to address all the moderators. During the intervention we identified that crack users (main drug) has a different acceptability of the intervention than cocaine users. Due to this, we think that is necessary to insert a question to separate cocaine from crack users. b)We can take off questions about the money that they receive, since most of the population don't have job (74.36%). 2)The application' period of the intervention (five days) doesn't work. As we can see, only 5.13% of participants ending the intervention. The screening' period is great, because is the time that the client, in the CAPS AD, wait for the Therapeutic Singular Project (PTS) and they don't have access to other activities in the CAPS AD neither appointments with other health professionals. What is good to evaluate the

		appointment works?	effectiveness of the intervention in the next step of the study.
		3)Evaluate the answer in the questionnaires and in the scales applied.	3) During the appointment participants complain about the amount of questionnaire, and we could realize that the answers in the last questionnaire was impaired.
		4) The heterogeneity of sample affects the results.	4)The heterogeneity, such as the kind of substance use and the number of appointments that the participants attendee affects the results. We observed that there is a tendency of the decreasing of anxiety level according the number of appointments (graph 3). In relation to the contamination, the participants when asked about other treatments or medicines that they are taking, everyone said that they are not doing other treatment, and they were waiting to be evaluate by the psychiatric in the CAPS AD.
Safety	Powerful enough to hurt or to misunderstanding symptoms	-Apply PHQ-9 on the first session - Assessment about alcohol intoxication - Assessment about possible overdose - Assessment about serious injuries (bleeding, wound, broke bond)	The mean of the PHQ- 9 was 18.9 consider moderately severe. Most of participants present the score higher than 10 in the PHQ -9, and we reported them to the CAPS AD health professional's team. Nobody present symptoms of alcohol intoxication, possible overdose, and panic. There were two clients that present bonds broken, and they were reported to the hospital to be evaluate Most participants presented bad nutrition, and we worked during the intervention healthy eating habits

		- Assessment about physiological symptoms (heart attack, diabetes, bad nutrition) - Assessment about the increase of anxiety during the appointment, that it could be generate panic because the awareness about anxiety	

Qualitative interview findings

The participants were positive about the ITASUD. They described as positive: 1) the strategies presented to management of anxiety in the intervention, 2) the length of the intervention, 3) The application of BAI scale during the appointments.

In relation to the **strategies to manage anxiety** providing to the participants, they cited more the breathing, and the awareness of relief behaviors that helping them to decrease anxiety.

"I used more the breathing when I am nervous and to sleep. My roommates look me, and they say that I am crazy, but I don't mind, I always breath before to sleep." (P.01)

"I liked to talk about others relief behaviors that I used to decrease anxiety, as coffee and tobacco. I think these relief behaviors help me a lot of to control my desire to use crack. And it is a way to decrease anxiety as well." (P.02)

The ITASUD' period was identified as a good period for both participants, only the P.01 said that he could participate more days if the intervention lasted more days**.**

"The time flies during the appointment, I didn't realize that today is the last appointment…5 days worked for me"(P.01)

"I think 5 days of appointment is ok for me" (P.02)

We would like to highlight the other **BAI function.** Besides to evaluate anxiety, one participant said that they liked to answer the BAI scale because they identified the physiological symptoms of anxiety.

"I learned the physiological symptoms of anxiety through the questions that you asked me before and after the appointment. This is good, because now I know that when I fell my heart pounding, nervous, and unable to relax it is anxiety".(P.02)

On the other hand, the **acceptability of outcome measures** is not so good evaluate. They complain about the application of an amount of scales in the first appointment, it was considered by participants boring.

"The questions in the first appointment were so many!" (P.01)

"I think the amount of questions in the first appointment were boring, I didn't like. I think only the questions about the symptoms of anxiety are ok." (P.02)

When asked about **the strategies that they will be able to use for a long time,** both cited breathing, but in different ways.

"I will use the breathing to get to sleep" (P.01)

"I will use the breathing to avoid a discussion, and when I realize that I am nervous with desire to fight." (P.02)

When asked why they **back for the other appointments** they answered that is because they really think that the intervention help them a lot of in the management of anxiety**.**

"You helped me a lot, I could realize that I was less anxious and nervous. It is because this that I came to the others appointment… Ah, and because you help me with the bus money to go back to my shelter." (P.01)

"I like to come here and talk with you, and it is because this that I keep going in the service and I don't change of idea about the treatment. Because during this appointment' period with you I don't have an appointment with any health professional, and if you wouldn't have here I will be here alone or in the street... And you know, one time we want stop and minutes after we want more drugs." (P.02)

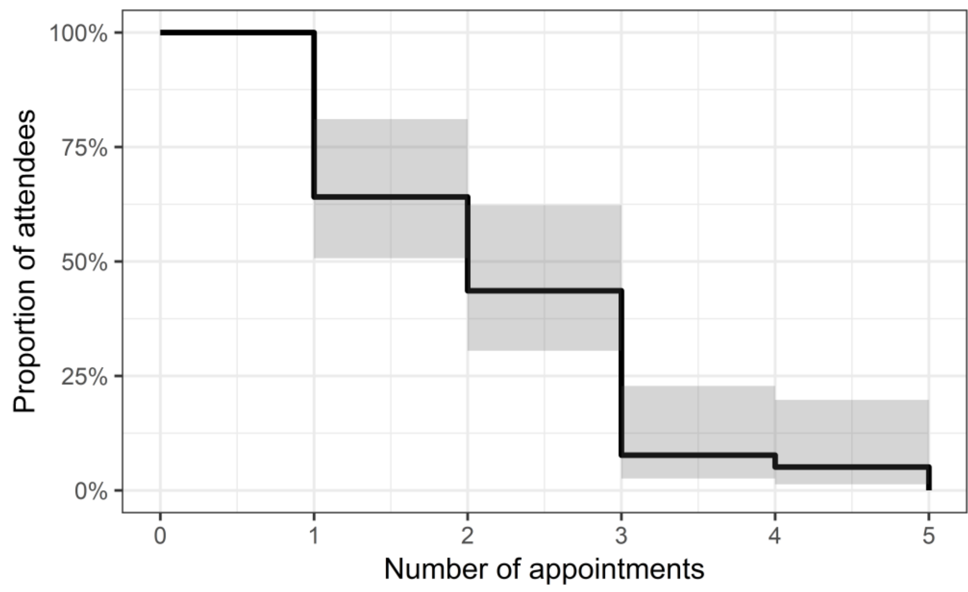
Re-modelling the intervention program

We can see in the figure 5 that the proportion of people that attending the appointment 1 and 2 is bigger than people that attending the 3, 4 and 5. Moreover, in the third appointment we have less than a half of participants that came to the first appointment, but the standard deviation (SD) still covers 50% (table 9). Due to this phenomenon we think that it is better to focus the main content of the intervention on first (100%) and second appointment (64.10%) and the resolution phase in the third appointment (43.59%) (table 9).

Table 9: Frequency of people that attending the appointments

Variable	Level	Count	Percent	Survival	IC95%.lo	IC95%.hi
Appointments	1	14	35.90	100.00	100.00	100.00
	2	8	20.51	64.10	50.68	81.10
	3	14	35.90	43.59	30.50	62.30
	4	1	2.56	7.69	2.59	22.80
	5	2	5.13	5.13	1.33	19.80

Figure 5: Proportion of attendees and number of appointments



We identified some moderators that we didn't identify during the development of the intervention. We think that one moderator is the day of the appointment' start. We observed (table 10) that 62.50% of clients who start the intervention on Monday ending on Wednesday,

totalizing three days attending the appointments. The half (50%) of participants that start on Wednesday and Thursday attending the intervention only until Friday, and 100% that start on Friday ending on Friday. These results demonstrate that weekday is the other moderator.

Table 10: Weekdays attending

	End data				
Start Data	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Monday	25.0%	0.0%	62.5%	0.0%	12.5%
Tuesday	0.0%	28.6%	42.9%	28.6%	0.0%
Wednesday	0.0%	0.0%	35.7%	14.3%	50.0%
Thursday	12.5%	12.5%	0.0%	25.0%	50.0%
Friday	0.0%	0.0%	0.0%	0.0%	100.0%

In relation to the mediators of the intervention, the self-efficacy (GSE), relation (MOS SSS), triggers/stress (PSS), and cocaine use (ASSIST), we couldn't evaluate because we have only two patients who finished the intervention.

Finally, in terms of anxiety change, we can observe that there is a tendency of anxiety level decrease according to the number of appointments. (figure 6). And evidence that there is a relation between the level of anxiety and the intervention ($p<0.0001$). The level of anxiety is 38 points less in average. (table 11).

Figure 6: Anxiety level and number of appointments

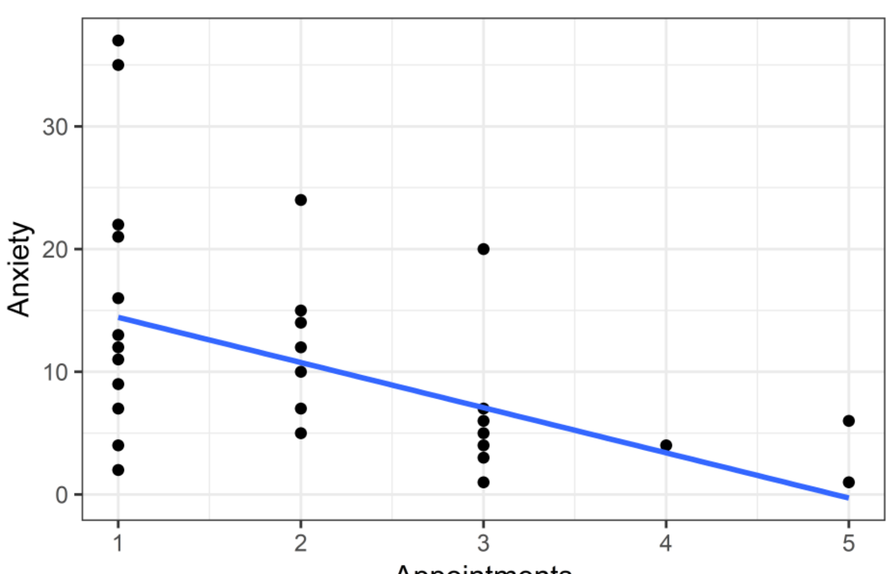


Table 11: Logistic regression with anxiety and appointments

	Value	Std.Error	IC95%.lo	IC95%.hi	DF	t-value	p-value
(Intercept)	52.051	1.688	48.635	55.468	38	30.841	< 0.0001
Pos-intervention	-37.861	3.807	-45.573	-30.148	37	-9.946	< 0.0001
Appointments	-1.900	1.458	-4.856	1.055	37	-1.303	0.2006

Discussion

The manual of intervention' content was long to be applied in 30 minutes in the baseline, because there were 6 scales to be applied, plus the sociodemographic, clinical and behavioral form. We did some adaptations during the first appointment. We collected the sociodemographic, clinical and behavioral data in the patient's chart, since the health professionals of the CAPS AD during the first attending asking these questions. But even with these strategies we had a long appointment, the mean of the first appointment was 90 minutes.

The length of appointment is another factor that need to be adapt to real scenario. Some appointments last longer than one hour, what it is consider so long, thinking that we are working with anxious people and we are in a public health facility that there is a high client's demand.

Most of the clients in the first appointment complain about the amount of scales that they need to answer. The strategy that we used were to create connections between the questions and moments of their lives, and to ask first the most important questionnaires.

The results showed that most of the participants (62.50%) attending the appointments for three days. Due to this, we decided that the new protocol of the intervention will be synthesize to three days. Additionally, we can think that the first appointment starts until Wednesday to the participants ending the intervention before the weekend, and the main content of the intervention will be present in the first and second appointment, owing the survival analysis.

Some factors that interfere in the assiduity of the client was the weekday of the first appointment. We observed that the clients that start the appointment on Monday had more chance to complete the intervention, since the length of the intervention was 5 days and they could complete the intervention during the weekday. The client that starts on Tuesday, Wednesday, Thursday or Friday didn't attend the next appointment after weekend. These results demonstrate that weekday interfere in the intervention, since Saturday and Sunday we didn't attend clients. Due to this, we believe that starts the intervention until Wednesday is the best option to achieve a major number of clients completing the intervention, since according to the new protocol of intervention, the intervention' length will be of 3 days.

The participants didn't have cell phone or any number contact, what it was identified as a moderator of the intervention, since we didn't get to remind the participants about the next appointment, and to know what happened to the participants that didn't finalize the intervention. In the main RCT (Randomized Control Trial) we will designate someone from research team to go until the localization that the client said that he lives to remind him about the appointment or to know what happened to the participant. This strategy is to increase the number of clients returning in the appointment, and to decrease the number of clients as disappear in the endpoint of study.

The first step of the intervention was to guide the participant name anxiety, and to categorize as a person that present anxiety symptoms. When the nurse started to talk about the intervention and she asked, if they think that they are anxious, all the participants said that they

are anxious people easily. Moreover, the nurse established the connection of anxiety, substance abuse and stronger levels of anxiety. We had hypothesized that this connection could generate a barrier, but we were wrong. All participants identified that cocaine use after the pleasure period, generate stronger levels of anxiety until panic.

In Brazil the specialized outpatient health facilities don't apply scales to evaluate depression and suicide, and consequently there aren't protocols to clients identified with high levels of depression. Most participants presented high levels of depression, and we decided include them in the research because during the appointment we could observe that they were absorbing the intervention. In relation to intoxication, we had in the CAPS AD detoxification's room to assist the clients.

The strength of our intervention is that it takes a new approach to the anxiety in cocaine users which takes account of the differing factors, environmental and behavior. We will be taking a holistic approach to the clients and focuses on the goals which are important to the participants through the interpersonal theory of nursing. As a feasibility study, we have included robust measurement of feasibility parameters, such as demand, acceptability, adaptability, practicability, and safety which will enable us to adapt the procedures used in the intervention and to determine whether it is feasible to proceed to a full randomized controlled trial.

We can measure the anxiety level, but we cannot attest that the ITASUD intervention is effective to decrease anxiety, since the effectiveness of the intervention is not a primary focus (Eldridge et al., 2016) of the feasibility study.

Limitations

During the screening there was an amount of participant's lose, due to the reduced number of people to apply the screening, only one researcher. Moreover, the sample size was small, as it was a feasibility study. Future studies should have a larger sample size. A power analysis is needed to determine the appropriate sample size to examine the potential effectiveness of ITASUD.

The study design was a single-arm repeated measure design, without a control or usual care comparison group. Preliminary findings of statistical significance should be viewed with caution. Future research designs should utilize a two-arm repeated measure with a usual care group. The preliminary findings (quantitative and qualitative) show that ITASUD has a potential benefit what endorse the conduction of a RCT based on the findings of this feasibility study.

Conclusion

ITASUD appears to be feasible, inexpensive and easy to use. Preliminary findings support its promise in helping cocaine user to deal with high levels of anxiety through interpersonal theory in nursing. Overall, these results provide the foundation for a future full-scale study, since it was used a combination of qualitative and quantitative approaches that evaluate the potential value of the intervention.

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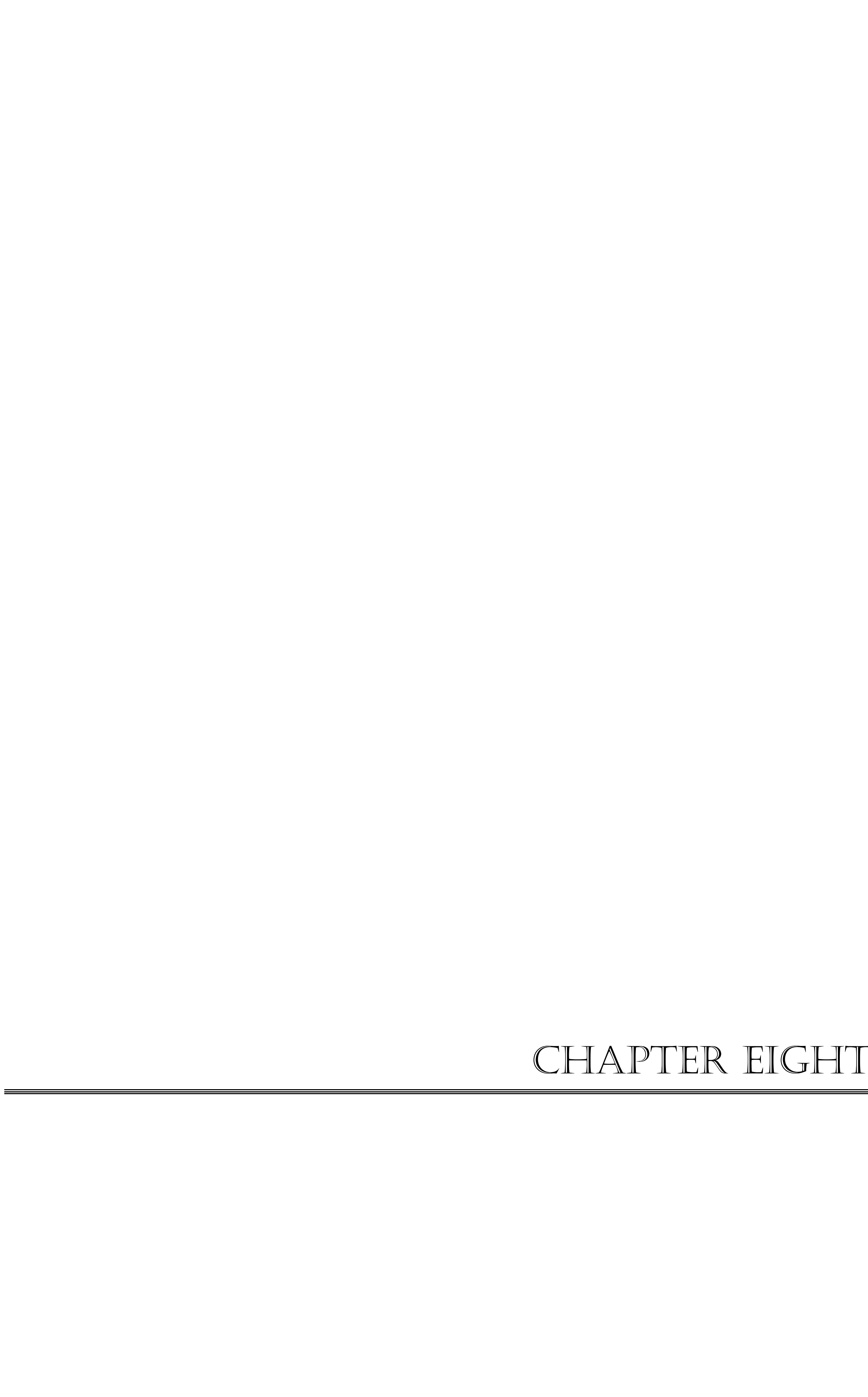

Chapter Eight

CHAPTER EIGHT

10. STRENGTHS AND LIMITATIONS

The strength of our intervention is that it takes a new approach to the anxiety in cocaine users which takes account of the differing factors, environmental and behavior. We will be taking a holistic approach to the clients and focuses on the goals which are important to the participants through the interpersonal theory of nursing. This study connected the Fawcett's model for theory generating research and Intervention Mapping approach to the development of the intervention program ITASUD. Fawcett's model guides us to translate and produce the relational propositions between the conceptual model (Peplau's theory) and the middle-range theory (Interpersonal Theory of nursing to anxiety management in people who substance use disorders). Through this model, we developed a complex intervention based on understanding of the conceptual model, interpersonal theory for nursing, practice focus and research methods in nurse discipline.

Intervention Mapping approach provide a clear vision of all the process of development of the intervention protocol, increasing the chance of the correct identification of the changes objectives, the selection and application of appropriate behavior change methods in an intervention, and adequate implementation of the intervention. These are the major quality of the IM, because the most frequent interventions failures are due to incorrect identification of change objectives, inappropriate choice of methods and applications, and inadequate implementation in terms of completeness and fidelity of the program being delivered (Kok, 2014). Moreover, IM provides a vocabulary for program planning and procedures for planning activities.

The development of the feasibility study was fundamental, since It was relied on to produce a set of findings that help determine whether an intervention should be recommended for efficacy or effectiveness trials (Bowen et al., 2009). The primary focus of this feasibility study wasn't effectiveness or efficacy, but it was developed to support a future RCT with an appropriately powered study focusing on effectiveness or efficacy (Eldridge et al., 2016a). The focus of the feasibility study was to identify moderators that we didn't identify on the theory framework, and the use of robust measurements of acceptability, demand, implementation, practicality, adaptation and safety which will enable us to determine whether it is feasible to proceed to a full randomized controlled trial and to adapt the procedures used in the intervention

to maximized the chances of success in any future trial. As result of the feasibility study we will readapt the prototype of the intervention that will increase the success of the intervention in the RCT, by identification of moderators, and some problems that might occur in an ensuing RCT of a complex intervention (Eldridge et al., 2016b)

One limitation of this study is the understanding about the neurobiological pathways of anxiety in cocaine users. Since the conceptual model don't include the changes that happens in the neurobiological circuit. We started to develop a systematic review about the neurobiological mechanisms of anxiety in cocaine users, but we are in the screening phase, once we found 11 075 articles to screen. This systematic review has been conducted with a team of experts in substance use disorders, interpersonal theory of nursing, anxiety and neuroscience. The goal of this systematic review is to bridge the gap of this conceptual model developed.

The fidelity of this intervention wasn't evaluated with the recommended criteria, such as recording, filming, and/or other people watching to see how the intervention has been conducted (Sidani, Braden, 2013). On the other hand, we understood that mental health interventions in nursing are not so rigid format, and we adapted the intervention to the needs of the client what it will affect the fidelity of the intervention.

We didn't get to evaluate the mediators of the intervention, once the number of people that completed the intervention program were low. But we could have done a case study with these two clients.

11. RECOMMENDATIONS FOR FUTURE RESEARCHES

The topics of anxiety in SUD are extensive open for research, since these topics have been studied separately, and most researchers have been conducted with animals (mainly mice), what difficult the understanding of these health problems in humans.

Substance use disorders are a broad theme and present different neurobiological pathways according to the kind of psychoactive substance. Due to this, we think that it is important to specify a kind of substance to describe the neurobiological mechanism according the neuroscience discipline.

It is fundamental the development of a conceptual model that integrates concepts from neuroscience about neurobiological pathways of anxiety and SUD, specifically cocaine, and concepts from psychiatric/mental health in nursing about anxiety and SUD. Through the development of this conceptual model with the knowledge integration of these disciplines

(neuroscience and nursing), it will be possible a comprehensive understanding of the factors that interfere in this comorbidity.

After the inclusion of the neuroscience perspective in the conceptual model, we think that it will be necessary an inclusion of some mediators in the intervention to anxiety management in cocaine users.

The results of the feasibility study showed that there are more moderators than those identified in the theoretical framework of the intervention, and that is necessary some changes in the intervention protocol. The next step of this study will be the development of a pilot trial, in a smaller scale, before the conduction of the main RCT.

12. PUBLIC HEALTH IMPLICATIONS

The main public health implications of this study are to reinforce the need to face the inequalities in the Brazilian context to face the substance use disorders, since as we show in this study the major participants are homelessness, and this situation increase the level of anxiety, the use of psychoactive substance and interfere in the clients' drop out during the treatment.

We think that one strategy to reduce this drop out level, is to reframe the period of CAPS AD attendance, once according clients is during weekend that they have an expressive amount of psychoactive substance available and they face high levels of anxiety without health professional support. Due to this reason, we think that the extension of the CAPS AD' attendance period could be a good alternative.

The results of this study suggest that the interpersonal relationship nurse-client have potential as an inexpensive and feasible intervention and could be a good strategy to be applied to decrease anxiety through the intervention program ITASUD in the Brazilian Health Scenario.

Lastly, the decrease of vulnerability conditions through the social policies, the increase of harm reduction' policies to substance use disorders, and the improvement of education about anxiety management strategies for people with substance disorders in the health scenario are strongly recommended to this issue.

CONCLUSION

CONCLUSION

The comorbidity of anxiety and substance use disorders has been shown to have a strong association. High levels of anxiety are critical to the increased risk of substance use disorders, relapse and withdrawal of related treatment. Research suggests that the onset of anxiety is primary to onset of substance use disorders and is associated with higher rates of impairment, health care cost, and decrease of work productivity. To date, attempts to intervene in substance use disorders, specifically cocaine use disorders, have focused on cocaine use and presented a limited efficacy. The limited efficacy may be because interventions address only the psychoactive substance. This study showed an alternative and novel approach, through the conceptualization of the anxiety felt by cocaine users as the problem that generates the use of cocaine, in order to consider underlying determinants of anxiety that could be targeted by interventions.

This study provides a detailed description of concepts and applications from Peplau`s interpersonal theory in nursing to nowadays nursing context. Additionally, the study provided tools to guide future researchers during the development of intervention theory through the description of the Fawcett's model for theory generating research that guide the translation of theories in nursing into empirical research methods.

The connection of Fawcett's model and Intervention mapping provided a valuable guidance for future researchers, health agencies, and health care professionals who are interested in reproducing these systematic approaches to developing a complex intervention. Moreover, ITASUD appears to be feasible, inexpensive and easy to use. Preliminary findings support its promise in helping cocaine user to deal with high levels of anxiety through interpersonal theory in nursing. Overall, these results provide the foundation for a future full-scale study, since it was used a combination of qualitative and quantitative approaches that evaluate the potential value of the intervention.

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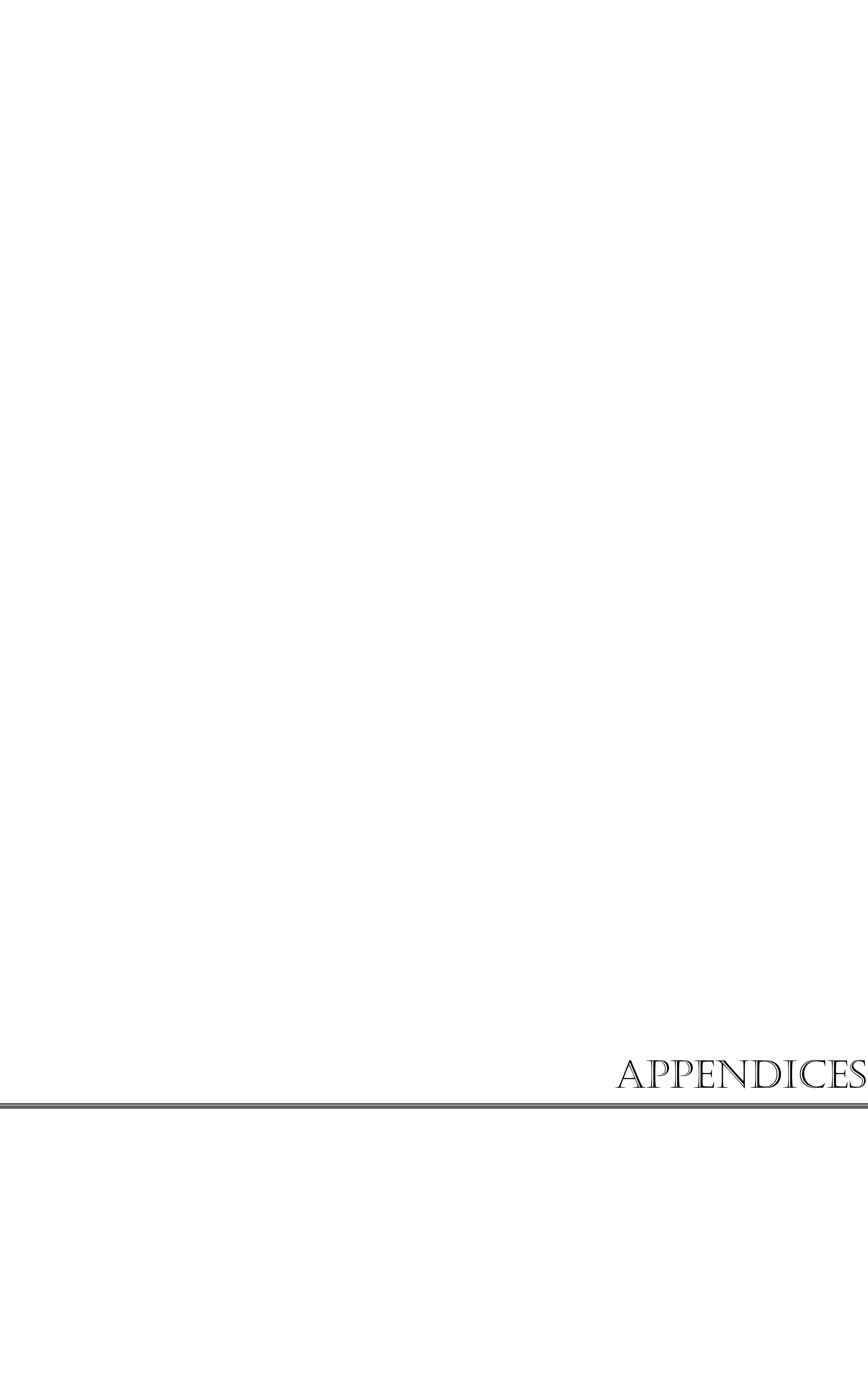

APPENDICES

APPENDICES

Appendix 1 – Programa da intervenção em português

Relacionamento interpessoal em enfermagem para o manejamento da ansiedade em pessoas com transtornos de uso de substâncias (ITASUD)

Orientação e treinamento

Orientação e treinamento
Obtendo o termo de consentimento
Dados coletados e agendamento do instrumento
Pré-consulta – chamada de telefone e mensagem
Dados 1 – Consulta 1
Dados 2 – Consulta 2
Dados 3 – Consulta 3
Dados 4 – Consulta 4
Dados 5 – Consulta 5
Dados 6 – Acompanhamento

Orientação e treinamento

Informação geral - A intervenção é baseada na Teoria da Peplau – Relacionamento Interpessoal em enfermagem é baseado na relação entre enfermeira e cliente com algumas metas a ser alcançadas. Durante esse tratamento nossa principal meta será equipar usuários de cocaína com estratégias para manejar ansiedade durante as 5 consultas, a primeira consulta terá duração de 30 minutos e as outras de 20 minutos. O tratamento baseado no relacionamento interpessoal para ansiedade foca na melhora do conhecimento e auto-eficácia em relação a ansiedade, reconhecimento dos gatilhos e comportamentos de alívio para a ansiedade, e como improver as relações sociais.

1) Dose da intervenção

A frequencia da intervenção será todo dia durante uma semana (Segunda – Sexta).

Cada sessão é auto-conteúdo. O cliente poderá vir na primeira sessão e talvez não volte para as outras sessões, pensando nessa população específica, a dose minima será uma consulta e a máxima será 5 consultas.

Consulta 1 *Orientação + trabalho*	Consulta 2 *Trabalho*	Consulta 3 *Trabalho*	Consulta 4 *Trabalho*	Consulta 5 *Resolução*
30 minutos	20 minutos	20 minutos	20 minutos	20 minutos

A intervenção é dividida em 4 fases:

Fase 1 – Screening – T0

4) Aplicação das escalas – a) Escala para identificar ansiedade – GAD-7
    c) Escala para identificar uso de cocaína – ASSIST
5) Convide o cliente para participar da intervenção (se o cliente tem todo o critério de inclusão)
6) Dê ao cliente um lembrete do dia e o horário da consulta

Fase 2 – Intervenção –T1

6) *Primeira consulta – orientação + trabalho: O conteúdo foca no manejamento da ansiedade*

❖ *Explicação sobre a intervenção*
❖ *Dar o termo de consentimento (TCLE) para os clientes*
❖ *Aplicando as escalas* – a) Escala para identificar ansiedade – BAI
    b) Escala para identificar uso de cocaína – ASSIST
    c) Escala para identificar disordens mentais comuns – PHQ-9
    d) Escala para identificar gatilhos - PSS (Perceived Stress Scale)
    e) Escala para identificar relações - MOS – (Medical outcome study)
    f) Escala para identificar auto-eficácia - GSE (General self- efficacy scale)

7) Segunda consulta – trabalho - O conteúdo foca no manejamento de ansiedade

- *Aplicando a escala* – a) escala para identificar a ansiedade – BAI (antes e depois da consulta)

8) Terceira consulta – trabalho – O conteúdo foca nos fatores ambientais

- *Aplicando a escala* – a) escala para identificar a ansiedade – BAI (antes e depois da consulta)

9) Quarta consulta – trabalho – O conteúdo foca nos fatores comportamentais

- *Aplicando a escala* – a) escala para identificar a ansiedade – BAI (antes e depois da consulta)

Fase 3 – Final da intervenção – T2

10) Quinta consulta – Resolução

- *Aplicando a escala* – a) escala para identificar a ansiedade – BAI (antes e depois da consulta)

  b) Escala para identificar o uso de cocaína – ASSIST (depois da consulta)

  c) Escala para identificar disordens mentais comuns – PHQ-9(depois da consulta)

  d) Escala para identificar gatilhos - PSS (Perceived Stress Scale) (depois da consulta)

  e) Escala para identificar relações - MOS – (Medical outcome study) (depois da consulta)

  f) Escala para identificar auto-eficácia - GSE (General self- efficacy scale) (depois da consulta)

Fase 4 – Acompanhamento (uma semana)- T3

- *Aplicando as escalas* – a) escala para identificar a ansiedade – BAI (antes e depois da consulta)

  b) Escala para identificar o uso de cocaína – ASSIST (depois da consulta)

  c) Escala para identificar disordens mentais comuns – PHQ-9(depois da consulta)

  d) Escala para identificar gatilhos - PSS (Perceived Stress Scale) (depois da consulta)

  e) Escala para identificar relações - MOS – (Medical outcome study) (depois da consulta)

  f) Escala para identificar auto-eficácia - GSE (General self- efficacy scale) (depois da consulta)

Dando consentimento informado para os clientes

Depois da explicação do estudo, a enfermeira deve apresentar o termo de consentimento. A enfermeira deve ler o termo de consentimento em voz alta para o cliente e explicar as dúvidas ou alguns termos necessários.

Peça para o cliente assinar todas as páginas do termo de consentimento e ressalte que a assinatura não é um contrato, é apenas para confirmar que o cliente entendeu o que está sendo perguntado para ele e que ele está de acordo em participar da intervenção.

Quando ele assinar, ele deve assinar as duas folhas e você deve dar uma para ele. Mostre o contato dos pesquisadores.

Nunca colete dados até que o cliente tenha assinado o termo de consentimento.

Agenda para coletar os dados e instrumentos

Dia de estudo	1	2	3	4	5	6	7	8	9	10	11	12	13
Dia da intervenção		1	2	3	4	5							
Observação BAI	A0	A1	A2	A3	A4	A5							A 6
Observação	T0	T1				T2							T3
Intervenção	01	X1	X2	X3	X4	X5							X6

Agenda constructos, Instrumentos & medidas

Constructos	Instrumentos	T1/A1	A2	A3	A4	T2/A5	T3/A6
Ansiedade screening	GAD 7	X					
Ansiedade	BAI	X	X	X	X	X	X
Auto-eficácia	GSE (General self-efficacy scale)	X				X	X
Relação	MOS – Medical outcome study	X				X	X

Gatilhos	PSS (Perceived Stress Scale)	X				X	X
Comportamentos de alívio	ASSIST (identificar uso de cocaina)	X				X	X
Segurança – Disordens mentais comuns	PHQ-9	X				X	X
Entrevista sobre aceitabilidade- cliente	Questões semi-estruturadas					X	

Dado 1: Consulta 1

D. Sessão inicial: Orientação + trabalho – relacionamento interpessoal em enfermagem (1)

Consulta 1

A primeira consulta estabelece os parâmetros da intervenção, usando avaliação que ajuda a determinar as necessidades e fortalezas do usuário de cocaína. Nós decidimos na primeira consulta colcoar junto 2 fases do relacionamento interpessoal (orientação + trabalho) por causa da alta taxa de abandono do tratamento nessa população.

- Dê o termo de consentimento

Fase 1: Introduza você mesma como terapista

- Fale o seu nome.
- Identifique sua função como terapeuta responsável por facilitar as sessões.

Roteiro:

- Eu gostaria de dar as boas-vindas a você na sua primeira sessão.
- Meu nome é “Maria”. Eu sou a enfermeira que irá facilitar as sessões e trabalhar com você através das sessões desse tratamento.

Fase 2: Explique a intervenção + Orientação sobre a consulta

- O que é essa intervenção e qual a meta da intervenção.

Roteiro:

- A intervenção é baseada na teoria da Peplau – relacionamento interpessoal em enfermagem, o qual é baseado na relação entre enfermeiro e cliente com alguma meta a ser atingida. Durante esse tratamento nossa principal meta será equipar os usuários de cocaína com estratégias para manejar ansiedade durante essas 5 consultas, a primeira consulta terá duração de 30 minutos e as outras de 20 minutos.
- O tratamento que você irá receber é um tratamento não-farnacológico para ansiedade. Isso significa que não envolve medicação ou pílula. O tratamento baseado no relacionamento interpessoal foca na melhora do conhecimento acerca da ansiedade, auto-eficácia em relação a ansiedade, reconhecimento dos gatilhos, comportamento de alívio para ansiedade, e como melhorar as relações com outras pessoas no atual contexto.
- Nós usaremos o questionário sobre características sociodemográficas e pessoais.
- Nós usaremos alguns instrumentos para medir fatores que interferem no nível de ansiedade e nos dois intrumentos para medir o nível de ansiedade:
  - Para medir ansiedade, nós usaremos o BAI (Beck Anxiety Inventory) antes e depois de cada consulta, esse instrumento contém 21 questões que avaliam o nível de ansiedade
  - Para medir auto-eficácia, nós usaremos o GSE (General Self-Efficacy Scale) na primeira e última consulta, o qual é um instrumento com 10 questões que avalia a auto-eficácia.

  - Para medir relações , nós usaremos o MOS- SSS (Medical Outcome Study – Social Support Scale) na primeira e na última consulta. Esse instrument é composto por 19 questões que avaliam as relações sociais
  - Para medir stress, nós usaremos o PSS (Perceived Stress Scale) na primeira e na última consulta. Esse instrument é composto por 10 questões que avaliam in quais situações a vida do indivíduo está gerando stress
  - Para medir o uso de cocaína nós usaremos o ASSIST
  - Para medir as disordens mentais comuns será o PHQ-9
- Relembre os clientes de que não há resposta correta ou errada no questionário e instrumentos
- Explique que os clientes podem ter o tempo necessário para completer o questionário, e pedir clarificações acerca de algo que não entendeu; o intervencionista pode responder , como necessário
- Administre o questionário/instrumentos no método selecionado
- Forneça o questionário/ instrumento completo
- Clarifique pre-concepções e expectativas do cliente

<u>Step 3:</u> 1) *Nome da intervenção*: trabalhando para manejar ansiedade – Nomear ansiedade

2) Metas da intervenção (objetivos de mudança + determinantes):

- Conhecimento sobre ansiedade;

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre ansiedade e o que ela significa (1.1 – 1.3)	1.3 Consciência aumentando acerca da ansiedade 1.4 Estar consciente da ansiedade	1.1 Mostrar alguns efeitos neurofisiológicos da ansiedade relacionado com as reações corporais 1.2 Fazer algumas questões sobre o individuo: - “Você está ansioso?”; “Você está nervoso?”; “Você está nervosa agora?”; “Você está triste?”; “Você está tenso agora?” 1.3 Se a pessoa diz que ela não está ansiosa,	1.6 Mostre imagens ou videos 1.7 Apresentação verbal

	1.3 Providencie comparações	você deve aplicar algum caso ficcional sobre uma pessoa com ansiedade, adequando esse caso para a realidade do individuo, porque o individuo pode se comparar com a pessoa descrita no caso ficcional. Se a pessoa diz “sim” para as questões acima, você deve seguir as questões abaixo.	1.3 Apresentação verbal
Conhecimento sobre a conecção entre a ansiedade e os comportamentos (1.4)	1.4 Síntese	1.4 Depois de ele dizer “sim” para as questões acima. Faça algumas questões para o individuo perceber a conecção entre ansiedade e os comportamentos – “O que você costuma fazer para aliviar o sentimento de nervosismo?”; “ O que você está fazendo agora para aliviar este sentimento/sensação?” Se o paciente disser: - “nada”, a enfermeira deve perguntar: “O que você normalmente faz para sentir-se confortável?”; “Quando você se sentiu triste no passado, o que você fez para sentir-se melhor?”	1.4 Apresentação verbal
Conhecimento das características comportamentais usadas para reduzir a ansiedade (1.5 – 1.7)	1.5 Consciência aumentando 1.6 Auto-reavaliação	1.5; 1.6 Lista das características comportamentais e nomeie os comportamentos	1.5 Apresentação escrita– escreva junto com o cliente, no papel, os comportamentos que

			ele diz que usa para reduzir a ansiedade
	1.7 Reavaliação do contexto	1.7 Encorage o paciente a descrever como os seus membros da família (ou pares, amigos) sentem-se sobre esses comportamentos	1.7 Apresentação verbal
Conhecimento das expectativas (desejo, meta...) (1.8)	1.8 Identificação	1.8 Depois do paciente estar claramente consciente da relação entre ansiedade e comportamentos, então as enfermeiras perguntam: - "No que você estava pensando antes de sentir-se triste?"	1.8 Apresentação verbal
Conhecimento sobre a influência das expectativas (1.9)	1.9 Elaboração	1.9 Quando as expectativas são colocadas na frente da mente dos pacientes, é necessário elaborar o significado das expectativas; - "Quais são as expectativas?"; "Essas expectativas são possíveis de ser atingidas?"; "Origens?"; "Por quanto tempo você tem essa expectativa?"; "É importante?" "Você pode mudar essas expectativas ou desistir delas?"; "Essa expectativa era razoável – capaz de ser alcançada?" Identifique o desconforto sentido, experenciado em: "Qual parte do corpo?"; "Qual nível?"; "O que foi	1.9 Apresentação verbal

		noticiado pelo paciente?"; "Foi comunicado para outros durante a situação?"	
Conhecimento profundo acerca das expectativas e o que acontece (1.10)	1.10 Consciência aumentando	1.10 Liste as expectativas e o que acontece	1.10 Escrita -Anote as expectativas e o que acontece
Conhecimento acerca da conecção das expectativas e o que acontece em vez das expectativas (1.11 – 1.12)	1.11 Síntese 1.12 Identificação	1.11 Quando o paciente tem claramente formulado as expectativas, então pergunte: - "O que acontece em vez das expectativas?" Quando as expectativas não são alcançadas, os pacientes precisam pensar sobre: - "O que interferiu no alcance sa expectativas?"; "O que aconteceu em vez das expectativas?"; "Quem estava envolvido na expectativa, quando, como?" 1.12 E identifique o comportamento de alívio usado quando a expectativa não é alcançada: - "quais atos comportamentais ou atos relacionados a algum padrão?"	1.11; 1.12 Apresentação verbal

Conhecimento dos fatores envolvidos e o que acontecem em vez das expectativas que podem ser amenizados (1.13 – 1.14)	1.13 Consciência aumentando 1.14 Calculando situações	1.13 Liste fatores que podem ser amenizados 1.14 Revise as expectativas em relação ao que é possível	1.13 Escrita -Faça nota dos fatores envolvidos 1.14 Apresentação verbal
Conhecimento sobre a conecção entre os fatores e ansiedade que pode ser controlado (conecção entre ansiedade e expectativas) (1.15-1.17)	1.15 Aprendizado ativo 1.16 Reevaliação do contexto	1.15 Discuta sobre quais chances pode ser possíveis, depois você identifica e controla alguns fatores na situação que aconteceu em vez das expectativas, através dessas questões: “ O que você acha que sentiria quando as expectativas não acontecessem? O que aconteceu em vez das expectativas? 1.16 Liste o desconforto sentido, e os comportamentos de alívio usados	1.15 Apresentação verbal 1.16 Escrita – Faça notas dos comportamentos de alívio usados

Step 4: Habilidades para reduzir a ansiedade

- Ensine habilidades para reduzir a ansiedade

Roteiro:

- Agora eu irei mostrar-lhe e aplicaremos nesses últimos 5 minutos as estapas de meditação descritas nesse folheto

Veja na próxima página o folheto com as etapas da respiração da meditação

Folheto – Respiração para ansiedade

Meta: A intenção desse exercício de respiração profunda é permitir que os pensamentos e sensações venham e vão, por meio da conexão entre mente e corpo para alcançar alívio de sentimentos desprazerosos. A chave da respiração é focar sua atenção na sua respiração, a inspiração e expiração.

Leia e aplique todas as etapas

- Etapa 1: Encontre um lugar confortável para sentar, preferencialmente um lugar onde você não seja perturbado. Você pode colocar seu pé abaixo da sua perna e o outro acima (posição de yoga), e tentar manter a postura ereta, sempre pensando emu ma linha imaginária desde a sua cabeça até o coccix;
    - Note: Não é necessário fazer posição de yoga, você pode sentar na melhor posição para você, a que sentir-se mais confortável.
- Etapa 2: Feche seus olhos ou mantenha-os abertos, o que for mais confortável para você. Você deve encontrar o jeito mais fácil para manter o foco, normalmente o jeito mais fácil é fechando os olhos, mas se você preferer mantê-los abertos, foco é algo natural;
- Etapa 3: Comece fazendo algumas respirações profundas:
    - Profunda inspiração pelo nariz (3 segundos), quando você inspira, você deve levanter o ombro junto durante o movimento de inspiração;
    - Segure a respiração (2 segundos);
    - E uma longa expiração por meio da boca (4 segundos) dizendo "ahhhh"
- Etapa 4: Depois de algumas respirações profundas, comece a respirar no ritmo normal. Permita que suas respirações encontre o seu próprio ritmo natural. Preste atenção para os movimentos de inspiração (ar entra pelo seu nariz e causa a expansão da barriga) e nos movimentos de expiração (sua barriga contrai e o ar sai pelo nariz ou pela boca – escolha o que achar melhor), e noticie que seu corpo está ficando mais estável. Também noticie os sons de sua respiração, quando você inspira e expira;
- Etapa 5: Quando você estiver distraída pelos pensamentos, sons, planos, problemas ou sensações físicas, noticie a distração, mas não coloque a atenção nela. Gentilmente volte a prestar atenção na sua respiração por meio da prática de deixar os pensamentos irem para longe;
- Etapa 6: Continue a focar na sua respiração e fique em um estado relaxado pelo tempo que você preferir;
- Etapa 7: Quando você estiver preparado, devagar abra os olhos e coloque sua atenção de volta ao presente momento, volte a ficar alerta e consciente.
    - Note: Cada vez mais que você pratica, melhor será para atingir a meditação e consequentemente a ansiedade.

Etapa 4: Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você
- Diga que você espera vê-lo novamente em uma próxima consulta
- Se o paciente tem um cellular diga que você enviará uma mensagem sobre o horário da próxima consulta

Tarefas do enfermeiro – Durante/ depois da consulta

Complete os formulários de informação:

- Questionário sociodemográfico
- Avaliação dos sintomas, questões (problemas), suporte
- Score do BAI, GSE, MOS, PSS, ASSIST
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

Dados 2: Consulta 2

E. Sessões do meio 2-4: Trabalho (identificação + exploração) Relacionamento Interpessoal em Enfermagem

Consulta 2

Etapa 1: Foque no sentimento do paciente

- Comece cada sessão mantendo o foco no presente e em como o paciente sente-se no presente dia (sentimentos).

Roteiro:

- Como você tem se sentindo desde a última consulta?
- Pacientes tipicamente respondem com alguma referência a sentimentos desagradáveis (tensão -ansiedade) ou os eventos na vida dele durante o última dia. Se os clientes providenciam informação sobre um evento interpessoal, a enfermeira deve linkar o evento ao sentimento desagradável que o paciente sentiu durante o dia reportado ou vice-versa.

Etapa 2: Relembre sobre a última consulta

- Saiba o que o paciente absolveu da última consulta

Roteiro:

- O que você lembra sobre a última consulta?
  - Note: Ele necessita nomear ansiedade (use a palavra ansiedade associada a sentimentos desprazerosos), e ele pode falar sobre alguma ação que ele usa para reduzir a ansiedade.
  - Note: Se ele não falar ao menos as duas coisas listadas abaixo, a enfermeira necessita fazer tudo listado na primeira consulta.
- O que você fazia para reduzir a ansiedade?
  - Note: ele deve ter mencionado a respiração profunda, mesmo se ele disser que ele não consegue fazer isto. (algumas respostas possíveis: Eu não gosto da respiração profunda. Eu tentei fazer a respiração profunda, mas é impossível fazer com muito barulho. Eu não posso me concentrar na respiração). Ele precisa mencionar o que ele lembra sobre o ensinamento da respiração profunda dado na última consulta.

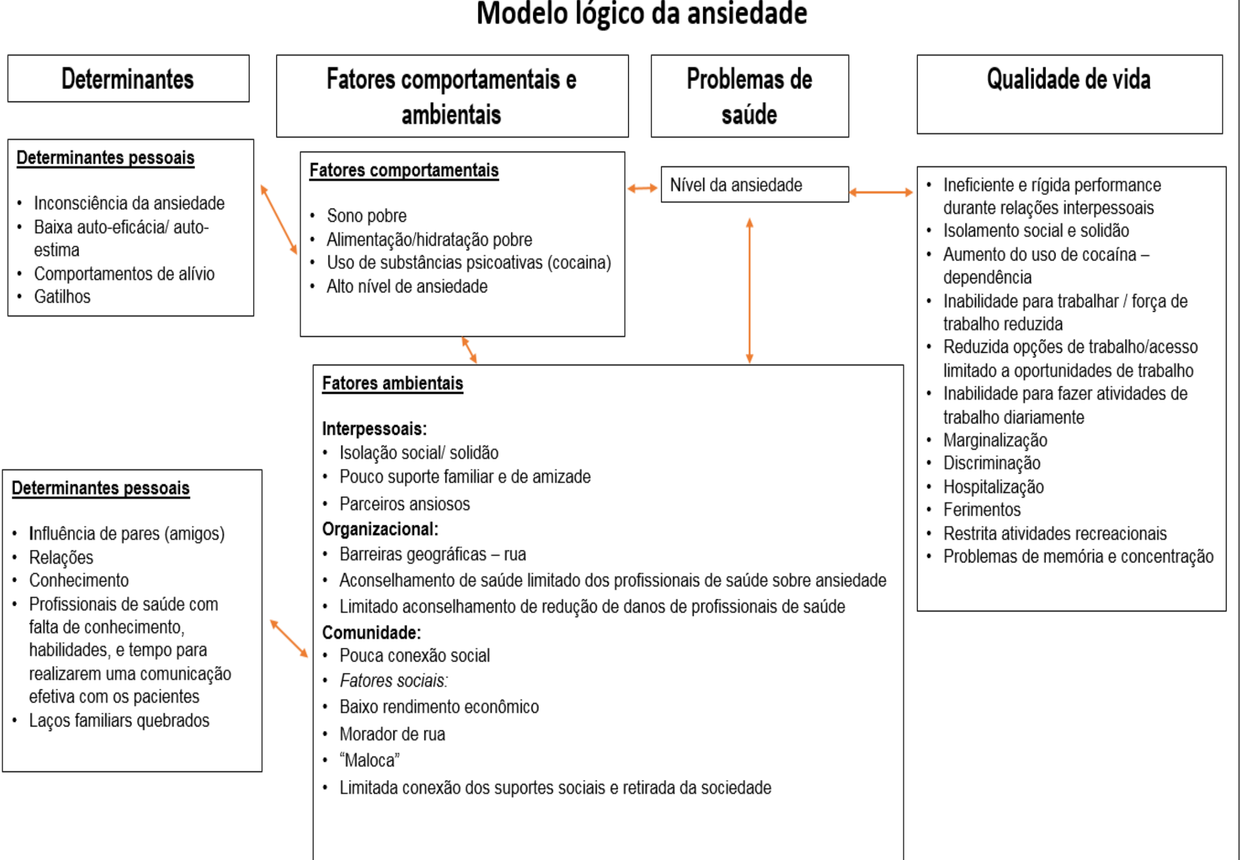
Nome da Intervenção: Lógico modelo do problema

2) Metas da intervenção (objetivos de mudança + determinantes):

- Conhecimento sobre o modelo lógico do problema (ansiedade)

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega

Conhecimento sobre a ansiedade como um problema	1.1 Mapa conceitual	1.1 Mostre a matriz do problema e pergunte para o paciente se ele gostaria de adicionar algo	1.8 Apresentação escrita: Distribua um folheto com o lógico modelo do problema



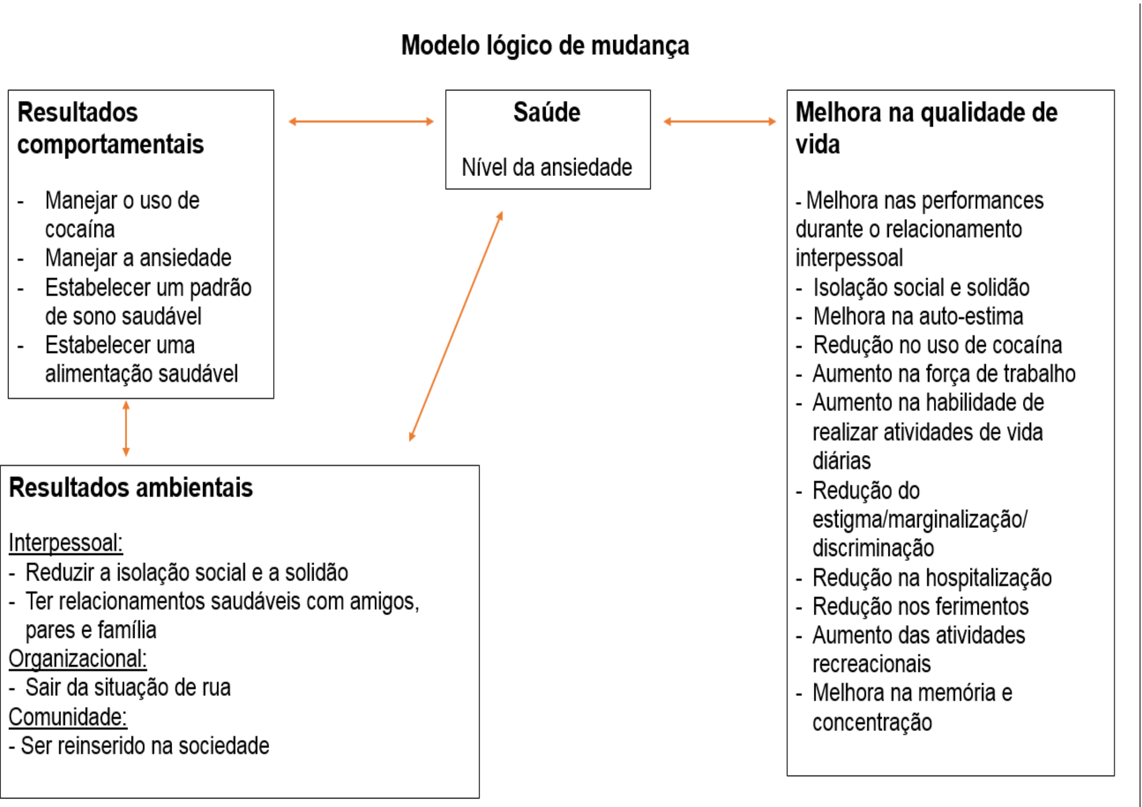
Etapa 2: Modelo lógico do problema + lógico modelo de mudança

- Traga uma tabela com o modelo lógico do problema e mostre o modelo lógico de mudança.
  - Note: Se o cliente adicionar algo no lógico modelo do problema, a enfermeira deveria readaptar o modelo do problema e se basear no novo modelo do problema durante toda a intervenção
- Fale sobre as interações entre os desfechos comportamentais e contextuais com a ansiedade (problema de saúde) e como eles podem melhorar a qualidade de vida.
- Discutir com o paciente sobre os desfechos comportamentais, contextuais e como isso irá afetar sua qualidade de vida.

Roteiro:

- Então, aqui é o lógico modelo do problema que nós trabalhamos juntos e agora eu gostaria de mostrar o lógico modelo da mudança que representa a transição dos fatores comportamentais e contextuais em desfechos comportamentais e contextuais, os quais

você pode alcançar afim de reduzir esses sentimentos desprazerosos (ansiedade) que você sente, e consequentemente irá melhorar a sua qualidade de vida.



- Para cada desfecho comportamental e contextual, nós temos algumas sugestões em como você pode alcançar esses desfechos. Eu apresentarei algumas sugestões para você , e nós Podemos trabalhar juntos para adequar essas sugestões em sua realidade.

Etapa 3: 1) *Nome da intervenção*: Trabalhando para manejar a ansiedade – gatilhos + comportamentos de alívio + auto-eficácia

2) Metas da intervenção (objetivos de mudança + determinantes):

- Reconhecimento dos gatilhos envolvidos na ansiedade;

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Identifique os gatilhos envolvidos nas expectativas (2.1 – 2.3)	2.1 Consciência aumentando 2.2 Aprendizado ativo	2.1; 2.2 Defina gatilhos junto com o paciente depois que o paciente identificou na primeira consulta	2.1; 2.2 Escrita -faça notas sobre os gatilhos 2.3 Escrita - faça notas sobre os

		as suas expectativas e os comportamentos de alívio utilizados (é fácil pensar sobre gatilhos quando você pensa em expectativas, e no que acontece em vez das expectativas e os comportamentos de alívio que usa). Pense junto com o paciente acerca disso 2.2 Providencie uma lista de gatilhos que estão relacionados com as expectativas 2.3 Liste as expectativas ao lado dos gatilhos	gatilhos + expectativas + o que acontece em vez das expectativas
Define the gatilhos (2.3 -2.5)	2.3 Consciência aumentando 2.4 Auto-reavaliação 2.5 Reavaliação contextual	2.3; 2.4 Liste as características dos gatilhos (quando, onde, quem, como) 2.5 Encorage os pacientes a descreverem se os membros da família (pares, amigos) identificam alguns gatilhos que precede a mudança no comportamento	2.3;2.4 Escrita -Faça notas das características dos gatilhos 2.5 Apresentação verbal
Elabore a conexão entre gatilhos, expectativas e o que acontece em vez das expectativas (2.7)	2.7 Elaboração	2.7 Faça uma observação ou validação consensual das variantes das operações de segurança (comportamento de alívio usado)	2.7 Escrita -Faça notas dos gatilhos + expectativas + comportamentos de alívio usado
Categorize os possíveis gatilhos	2.8 Risco personalizado	2.8 Instrua o indivíduo a evitar situações que podem	2.8; 2.9 Apresentação verbal

para mudança (2.8 – 2.9)	2.9 Planejando respostas	gerar problemáticos gatilhos 2.9 Formular junto com o paciente estratégias para evitar essas situações	

- Identificação, análise e conexão dos comportamentos de alívio;

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Identifique os comportamentos de alívio usados durante a ansiedade (3.1-3.2)	3.1 Consciência aumentando 3.2 Elaboração	3.1 Conecte a ansiedade e o comportamento de alívio 3.2 Quais padrões de comportamentos são usados?	3.1; 3.2 Apresentação verbal
Analise os comportamentos de alívio usados (3.3)	3.3 Elaboração	3.3 Depois identifique os comportamentos de alívio usados (questões abaixo), a enfermeira tem que seguir essas questões para o paciente fazer uma análise de comportamentos de alívio: Há uma série de comportamentos de alívio que você usa? As séries do comportamento de alívio recorrem na mesma ordem e consequentemente produzem comportamentos que configuram ansiedade? O montante de	3.3 Apresentação verbal

		ansiedade é também inferido a partir dos comportamentos de alívio identificados no lugar do desconforto experenciado: “Qual parte do corpo você sente o desconforto?”	
Conexão dos comportamentos de alívio e ansiedade (3.4)	3.4 Possessão	3.4 Depois de analisar os comportamentos de alívio (série, ordem e montante de comportamentos em série), o paciente deve ser conectado aos comportamentos de alívio com o desejo de reduzir ou parar o desconforto extremo e tensões internas (ansiedade) que são experenciados no seu corpo e na sua mente.	3.4 Apresentação verbal
Modifique os comportamentos de alívio que são cabíveis de mudança (3.5)	3.5 Auto-reavaliação	3.5 A pessoa pode comparar sua imagem com o atual comportamento de alívio, e uma possível imagem com o novo comportamento de alívio (e.g.: Uma pessoa pode comparar sua imagem como uma pessoa sedentária para uma possível imagem dela mesma como uma pessoa ativa, usando a atividade física como um comportamento	3.5 Apresentação verbal

		de alívo em vez do uso de cocaína)	

- Expresse auto-eficácia para lidar com a ansiedade.

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia para reconhecer ansiedade (4.1)	4.1 Persuasão verbal	4.1 Use mensagens positivas (reforço positivo) para mostrar que o paciente é capaz de reconhecer ansiedade	4.1 Apresentação verbal
Demonstre auto-eficácia (abilidade) para estabelecer conexão entre comportamentos que são usados para aliviar a ansiedade (4.2- 4.3)	4.2 Auto-monitoramento de comportamento 4.3 Alinhamento	4.2; 4.3 Clientes mantêm diário para fazer notas sobre o desconforto (onde no corpo - a enfermeira pode providenciar uma figura de qual parte do corpo o paciente identifica que sente o desconforto) que vem antes da sensação de desprazer (ansiedade) e o comportamento de alívio usado para reduzir a sensação de desconforto	4.2; 4.3 apresentação escrita – caderno (diário) que será mantido com a enfermeira– circule a parte do corpo no caderno
Expresse auto-eficácia para reconhecer as expectativas (4.4)	4.4 Persuasão verbal	4.4 Use mensagens positivas (reforço positivo) para mostrar que o cliente é capaz de reconhecer as expectativas	4.4 Apresentação verbal

Demonstre auto-eficácia (abilidade) para identificar a conexão entre as expectativas, e o que acontece em vez das expectativas e os comportamentos de alívio utilizados (4.5)	4.5 Síntese	4.5 Ensine o cliente como reconhecer o mais breve possível a conexão entre as expectativas, o que acontece em vez das expectativas, e os comportamentos de alívio utilizados para lidar com a ansiedade. Porque uma vez que o paciente aprende a identificar esse ciclo, ele pode quebrar o ciclo, ou usar outro tipo de comportamento de alívio.	4.5 Apresentação verbal
Expresse auto-eficácia para mudar algumas expectativas e fatores envolvidos no ciclo de sentimentos desprazerosos (4.6)	4.6 Guia prático	4.6 Use todos os modelos para atingir o comportamento que constitue ansiedade (respire profundamente; meditação; atividade física, dieta saudável; use menos cocaína)	4.6 Apresentação escrita: Distribua o folheto com instruções de respiração profunda– meditação ; tipos de atividades físicas - por quanto tempo fazer, como fazer ; e dieta saudável)

<u>Etapa 4:</u> Explicação sobre os folhetos e aplicações

- Explique cada folheto

Roteiro:

- Eu tenho esses 3 folhetos sobre os possíveis comportamentos de alívio que podem substituir os comportamentos de alívio ruins.
- Eu irei falar profundamente sobre os dois outros comportamentos de alívio bons nas próximas consultas e nós teremos a oportunidade de adequá-los melhor para a sua realidade
- Agora eu gostaria de saber se você está usando as etapas da respiração profunda descritas no folheto entregue a você na última consulta

- Note: se ele disser que ele não está usando, a enfermeira pode sugerir aplicr com ele as etapas da respiração profunda.

<u>Etapa 5</u>: Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você
- Diga que você espera vê-lo novamente em uma próxima consulta
- Se o paciente tem um cellular diga que você enviará uma mensagem sobre o horário da próxima consulta

Tarefas do enfermeiro – Durante/ depois da consulta

Complete os formulários de informação:

- Avaliação dos sintomas, questões (problemas), suporte
- Score do BAI (antes e depois da consulta)
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

Dados 3 – Consulta 3

Consulta 3

Etapa 1: Foque no sentimento do paciente

- Comece cada sessão mantendo o foco no presente e em como o paciente sente-se no presente dia (sentimentos).

Roteiro:

- Como você tem se sentindo desde a última consulta?
- Pacientes tipicamente respondem com alguma referência a sentimentos desagradáveis (tensão -ansiedade) ou os eventos na vida dele durante o última dia. Se os clientes providenciam informação sobre um evento interpessoal, a enfermeira deve linkar o evento ao sentimento desagradável que o paciente sentiu durante o dia reportado ou vice-versa.

Etapa 2: 1) *Nome da intervenção*: Trabalhando para estabelecer um padrão de sono saudável

2) Metas da intervenção (objetivos de mudança + determinantes):

- Conhecimento sobre o padrão de sono mais comum

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre o padrão de sono mais comum (1.1-1.2)	1.1 Consciênica aumentando 1.2Usando imagem	1.1 Guia sobre o padrão comum de sono 1.2 Imagem com o tempo de sono e o humor relacionado (cansado, muito cansado, bem)	1.1; 1.2 Apresentação escrita: Distribua um folheto com informação sobre o padrão de sono e figuras de humor relacionado com o padrão de sono
Conhecimento dos benefícios da atividade física para melhorar o padrão de sono (1.5-1.7)	1.5 Consciência aumentando 1.6 Usando imagem	1.5 Guia sobre os benefícios da atividade física (folheto) 1.6 Imagem sobre a função da atividade	1.5 -1.7 apresentação escrita

	1.7 Selecionando crenças	física no corpo (folheto) 1.7Videos/jornais sobre a relação entre atividade física e a melhora do sono	
Conhecimento sobre o padrão de sono habitual (1.8)	1.8 Auto-monitoramento do comportamento	1.8 Diario para fazer notas sobre o padrão de sono (caderno)	1.8 Apresentação escrita – caderno
Conhecimento dos desafios para atingir um bom padrão de sono na sua realidade e possíveis lugares seguros para dormir (1.9-1.13)	1.9 Consciência aumentando 1.10 Aprendizado ativo 1.11 Consciência aumentando 1.12 Mobilizando suporte social 1.13 Reforço	1.9 Discussão sobre os desafios de atingir um bom padrão de sono 1.10 Desenvolvimento de uma lista individual (papel) apontando desafios individuais 1.11;1.12 Providencie uma lista (com localização e contato) de lugares seguros que o paciente possa ir dormir 1.13 Providencie informação sobre como lugares seguros contribuem para estabelecer um padrão de sono saudável	1.9; 1.13 Apresentação verbal 1.10- 1.12 Apresentação escrita – Distribua um folheto com a informação

- Reconhecimento dos gatilhos envolvidos no sono

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Gatilhos que estão presents no seu estilo	2.1 Consciência aumentando	2.1;2.2Providencie uma lista com alguns	2.1- 2.2 Apresentação

de vida que interferem no sono (2.1-2.3)	2.2 Aprendizado ativo 2.3 Elaboração	gatilhos que interferem no sono 2.3 Identifique junto com os pacientes os gatilhos que interferem no sono, e providencie alternativas de inibição desses gatilhos (menu de opção)	escrita: Distribua um folheto com a lista de gatilhos 2.3 Apresentação verbal + Apresentação escrita (adicione na lista dada ao cliente os novos gatilhos que ele identificou)
Gatilhos que interferem para não realizar atividade física (2.4 -2.5)	2.4 Consciência aumentando 2.5 Reestruturando o contexto físico	2.4 Faça um link dos gatilhos (frequencia e probabilidade) com a abstinência da atividade física 2.5 Proponha ao paciente identificar as barreiras de começar uma nova rotina de exercícios (e.g., falta de motivação, e discutir modos em que eles poderiam superar essa falta de motivação – e.g., indo ao parque fazer exercícios com o amigo)	2.4; 2.5 Apresentação verbal
Modificar os Gatilhos que interferem no padrão de sono (2.6-2.8)	2.6 Planejar estratégias de enfrentamento 2.7Mobilizar suporte social 2.8 Feedback	2.6; 2.7 Oferecer algum suporte social para enfrentar os gatilhos 2.8 Dar reforço positive para mudificar o padrão de sono	2.6 -2.8 Apresentação verbal

- Identificação, analise e conexão dos comportamentos de alívio;

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Comportamentos de alívio para obter sono (3.1-3.3)	3.1 Consciência aumentando 3.2 Aprendizado ativo 3.3 Modelando	3.1 Reforço da importância da respiração profunda (meditação) para alcançar sono, mas o paciente pode escolher fazer somente a respiração profunda antes de dormir. Ele pode decidir o que funciona melhor para ele. 3.2 Ensine o paciente a fazer respiração profunda antes de dormir (Etapa 3 no folheto da respiração profunda) 3.3 Discussão com o paciente sobre a situação do contexto em que vive. Porque algumas vezes os pacientes dizem que eles necessitam manter-se acordados a noite para manter-se seguros em lugares perigosos (contexto em que vivem- rua). Você pode ensiná-los que eles podem adaptar a respiração profunda antes de dormir, por meio de colocar na mente antes de dormir que quando eles ouvirem barulhos que representam perigo para eles acordarão E.g. Em vez de	3.1 Apresentação verbal 3.2 Aplicação prática 3.3 Apresentação verbal

		deixar todos os pensamento irem para longe, você necessitará manter na sua consciência que você reconhecerá barulhos que representam perigo e acordará e ficará alerto no mesmo tempo que ouviu o barulho.	
Atividade física como um comportamento de alívio (3.4 -3.5)	3.4 Consciência aumentando 3.5 Usando imagem	3.4; 3.5 Providencie informação de como a função da atividade física reduz a ansiedade (relaxamento corporal) através do folheto, videos e figuras.	3.4; 3.5 Apresentação escrita
Distinguir os comportamentos de alívio que dificultam o sono dos que ajudam a ter um bom sono (3.6)	3.6 Aprendizado ativo	3.6 Desenvolva uma tabela com duas colunas cujo uma coluna será o comportamento de alívio que dificulta o sono e a outra será o comportamento de alívio que ajuda no processo de dormir.	3.6 Apresentação escrita: Desenvolvimento de colunas comparativas juntamente com o paciente
Modificar os comportamentos de alívio que são usados para atingir o sono (3.7)	3.7 Aprendizado ativo	3.7 Use a tabela desenvolvida previamente para identificar os maus e bons comportamentos de alívio usados , e como o paciente tenta substituir os maus comportamentos de alívio por outros (bons comportamentos de alívio).	3.7 Apresentação escrita

- Expresse auto-eficácia para alcançar padrão de sono saudável

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Auto-eficácia na habilidade de adequar o padrão de sono no seu estilo de vida (4.1 – 4.2)	4.1 Guia prático 4.2 Auto-monitoramento do comportamento	4.1 O cliente primeiramente mostrará como ele está usando as técnicas para melhorar seu padrão de sono (meditação, respiração profunda...) e então a enfermeira pedirá para o paciente fazer algumas vezes a técnica que ele utiliza com o intuito de analizar como o paciente está realizando a técnica ensinada. Após isso, a enfermeira fará comentários breves da performace do paciente, enfatizando aspectos realizados bem. 4.2 Pacientes manterão o diário sobre seu padrão de sono, e farão notas sobre como as técnicas estão ajudando na adequação do padrão de sono no estilo de vida	4.1 Aplicação prática 4.2 Apresentação escrita – caderno
Expresse auto-eficácia na habilidade de realizar atividade física (4.3 - 4.5)	4.3 Organizando metas	4.3 Paciente e enfermeira discutem sobre as metas para a próxima consulta, decidindo pela meta que é aceitável no seu	4.3; 4.5; 4.6 Apresentação verbal 4.4 Apresentação escrita – notebook

	4.4 Auto-monitoramento de comportamento 4.5 Planejando estratégias de enfrentamento 4.6 Oportunidade	estilo de vida para melhorar a atividade física 4.4 Pacientes manterão um diário sobre a atividade física realizada 4.5 Enfermeiras providenciarão uma lista de barreiras potenciais e maneiras de enfrentá-las, por exemplo, se o parque que o paciente usa normalmente para realizar atividade física está fechado, ele pode ter outras opções perto desse parque para realizar atividade física 4.6 Pacientes devem manter em mente que atividades físicas são importante para reduzir ansiedade, e consequentemente alcançar um padrão de sono melhor	
Expresse auto-eficácia na habilidade de mudar o padrão de sono (4.7 – 4.8)	4.7 Melhorar o estado físico e emocional	4.7 Paciente está pensando na respiração profunda e relaxamento antes de ir dormir, e consequentemente ele terá mais chance de dormir bem. Para os pacientes que vivem na rua, a enfermeira terá que reafirmar que durante a respiração o paciente terá que manter em mente que ao ouvir algum barulho que representa perigo, ele	4.7 Apresentação verbal

	4.8 Sugestão de alteração	irá levantar rapidamente e ficará alerta (mensagem do inconsciente – isso é o que acontece quando a mãe levanta instantaneamente ao aouvir o choro do seu bebê). 4.8 Paciente procura um lugar mais Seguro que o de antes (que ele constumava dormir), com intuito de evitar disturbios no seu sono	

Etapa 3: 1) *Nome da intervenção*: Trabalhando para estabelecer uma dieta saudável

2) Metas da intervenção (objetivos de mudança + determinantes):

- Conhecimento sobre o padrão mais comum de alimentação

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre o padrão de alimentação mais comum (1.1-1.2)	1.1 Consciência aumentando 1.2Usando imagem	1.1 Guia sobre o padrão comum de alimentação 1.2 Imagem com comidas que o indivíduo pode comer por dia	1.1; 1.2 Apresentação escrita: Distribua o folheto com informação sobre o padrão de alimentação e figuras com comida
Conhecimento sobre seu padrão habitual de alimentação (1.3 - 1.4)	1.3 Auto-monitoramento do comportamento 1.4 Feedback	1.3 Diário do consumo de comida 1.4 Feedback sobre o melhor encaixe entre o esperado hábito saudável de alimentação e o atual hábito de alimentação	1.3 Apresentação escrita – caderno 1.4 Apresentação verbal
Conhecimento sobre os lugares para	1.5 Consciência aumentando	1.5 Liste lugares para comer	1.9 Apresentação escrita –

comer algo saudável (1.5 -1.6)	1.6 Feedback	1.6 Feedback sobre os lugares para comer, com ênfase nas comidas saudáveis	providencie uma lista em um papel 1.10 Apresentação verbal
Conhecimento sobre os desafios para alcançar um bom padrão de alimentação de acordo com a realidade do paciente (1.7 -1.8)	1.7 Consciência aumentando 1.8 Aprendizado ativo	1.7 Liste alguns gatilhos de má alimentação 1.7 Discussão sobre os desafios de atingir um bom padrão de alimentação 1.8Desenvolvimento de uma lista individual com pontos acerca dos desafios individuais	1.11 Apresentação escrita – providencie uma lista em um papel 1.12 Apresentação verbal

- Reconhecimento dos gatilhos envolvidos na alimentação

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Gatilhos que estão presentes no estilo de vida que interferem na sua dieta (2.1-2.2)	2.1 Consciência aumentando 2.2 Aprendizado ativo	2.1 Providencie uma lista de gatilhos possíveis que interferem na dieta saudável 2.2 Adapte uma lista para a realidade do paciente	2.1 Apresentação escrita: Distribua a lista com os gatilhos em um folheto 2.2 Apresentação verbal + Apresentação escrita (adicione na lista dada ao paciente os novos gatilhos identificados)
Modifoque os gatilhos que interferem na alimentação saudável (2.3)	2.3 Reforço	2.3 Providencie um reforço positivo para enfrentar os gatilhos que interferem na alimentação saudável	2.3 Apresentação verbal

- Identificação, análise e conexão dos comportamentos de alívio

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Crie novos comportamentos de alívio para alcançar uma boa alimentação no seu estilo de vida (3.1 – 3.2)	3.1 Condicionamento 3.2 Sugestão de alteração	3.1; 3.2 Encorage o paciente a aprender comportamentos saudáveis que podem substituir o comportamento problemático (agende um horário regular para comer; não coma aperitivos antes da refeição; não beba álcool antes da refeiçãol)	3.1; 3.2 Apresentação verbal
Distingua os comportamentos de alívio que dificultam uma dieta saudável dos que ajudam a obter uma dieta saudável (3.3)	3.3 Aprendizado ativo	3.3Desenvolva uma tabela com duas colunas, cuja uma coluna será de comportamentos de alívio que ajudam na obtenção de uma alimentação saudável e outra coluna com comportamentos de alívio que dificultam a alimentação saudávelto que o paciente está acostumado a usar	3.3 Apresentação escrita: Desenvolvimento das colunas com o paciente em um papel
Modifique os comportamentos de alívio que são usados para alcançar uma dieta saudável (3.4)	3.4 Aprendizado ativo	3.4 Use a tabela desenvolvida previamente para identificar os maus e bons comportamentos de alívio utilizados, e como o paciente tenta substituir os comportamentos de	3.4 Apresentação escrita

		alívio ruins por outros	

- Expresse auto-eficácia para alcançar uma dieta saudável

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia na habilidade em adequar padrões de alimentação no seu estilo de vida (4.1)	4.1 Reforço	4.1 Use positiva mensagens (reforço positivo) para mostrar que o paciente é capaz de alcançar o padrão de alimentação adequado	4.1 Apresentação verbal
Expresse auto-eficácia na habilidade em monitorar o próprio consumo de comida (4.2)	4.2 Auto-monitoramento de comportamento	4.2 Diário para fazer notas sobre o consumo de comida (caderno)	4.2 Apresentação escrita – caderno
Expresse auto-eficácia na habilidade em enfrentar os desafios encontrados frente ao padrão de alimentação (4.3-4.5)	4.3 Sugestão de alteração 4.4 Mobilizando suporte social	4.3 Paciente procura um lugar que possa providenciar mais alimentos saudáveis, com o intuito de evitar alimentação que não é saudável 4.4 Ofereça algum suporte social que providencie comida	4.3-4.5 Apresentação verbal

	4.5 Planejando estratégias de enfrentamento	de graça ou de baixo custo saudável 4.5 Enfermeiras providenciam uma lista de barreiras potenciais e caminhos para enfrentá-las	

Etapa 4: 1) *Nome da intervenção*: trabalhando para manejar o uso de cocaína

2) Metas da intervenção (objetivos de mudança + determinantes):

- Conhecimento sobre o uso de cocaína

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre o consumo habitual de cocaína e as características desse consumo (1.1 - 1.3)	1.1 Consciência aumentando 1.2 Auto-monitoramento do comportamento 1.3 Usando imagem	1.1; 1.2 Diário do uso de cocaine e outra substância psicoativa normalmente usada junto com a cocaína 1.3 Imagem com a medida da cocaína (uma pedra, 250 gramas) 1.3 Imagem com a medida da outra substância (e.g.: alcool - dose) 1.1; 1.3 Conhecimento sobre os mecanismos da cocaína por figura e/ou video	1.3 -1.3 Apresentação escrita – imagens 1.4 Apresentação escrita – caderno
Conhecimento sobre os desafios na redução do consumo de cocaína (1.4 -1.6)	1.4 Consciência aumentando 1.5 Aprendizado ativo	1.4 Liste alguns gatilhos do consumo de cocaína 1.4; 1.5 Discussão sobre os desafios	1.9 Apresentação escrita: Distribua uma lista com os gatilhos 1.10 Apresentação escrita – caderno

	1.6 Auto-monitoramento do comportamento	para atingir menos consumo de cocaína 1.4; 1.5 Desenvolvimento de uma lista individual apontando os desafios individuais de cada indivíduo 1.4 ;1.6Diário do uso de cocaína com descrição do local, horário, e pessoas que o indivíduo normalmente faz uso junto	1.6 Apresentação verbal

- Reconhecimento dos gatilhos envolvidos no uso de cocaína

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Gatilhos que estão presentes no seu estilo de vida que interferem diretamente e indiretamente no uso de cocaína (2.1 -2.3)	2.1 Consciência aumentando 2.2 Risco personalizado 2.3 Prevenção de recaída	2.1 Identifique especificamente os gatilhos que geram a necessidade de cocaína 2.2 Analise todos os fatores envolvidos com o gatilho 2.3 Desenvolva estratégias para evitar gatilhos do ambiente (context)	2.1 -2.3 Apresentação verbal (prencha a tabela)
Modifique os gatilhos que interferem no uso de cocaína(2.4-2.7)	2.4 Planejando estratégias de enfrentamento 2.5 Mobilizando suporte social 2.6 Evitando/ reduzindo a	2.4; 2.5 Providencie suporte social para enfrentar os gatilhos presentes no uso de cocaína 2.6 Evite as situações que provoquem gatilhos para o uso de cocaína	2.4-2.7 Apresentação verbal

	exposição a gatilhos para o uso de cocaína 2.7 Reestruturando o context social	2.7 Mude (se possivel) seu contexto social altual	

- Identificação, análise e conexão de comportamentos de alívio

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Crie um novo comportamento de alívio no seu estilo de vida (3.1 -3.2)	3.1Condicionamento 3.2 Consciência aumentando	3.1; 3.2 Discuta com o paciente sobre outros comportamentos de alívio que dão a ele prazer similar a cocaína (meditação, atividade física, sexo seguro , comida..)	3.1-3.2 Apresentação verbal
Modifique o comportamento de alívio (3.3 – 3.4)	3.3 Condicionamento 3.4 Reavaliação do contexto	3.3 Depois de descobrir outros comportamentos de alívio, o paciente pode tentar usá-los como novos comportamentos de alívio ao inves da cocaina 3.4 Encorage o paciente a comparar o novo comportamento de alívio com a grande quantidade de uso de cocaína (o paciente aqui, el epode manter o uso de cocaína, mas ao menos deve reduzir um pouco o consumo de cocaína ou o uso de outro tipo	3.3-3.4 Apresentação verbal

		de droga – “crack – cocaina em pó”)	

- Expresse auto-eficácia para manejar o uso de cocaína

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia na habilidade em monitorar o seu próprio consumo de cocaína (4.1-4.2)	4.1 Auto-reavaliação 4.2 Auto-monitoramento do comportamento	4.1; 4.2 Diário com notas sobre o uso de cocaína e o jeito que é consumida a substância	4.1-4.3 Apresentação escrita – caderno
Expresse auto-eficácia na habilidade em gerar estratégias de enfrentamento para enfrentar os desafios (4.3 – 4.7)	4.3 Sugestão de alteração 4.4 Mobilizando suporte social 4.5 Oportunidade 4.6 Planejando estratégia de enfrentamento 4.7 Prevenção de recaída	4.3 Paciente procura por um lugar que ele não pode ter bastante acesso a cocaina 4.4 Ofereça alguns suportes sociais que providencie outros comportamentos de alívio ao inves de cocaína 4.5 Fale para os pacientes irem para a academia para controlarem a ansiedade, em vez de usar cocaína 4.6 Enfermeira devem providenciar uma lista com as barreiras potenciais e os caminhos de superá-las 4.7 Desenvolvimento de estratégias para evitar gatilhos do	4.3-4.7 Apresentação verbal

		ambiente em que vivem	

- Note: Depois de trabalhar com todas essas estratégias para manejar o consume de cocaína, e o paciente manter-se resistente em tentar essas estratégias novas. A enfermeira deve falar algumas mensagens de reforço: - Eu não posso competir com as drogas, porque as drogas fornecem uma sensação de prazer muito rápido, mas eu e você sabemos que essa sensação de prazer vem rápido, e termina rápido também. Então, todas as coisas que falamos hoje, eu posso lhe dizer que a duração de alívio é mais longa que as drogas, mas você precisa praticá-los diariamente para que atinja uma sensação mais prazerosa.

Etapa 5: Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você
- Diga que você espera vê-lo novamente em uma próxima consulta
- Se o paciente tem um celular diga que você enviará uma mensagem sobre o horário da próxima consulta

Tarefas da enfermeira – Durante/ depois da consulta

Complete os formulários de informação:

- Avaliação dos sintomas, questões (problemas), suporte
- Score do BAI
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

Dados 4 – Consulta 4

Consulta 4

Etapa 1: Foque no sentimento do paciente

- Comece cada sessão mantendo o foco no presente e em como o paciente sente-se no presente dia (sentimentos).

Roteiro:

- Como você tem se sentindo desde a última consulta?
- Pacientes tipicamente respondem com alguma referência a sentimentos desagradáveis (tensão -ansiedade) ou os eventos na vida dele durante o última dia. Se os clientes providenciam informação sobre um evento interpessoal, a enfermeira deve linkar o evento ao sentimento desagradável que o paciente sentiu durante o dia reportado ou vice-versa.

Etapa 2: 1) *Nome da intervenção*: Trabalhando para reduzir o isolamento social

2) Metas da intervenção (Objetivos de mudança + determinantes):

- Conhecimento para reduzir a isolação social

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre diferentes lugares perto do lugar que o cliente vive (1.1 – 1.3)	1.12 Consciência aumentando 1.13 Prós e contras 1.14 Modelando	1.15 Liste diferentes lugares saudáveis 1.16 Aconselhe o individuo a listar e comparar as vantagens e desvantagens sobre cada lugar demonstrado 1.17 Providencie mapas sobre a localização dos novos lugares e rotas de como chegar neles	1.3 ; 1.3 Apresentação escrita: Distribua um folheto com lugares e a localização 1.4 Apresentação verbal

Conhecimento sobre a história da família do paciente (1.4 -1.5)	1.4Link empático 1.5 Feedback	1.18 Ouça cuidadosamente sobre a história da sua família 1.19 Dê feedback sobre os pontos principais da história da sua família	1.15 -1.5 Apresentação verbal
Conhecimento sobre a importância de laços saudáveis (1.6)	1.6 Elaboração	1.20 Desenvolva link entre amizades não saudáveis com o aumento da ansiedade, e continuidade de comportamentos de alívio ruins	1.6 Apresentação verbal
Conhecimento sobre a importância de alguém na sua rede de amizade que possa ajudá-lo no quesito emprego (1.7 -1.8)	1.7 Elaboração 1.8 Treinando habilidades sociais	1.21 Conhecimento sobre a importância de ter uma amizade saudável para atingir oportunidades de trabalho 1.22 Ensine efetivas formas de interação social em situações específicas (e.g: entrevistas de trabalho, comendo fora) com técnicas de comportamento. Desenvolva um caso ficcional para que o paciente pense em como reagir a situação	1.7 Apresentação verbal
Conhecimento sobre lugares diferentes (centros recreacionais) perto dos lugares que o paciente costuma viver e que haja	1.9 Elaboração 1.10 Pros e contras	1.9 Liste diferentes lugares para praticar atividades físicas 1.10 Discuta com o paciente os pros e	1.23 Apresentação escrita: Distribua folder com a lista de lugares e sua respectiva localização

programas de atividade física (1.96 – 1.10)		contras sobre cada lugar apresentado	1.24 Apresentação verbal

- Auto-eficácia para redução do isolamento social

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Auto-eficácia no reconhecimento das barreiras do cliente em conhecer diferentes lugares (2.1)	2.1 Mudando a rotina	2.1 Aconselhe maneiras de mudar a rotina diariamente ou semanalmente para limitar a exposição a comportamentos ruins, e criar oportunidade de conhecer outras pessoas	2.4 Apresentação verbal
Expresse auto-eficácia na sua habilidade de estabelecer contato entre o paciente e a família dele (2.2)	2.2 Link empático	2.2 Através do link empatico é desenvolvido "vínculo" entre a enfermeira e o paciente, e enfermeiras podem falar/ouvir mais sobre a família do paciente e encorajá-lo a contatar sua família	2.5 Apresentação verbal
Expresse auto-eficácia praticar atividade física(2.3 – 2.4)	2.3Planejando ação 2.4 Oportunidade	2.3 Proponha o planejamento da performace de uma atividade física particular (e.g. corrida) em um horário particular, em certos dias da semana . 2.4 Leve o paciente para a academia para	2.6 Apresentação verbal

		superar a ansiedade e engajar em atividade física	

- Melhora nas relações interpessoais

Objetivos de mudança (Determinantes)	Método (Ingrediente ativo)	Aplicação (Componente)	Modo de entrega
Prepare os clientes para estabelecer relações interpessoais (vínculos) em novos lugares (3.1)	3.1 treinando habilidades sociais	3.1 Ensine interações sociais efetivas com técnicas de comportamento reverso. Desenvolva uma simulação situacional com a paciente para pensar sobre como reagir a situação	3.1 Apresentação verbal
Proponha o reestabelecimento de vínculos (3.2- 3.3)	3.2 Reavaliação contextual 3.3 Treinamento em habilidades sociais	3.2 Encorage pacientes em descrever como membros da família (ou pares, amigos)sentem-se acerca das antigas amizades (vínculos) que eles costumavam a sair antes de aumentar o nível de ansiedade 3.3 Ensine interação social efetiva por meio de técnicas de comportamento reverso. Desenvolva uma simulação para que o paciente tente pensar como reagir a situação simulada. Como reestabelecer vínculos relacionais (mensagem,	3.2; 3.3 Apresentação verbal

		Facebook, conhecer pessoas pessoalmente)	
Proponha aos clientes o estabelecimento de vinculos relacionais para incentiva-los a fazer atividade física (3.4)	3.4 Restruturando o contexto social	3.4 Proponha ao paciente identificar as barreiras para que eles comecem um novo regime de exercícios (e.g., falta de motivação) e discuta maneiras em como eles podem superar as barreiras (e.g., indo para a academia com amigo)	3.4 Apresentação verbal

Step 3: 1) *Nome da intervenção*: Trabalhando para estabelecer um relacionamento saudável

2) Metas da intervenção (objetivos de mudança + determinantes):

- Estabelecer relacionamentos saudáveis

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre os relacionamentos que o paciente tinha, tem e poderia ter no futuro (1.1 – 1.4)	1.1 Elaboração 1.4 Providenciando sugestões 1.3 Reavaliação contextual 1.4Restruturando o context social	1.1 Discuta sobre os relacionamentos desenvolvidos e seu mecanismo para existir 1.2 Desenvolva comparação entre características das relações do passado e do presente 1.3Encorage os pacientes a descrever como os membros da família (ou pares,amigos) sentem-se sobre os antigos amigos (vínculos) que eles costumavam sair antes de aumentar a	1.1 Apresentação verbal 1.2 Apresentação escrita - caderno

		ansiedade. Como os membros da família(ou pares, amigos) sentem-se sobre suas relações (vínculos) atuais. E discuta sobre a reação de seus amigos, pares e família em relação ao relacionamento atual desenvolvido. 1.4Proponha ao paciente identificar as barreiras e preveni-las para o estabelecimento do começo da nova amizade.	
Conhecimento sobre como evitar relações que não são saudáveis (1.5)	1.5 Elaboração	1.5 Construção de algumas estratégias junto com o paciente sobre as ações possíveis para evitar relações que não são saudáveis	1.5 Apresentação verbal

- Aumentar a auto-eficácia para alcançar relacionamentos saudáveis

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia na habilidade de encorajar o cliente a mudar/ terminar relações problemáticas (2.1 - 2.3)	2.1 Condicionamento 2.2 Prós e contras 2.3 Controle de estímulos	2.1; 2.2 Liste no “caderno” as relações problemáticas por meio de uma tabela com prós e contras do relacionamento 2.3 Romper os hábitos- se o paciente sabe que ele pode encontrar alguém (cujo ele tem	2.1- 2.2 Apresentação escrita: Desenvolvimento de uma tabela com prós e contras juntamente com o paciente 2.3 Apresentação verbal

		uma relação problemática) em um específico lugar, é importante que o paciente reconheça que ir a esse específico lugar não ajuda-o.	

- Aumento das relações saudáveis

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Proponha aos pacientes um profundo entendimento sobre suas relações que são significantes (vínculos e laços relacionais) (3.1 – 3.3)	3.1 Consciência aumentando 3.2 Prós e contras 3.3 Reavaliação contextual	3.1 Providencie uma conversa com as relações que o paciente tem 3.2 Identifique prós e contras dessas relações 3.3 Encorage pacientes a descrever como os membros da família (ou pares, amigos) sentem sobre as relações que ele tem	3.1 – 3.3 Apresentação verbal
Prepare para reconhecer relações (vínculos relacionais e laços relacionais) que não são saudáveis para os clientes (3.4 – 3.5)	3.4 Prós e contras 3.5 Controle de estímulos	3.4 Identifique prós e contras sobre os vínculos relacionais e linke-os com o aumento do sentiment desagradável (ansiedade) e comportamentos de alívio ruins 3.5 Quebrar hábitos-se o paciente sabe que ele pode encontrar alguém	3.4 – 3.5 Apresentação verbal

		(cujo ele tem uma relação problemática) em um específico lugar, é importante que o paciente reconheça que ir a esse específico lugar não ajuda-o, e se ele continuar indo neste lugar talvez seja pior	

<u>Etapa 4:</u> 1) *Nome da intervenção*: Deixar a situação de rua

2) Metas da intervenção (objetivos de mudança + determinantes):

- Deixar a situação de rua

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Conhecimento sobre os albergues ou hotéis de baixo custo disponíveis na sua cidade e as regras (1.1 – 1.3)	1.1 Elaboração 1.2 Prós e contras 1.3 Usando imagem	1.1 Liste diferentes albergues perto do seu contexto 1.2 Discuta com o paciente os prós e contras sobre os albergues apresentados 1.3 Providencie mapas sobre a localização do lugares e rotas para chegar nos lugares apresentados	1.1 Apresentação escrita: Distribua em um papel uma lista dos lugares e da localização 1.2 Apresentação verbal
Conhecimento sobre a importância da familia (1.4)	1.4 Elaboração	1.4 Conectanto a falta do contato familiar com a situação de rua	1.4 Apresentação verbal

- Aumentar a auto-eficácia para sair da situação de rua

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia na habilidade de encontrar um melhor albergue para sua realidade (2.1-2.2)	2.1 Feedback 2.2 Prós e contras	2.1 Forneça o reforço positive para encontrar albergues 2.2 Liste prós e contras para cada albergue mencionado	2.2; 2.2 Apresentação verbal
Expresse auto-eficácia na habilidade em ajudar o paciente manter contato com sua família e talvez voltar para a casa da família (2.3)	2.3 Prós e contras	2.3 Liste prós e contras para a casa da família do paciente	2.3 Apresentação verbal

- Estabelecer a relação entre sair da situação de rua e desenvolver novas relações

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Proponha ao paciente um “albergue” como uma oportunidade para estabelecer laços relacionais com novas pessoas (3.1)	3.1 Elaboração	3.1 Fale com o paciente que o albergue pode ser um lugar que ele pode estabelecer relação com outras pessoas que dividem a mesma realidade	3.1 Apresentação verbal

Etapa 5: 1) *Nome da intervenção*: Reinserção na sociedade

2) Metas da intervenção (mudança de objetivos + determinantes):

- Reinserção na sociedade

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Conhecimento por meio do estado de vantagens para evitar lugares perigosos ou lugares que relembrem o antigo padrão de comportamento(1.1-1.4)	1.1 Elaboração 1.2 Providenciando sugestões 1.3 Modelando 1.4 Reforço	1.1 Relação dos lugares perigosos com o aumento da ansiedade e marginalização 1.2 Link lugares perigosos com comportamentos de alívio ruim 1.3; 1.4 Mostre documentarios sobre a relação de lugares perigosos com o aumento da marginalização	1.2 – 1.2 Apresentação verbal 1.3Video
Conhecimento sobre o suporte social disponível na sua cidade (1.5 – 1.7)	1.5 Aprendizagem ativa 1.6 Reforço 1.7 Mobilizando suporte social	1.5 Liste contato com o suporte social para pessoas em situação de rua 1.6; 1.7 Encorage paciente a entrar em contato com esse serviço	1.16 Apresentação escrita: Distribua um papel com uma lista com o contato do suporte social 1.17 Apresentação verbal
Conhecimento sobre as políticas específicas para pessoas em situação de rua e pessoas que usam substâncias psicoativas disponíveis na sua cidade (1.8 – 1.9)	1.8 Usando imagem 1.9 Mobilizando suporte social	1.8; 1.9 Providencie informação sobre políticas específicas para moradores de rua por meio de imagens que fornecem um rápido entendimento	1.8;1.9 Apresentação verbal

- Aumentar a auto-eficácia para reinserção na sociedade

Objetivos de mudança (Determinantes)	Métodos (Ingredientes ativos)	Aplicação (Componente)	Modo de entrega
Expresse auto-eficácia na habilidade para gerar estratégias de enfrentamento para lidar com os desafios contextuais (2.1 – 2.2)	2.1Ccontrole de estímulos 2.2 Restruturando o contexto social	2.1 Cessar hábitos- falar com o paciente sobre alguns hábitos que não são bem vistos pela sociedade 2.2 Proponha ao paciente identificar barreiras para a reinserção na sociedade	2.1- 2.2 Apresentação verbal

Etapa 6: Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você
- Diga que você espera vê-lo novamente em uma próxima consulta
- Se o paciente tem um celular diga que você enviará uma mensagem sobre o horário da próxima consulta

Tarefas da enfermeira – Durante/ depois da consulta

Complete os formulários de informação:

- Avaliação dos sintomas, questões (problemas), suporte
- Score of the BAI
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

<u>Dados 5: Consulta 5</u>

F. Terminação Sessão 5: Resolução – Relacionamento Interpessoal em Enfermagem *Consulta 5*

A meta da sessão de resolução é sumarizar todas as sessões prévias, identificando a habilidade mais importante que o paciente desenvolveu para alcançar a meta (redução da ansiedade), desenvolvimento de estratégias para os pacientes manterem as habilidades em seu contexto diário, e terminar o relacionamento entre enfermeira e paciente. Essa sessão pode ser cheia de sentimentos, então a enfermeira deve estar preparada para tristeza e lágrimas que possivelmente devam ocorrer.

<u>Etapa 1:</u> Foque no sentimento do paciente

- Comece cada sessão mantendo o foco no presente e em como o paciente sente-se no presente dia (sentimentos).

Roteiro:

- Como você tem se sentindo desde a última consulta?
- Pacientes tipicamente respondem com alguma referência a sentimentos desagradáveis (tensão -ansiedade) ou os eventos na vida dele durante o última dia. Se os clientes providenciam informação sobre um evento interpessoal, a enfermeira deve linkar o evento ao sentimento desagradável que o paciente sentiu durante o dia reportado ou vice-versa.

Etapa 2: Resolução

- Reveja as metas

Roteiro:

- Durante esses dias nóa falamos sobre maneiras de alcançar um nível de ansiedade melhor. Os principais pontos para alcançar essa mudança são: padrão de sono saudável; comida ingerida e uso de cocaína; e mudança nas suas relações e redução da isolação social.
    - Note: Se o paciente é morador de rua, mudar essa situação é um importante fator a ser considerado neste momento.
- Nós trabalhamos juntos para adaptar algumas estratégias para atingir essas mudanças para sua realidade. Talvez novas situações podem aparecer na sua vida que demande novas estratégias para enfrentá-las, mas você deve manter em mente que as principais estratégias são essas apresentadadas, e você pode readaptar ou criar outras baseadas nas estratégias principais.
- Revisão das estratégias que o paciente irá utilizar.
- Agora você sabe como reconhecer ansiedade e suas expectativas, e quando você está no modo "sintático" da ansiedade você pode criar novos comportamentos de alívio

para lidar com os sentimentos desagradavéis (ansiedade), e você pode escolher um comportamento de alívio saudável em vez de problemático.

Etapa 3: Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você
- Termine o relacionamento entre enfermeira e o paciente, mas fale ao paciente que el epode sempre voltar ao serviço especializado em álcool e outras drogas quando ele achar que é necessário em qualquer hora ou dia, pois ele será atendido pelo professional de saúde do CAPS AD.
- Se o cliente perguntar se el epode ser atendido por você, você tem que deixar claro que você não estará apta a realizar mais consultas com ele.
- Permita que a enfermeira e o paciente tenham o luto da perda da relação

Tarefas da enfermeira – Durante/ depois da consulta

Complete os formulários de informação:

- Avaliação dos sintomas, questões (problemas), suporte
- Score do BAI, GSE, MOS SSS, PSS, ASSIST
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

Dado 6 – Consulta de acompanhamento

A sessão de acompanhamento foca na avaliação de todos os determinantes da ansiedade novamente, depois de uma semana. Com o objetivo de avaliar a durabilidade da intervenção sem consulta.

Etapa 1: Foque no sentimento do paciente

- Comece cada sessão mantendo o foco no presente e em como o paciente sente-se no presente dia (sentimentos).

Roteiro:

- Como você tem se sentindo desde a última consulta?
- Pacientes tipicamente respondem com alguma referência a sentimentos desagradáveis (tensão -ansiedade) ou os eventos na vida dele durante o última dia. Se os clientes providenciam informação sobre um evento interpessoal, a enfermeira deve linkar o evento ao sentimento desagradável que o paciente sentiu durante o dia reportado ou vice-versa.

Etapa 2: Foque nas estratégias que o paciente está usando para manejar ansiedade

- Pergunte sobre quais estratégias o paciente tem usado para manejar a ansiedade desde a última consulta

Roteiro:

- Quais estratégias você tem usado para manejar ansiedade?
- Se o cliente não citar nenhuma estratégia providenciada durante a intervenção, cite algumas estratégias para relembrá-lo.

Fim da consulta

- Anúncio do fim da consulta

Roteiro:

- Diga obrigada para o paciente por ter comparecido a consulta
- Diga que você está feliz pelo paciente ficar toda a consulta com você

Tarefas de enfermagem – Durante/ depois da consulta

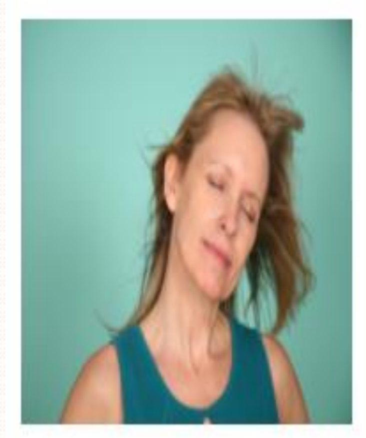
Complete os formulários de dados:

- Questionário sociodemográfico
- Avaliação dos sintomas, questões (problemas), suporte
- Score do BAI, GSE, MOS SSS, PSS, ASSIST
- Narrativa das enfermeiras e suas notas
- Prepare-se para a reunião de supervisão

Appendix 2 – Information Paper – physical activity

1)Aumenta a auto-eficácia – aumento de resistência e reduz as dores

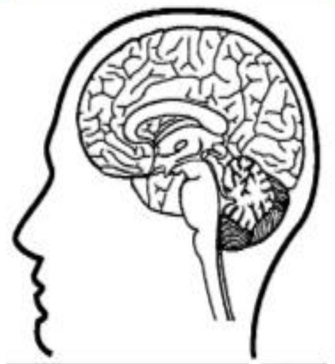
2)Aumenta sentimentos de prazer



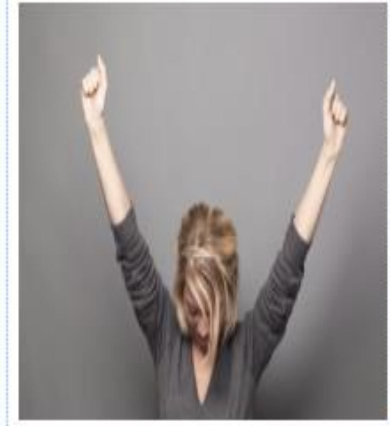
3) "Intervalo" nas atividades diárias

4) Reduz a auto-administração de medicamentos

5) Muda funções e estruturas do cérebro, gerando mais prazer



6) Aumenta a auto-estima – Melhora na força, poder, e massa corporal saudável



Appendix 3 – Information paper – Sleep

1) Evite estes produtos 4-6 horas antes de dormir
TYLENOL DC
2) Vá para cama quando estiver verdadeiramente cansado
Ficar lutando para pegar no sono – gera frustração!
Se você não dormir em 20 minutos – Saia da cama (ou local que dorme), ou tente exercícios de relaxamento
3)Deixe a cama (ou lugar que dorme) apenas para dormir
4) Estabeleça uma rotina antes de dormir
5) Não fique olhando o relógio a noite toda
6)Use a luz a seu favor
Mantenha a luz natural (sol) como um relógio interno

Appendix 4 – RedCap

Confidential

Elegibilidade

Record ID ______________________

Criterios de inclusao

	nao	sim
Idade >= 18 anos	○	○
Ser usuario de cocaina/crack como droga principal	○	○
Ser homem (sexo)	○	○
Apresentar níveis moderados e severos de ansiedade	○	○
Morar em Sao Paulo	○	○
Estar no periodo de construcao do plano terapeutico singular	○	○
Portugues como primeira linguagem	○	○
Aceitar participar e assinar o TCLE	○	○

Participante atende aos critérios de elegibilidade do estudo.
Por favor selecione a opção "Sim" na pergunta "Paciente foi incluido no estudo?".

Paciente foi incluido no estudo? ○ nao ○ sim

Data da assinatura do TCLE ______________________

Copia do TCLE

Dados Demograficos

Dados de identificacao	
Nome do paciente (nome completo)	______________ (Colocar o nome sem acentos ou caracteres especiais)
Registro	______________ (Registro do servico de saude)
Data da inclusao	______________
Data de nascimento	______________ (Formato: DD-MM-YYYY)
Idade (no inicio do estudo)	______________ (Campo com calculo automatico)
Sexo	○ Feminino ○ Masculino
Qual cor voce considera que seja sua pele?	○ Branca ○ Preta ○ Parda ○ Amarela ○ Indigena ○ Desconhecido/nao informado
Nacionalidade	○ Brasileira ○ Outras
Qual é a sua nacionalidade?	______________
Estado conjugal	○ Solteiro ○ Casado ○ Viuvo ○ Divorciado/Separado ○ Uniao estavel
Qual o numero de filhos?	______________
Você é praticante de alguma religião?	○ Nao ○ Sim

Qual religião ?	◯ catolico ◯ evangelico ◯ testemunha de jeova ◯ espirita ◯ umbanda ◯ candomble ◯ judaismo ◯ hinduismo ◯ budismo ◯ ateu ◯ agnostico (Agnostico = Pode acreditar ou nao em Deus. Acha que ha certas coisas que nao da para explicar racionalmente)
Estado em que nasceu	________________________
Cidade em que nasceu	________________________
Escolaridade	◯ Analfabeto ◯ Ensino fundamental incompleto ◯ Ensino fundamental completo ◯ Ensino medio incompleto ◯ Ensino medio completo ◯ Nivel tecnico ◯ Ensino superior incompleto ◯ Ensino superior completo ◯ Pos graduacao ◯ Informacao nao disponivel
Situacao laboral	◯ Desempregado ◯ Estudante ◯ Emprego formal (carteira assinada) ◯ Emprego informal ◯ Aposentando ◯ Autônomo ◯ outros ◯ Informacao nao disponivel
Qual a outra situacao laboral?	________________________
Situacao de moradia	◯ Albergue/ centro de acolhida ◯ Propria ◯ Aluguel ◯ Rua ◯ "Maloca" ◯ Ocupacao ◯ Pensao ◯ Republica ◯ Outros ◯ Informacao nao disponivel
Qual a outra situacao de moradia?	________________________

Dados de contato

Endereço (rua, avenida, alameda)	__________________
Numero	__________________ (numero da casa)
Complemento	__________________ (numero do apartamento)
Bairro	__________________
Cidade	__________________ (Formato: Sao Paulo)
Estado	__________________
CEP	__________________ (Formato: 00000-000)
Telefone residencial	__________________ (Incluir codigo de area (xx) 0000-0000)
Telefone celular	__________________ (Incluir codigo de area (xx) 0000-0000)

Dados basais

Faz atividade fisica?	○ nao ○ sim
Faz uso de medicamentos?	○ nao ○ sim

Medicamentos em uso

	nao	sim
ansioliticos sedativos e hipnoticos	○	○
ansioliticos atipicos/ ansioliticos nao barbituricos	○	○
inibidores seletivos da recaptacao de serotonina (ISRS)	○	○
antideressivos atipicos	○	○
Inibidores da monoaminoxidose	○	○

Outros medicamentos? ________________________

Comorbidades

Tem algum destes problemas de saúde?	○ nao ○ hipertensao arterial ○ diabetes ○ triglicerides aumentado ○ colesterol aumentado ○ problemas gastrointestinais ○ problemas cardiovasculares ○ problemas hepaticos (figado)
Identifique os problemas gastrointestinais ?	☐ nausea ☐ vomito ☐ diarreia ☐ gastrite ☐ ulcera ☐ neoplasia gastrica ☐ outros
Identifique os problemas cardiovasculares	☐ cardiomiopatica alcoolica ☐ doenca arterial coronariana ☐ acidente vascular cerebral ☐ outros
Identifique problemas hepáticos	☐ esteatose hepatica (gordura no figado) ☐ fibrose hepatica ☐ cirrose alcoolica ☐ cancer de figado ☐ outros
Tem mudancas bruscas no humor?	○ nao ○ sim
Faz algum tratamento para saude mental?	○ nao ○ ja fiz ○ atualmente faço
O tratamento para saude mental foi motivado por quais itens?	☐ depressao ☐ esquizofrenia ☐ transtorno bipolar ☐ ansiedade ☐ outros

Comorbidades

Tem algum destes problemas de saúde?	○ nao ○ hipertensao arterial ○ diabetes ○ triglicerides aumentado ○ colesterol aumentado ○ problemas gastrointestinais ○ problemas cardiovasculares ○ problemas hepaticos (figado)
Identifique os problemas gastrointestinais ?	☐ nausea ☐ vomito ☐ diarreia ☐ gastrite ☐ ulcera ☐ neoplasia gastrica ☐ outros
Identifique os problemas cardiovasculares	☐ cardiomiopatica alcoolica ☐ doenca arterial coronariana ☐ acidente vascular cerebral ☐ outros
Identifique problemas hepáticos	☐ esteatose hepatica (gordura no figado) ☐ fibrose hepatica ☐ cirrose alcoolica ☐ cancer de figado ☐ outros
Tem mudancas bruscas no humor?	○ nao ○ sim
Faz algum tratamento para saude mental?	○ nao ○ ja fiz ○ atualmente faço
O tratamento para saude mental foi motivado por quais itens?	☐ depressao ☐ esquizofrenia ☐ transtorno bipolar ☐ ansiedade ☐ outros

Dados comportamentais

Faz uso de álcool?	○ nao ○ sim
Qual foi a idade do primeiro contato com o álcool?	__________________
Qual foi a idade do primeiro contato com cocaína?	__________________
Como foi seu primeiro contato com cocaína?	○ festa ○ em casa com familiares ○ em casa com amigos ○ bar ○ rua ○ outros
Em que ocasioes voce costuma usar cocaina?	○ em festas/baladas ○ em casa ○ na rua ○ para relaxar ○ outros
Tem parentes próximos com problemas com cocaína/crack?	○ nao ○ sim
Tem parentes proximos com problemas de uso de outras drogas?	○ nao ○ sim (outras drogas que não seja cocaína/crack)
Qual a outra droga que seu parente usa?	☐ tabaco ☐ maconha ☐ calmantes ☐ alcool ☐ lsd/ecstasy ☐ outras

GAD 7

Durante as 2 ultimas semanas, com que frequencia voce foi incomodado pelos problemas abaixo?	
Sentir-se nervoso, ansioso ou muito tenso	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Nao ser capaz de impedir ou de controlar as preocupacoes	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Preocupar-se muito com diversas coisas	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Dificuldade para relaxar	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Ficar tao agitado que se torna dificil permanecer sentado	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Ficar facilmente aborrecido ou irritado	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Sentir medo como se algo horrivel fosse acontecer	◯ nenhuma vez ◯ varios dias ◯ mais da metade dos dias ◯ quase todos os dias
Score GAD 7 Soma	________________ (Soma simples)
Score GAD7	________________ (11= Ansiedade media 12= Ansiedade moderada 13 = Ansiedade severa)

BECK (BAI)

Dormência ou formigamento	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Sensacao de calor	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Tremores nas pernas	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Incapaz de relaxar	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Medo que aconteca o pior	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Atordoado ou tonto	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Palpitacao ou aceleracao do coracao	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Sem equilíbrio	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)
Aterrorizado	○ Absolutamente nao ○ Levemente (nao me incomodou muito) ○ Moderadamente(foi muito desagradável, mas pude suportar) ○ Gravemente (dificilmente pude suportar)

Nervoso	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Sensacao de sufocacao	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Tremores nas maos	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
tremulo	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Medo de perder o controle	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Dificuldade de respirar	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Medo de morrer	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Assustado	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Indigestao ou desconforto no abdomen	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Sensacao de desmaio	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)

Rosto afogueado	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)
Suor (nao devido ao calor)	◯ Absolutamente nao ◯ Levemente (nao me incomodou muito) ◯ Moderadamente(foi muito desagradável, mas pude suportar) ◯ Gravemente (dificilmente pude suportar)

ASSIST

1) Na sua vida, qual (is) destas susbtancias voce ja usou? (somento uso nao medico)	
Derivados do tabaco (cigarros, charutos, caximbos, fumo de corda..)	◯ nao ◯ sim
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nao ◯ sim
Maconha (baseado, erva, haxixe...)	◯ nao ◯ sim
Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nao ◯ sim
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nao ◯ sim
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança-perfume,benzina...)	◯ nao ◯ sim
Hipnóticos/sedativos (remédios para dormir: diazepam, lorazepan, lorax, dienpax, rohypnol)	◯ nao ◯ sim
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nao ◯ sim
Opióides (heroína, morfina, metadona, codeína...)	◯ nao ◯ sim
Outras	◯ nao ◯ sim
Especifique as outras	____________________

2) Durante os três últimos meses, com que freqüência você utilizou essa(s) substância(s) que mencionou? (Primeira droga, depois a segunda droga, etc)	
Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia

Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança-perfume, benzina...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir: diazepam, lorazepan, lorax, dienpax, rohypnol).	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	__________________________

3) Durante os três últimos meses, com que freqüência você teve um forte desejo ou urgência em consumir? (Primeira droga, depois a segunda droga, etc)

Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia

Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança-perfume,benzina...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir: diazepam, lorazepan, lorax, dienpax, rohypnol).	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	______________________

4) Durante os três últimos meses, com que freqüência o seu consumo de (Primeira droga, depois a segunda droga, etc) resultou em problema de saúde, social, legal ou financeiro?	
Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Cocaína, crack (pó, pedra, branquinha, nuvem...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança-perfume,benzina...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir: diazepam, lorazepan, lorax, dienpax, rohypnol).	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	○ nunca ○ 1 ou 2 vezes ○ mensalmente ○ semanalmente ○ diariamente ou quase todo dia

Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	__________________

5) Durante os três últimos meses, com que freqüência por causa do seu uso de (Primeira droga, depois a segunda droga, etc) você deixou de fazer coisas que eram normalmente esperadas por você?

Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança-perfume,benzina...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir: diazepam, lorazepan, lorax, dienpax, rohypnol).	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia

Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	____________________

6) Há amigos, parentes ou outra pessoa que tenha demonstrado preocupação com seu uso de (Primeira droga, depois a segunda droga, etc)?

Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia

Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança- perfume, benzina...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir:diazepam, lorazepan, lorax, dienpax, rohypnol...).	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	__________________________

7) Alguma vez você já tentou controlar, diminuir ou parar o uso de (Primeira droga, depois a segunda droga, etc)?

Derivados do tabaco (cigarros, charuto, cachimbo, fumo de corda...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Bebidas alcoólicas (cerveja, vinho, destilados como pinga, uísque, vodka, vermutes...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Maconha (baseado, erva, haxixe...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia

Cocaína, crack (pó, pedra, branquinha, nuvem...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Estimulantes como anfetaminas ou ecstasy (bolinhas, rebites...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Inalantes (cola de sapateiro, cheirinho-da-loló, tinta, gasolina, éter, lança- perfume, benzina...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Hipnóticos/sedativos (remédios para dormir:diazepam, lorazepan, lorax, dienpax, rohypnol...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Drogas alucinógenas (como LSD, ácido, chá-de-lírio, cogumelos...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Opióides (heroína, morfina, metadona, codeína...)	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Outras	◯ nunca ◯ 1 ou 2 vezes ◯ mensalmente ◯ semanalmente ◯ diariamente ou quase todo dia
Especificar outras	______________________
8) Alguma vez você já usou drogas por injeção? (Apenas uso não-médico)?	◯ nao , nunca ◯ sim , mas nao nos ultimos 3 meses ◯ sim, nos ultimos 3 meses
Tabaco soma	______________________ (Soma simples)
Score Tabaco	______________________ (10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)

alcool soma	(Soma simples)
Score alcool	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
maconha soma	(Soma simples)
Score maconha	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
cocaina soma	(Soma simples)
Score cocaina	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
anfetamina soma	(Soma simples)
Score Anfetaminas	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
Inalante soma	(Soma simples)
Score Inalantes	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
Sedativo soma	(Soma simples)
Score sedativos	(10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
Alucinogeno soma	(Soma simples)

Score alucinogenos	______________________ (10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)
Opiaceo Soma	______________________ (Soma simples)
Score opiaceos	______________________ (10= Uso Ocasional 20= Sugestivo de abuso 30=Sugestivo de dependência)

PHQ 9

Durante as ultimas 2 semanas, com que frequencia voce foi incomodado por qualquer um dos problemas abaixo?	
Pouco interesse ou pouco prazer em fazer as coisas	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Se sentir "para baixo", deprimido ou sem perspectiva	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Dificuldade para pegar no sono ou permanecer dormindo, ou dormir mais do que de costume	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Se sentir cansado ou com pouca energia	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Falta de apetite ou comendo demais	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Se sentir mal consigo mesmo - ou achar que voce e um fraccasso ou que decepcionou sua familia ou voce mesmo	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Dificuldade para se concentrar nas coisas, como ler o jornal ou ver televisao	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Lentidao para se movimentar ou falar, a ponto das outras pessoas perceberem? ou o oposto - estar tao agitado ou irrequieto que voce fica andando de um lado para o outro muito mais do que de costume	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Pensar em se ferir de alguma maneira ou que seria melhor estar morto	○ nenhuma vez ○ varios dias ○ mais da metade dos dias ○ quase todos os dias
Se voce assinou qualquer um dos problemas, indique o grau de dificuldade que os mesmos lhe causaram para realizar seu trabalho, tomar conta das coisas em casa ou para se relacionar com as pessoas?	○ nenhuma dificuldade ○ alguma dificuldade ○ muita dificuldade ○ extrema dificuldade

Score PHQ9 soma

____
(Soma simples)

Score PHQ 9

____
(11 = Média depressão 12= Moderada depressão 13 = Severa Depressão)

GSE

Eu posso resolver a maioria dos problemas, se fizer o esforco necessario	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Mesmo que alguem se oponha eu encontro maneiras e formas de alcançar o que quero	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Tenho facilidade para persistir em minhas intencoes e alcancar meus objetivos	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Tenho confianca para me sair bem em situacoes inesperadas	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Devido as minhas capacidades, sei como lidar com situacoes imprevistas	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Consigo sempre resolver os problemas dificies quando me esforco bastante	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Eu me mantenho calmo mesmo enfrentando dificuldades porque confio na minha capacidade de resolver problemas	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Quando eu enfrento um problema, geralmente consigo encontrar diversas solucoes	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Se estou com problemas, geralmente encontro uma saida	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Nao importa a adversidade, eu normalmente consigo enfrenta-la	○ nao e verdade ao meu respeito ○ e dificilmente verdade ao meu respeito ○ e moderadamente verdade ao meu respeito ○ e totalmente verdade ao meu respeito
Score GSE	________________ (Soma simples)

MOS SSS

Com quantos PARENTES voce se sente a vontade e pode falar sobre quase tudo? (se for o caso , inclua esposo(a) , companheiro(a), ou filhos nesta resposta)	○ nao tenho nenhum parente ○ tenho parente
Com quantos PARENTES voce se sente a vontade e pode falar sobre quase tudo? (se for o caso , inclua esposo(a) , companheiro(a), ou filhos nesta resposta)	____________________
Com quantos AMIGOS você se sente a vontade e pode falar sobre quase tudo ? (nao inclua nesta resposta esposo(a), companheiro(a), filhos ou outros parentes)	○ nao tenho nenhum amigo ○ tenho amigo
Com quantos AMIGOS você se sente a vontade e pode falar sobre quase tudo ? (nao inclua nesta resposta esposo(a), companheiro(a), filhos ou outros parentes)	____________________

Se voce precisar, com que frequencia voce conta com alguem:

Que o ajude se voce ficar de cama?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre
Para lhe ouvir quando voce precisa falar?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre
Para lhe dar bons conselhos em uma situacao de crise?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre
Para leva-lo ao medico?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre
Que demonstre amor e afeto por voce?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre
Para divertirem-se juntos?	○ nunca ○ raramente ○ as vezes ○ quase sempre ○ sempre

Para lhe dar informação que o ajude a compreender determinada situacao?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Em quem confiar ou para falar de voce ou sobre os seus problemas?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Que lhe dê um abraço?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Com quem relaxar?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Para preparar suas refeicoes se voce nao puder prepara-las?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
De quem realmente quer conselhos?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Com quem distrair a cabeça?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Para ajuda-lo nas tarefa diarias se voce ficar doente?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Para compartilhar seus medos e preocupacoes mais intimos?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Para dar sugestao sobre como lidar com um problema pessoal ?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre

Para fazer coisas agradaveis?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Que compreenda seus problemas?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Que voce ama e faca voce se sentir querido?	◯ nunca ◯ raramente ◯ as vezes ◯ quase sempre ◯ sempre
Score MOS SSS	____________________ (Soma simples)

PSS

Voce tem ficado triste por causa de algo que aconteceu inesperadamente?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem sentido incapaz de controlar as coisas importantes em sua vida?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Você tem se sentido nervoso e "estressado"?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem tratado com sucesso dos problemas dificeis da vida?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem sentido que esta lidando bem as mudancas importantes que estao ocorrendo em sua vida?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem se sentindo confiante na sua habilidade de resolver problemas pessoais?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem sentido que as coisas estao acontecendo de acordo com a sua vontade?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem achado que nao conseguiria lidar com todas as coisas que tem que fazer?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre
Voce tem conseguido controlar as irritacoes em sua vida?	○ nunca ○ quase nunca ○ as vezes ○ quase sempre ○ sempre

Voce tem sentido que as coisas estao sob o seu controle?	◯ nunca ◯ quase nunca ◯ as vezes ◯ quase sempre ◯ sempre
Voce tem ficado irritado porque as coisas que acontecem estao fora do seu controle?	◯ nunca ◯ quase nunca ◯ as vezes ◯ quase sempre ◯ sempre
Voce tem se encontrado pensando sobre as coisas que deve fazer?	◯ nunca ◯ quase nunca ◯ as vezes ◯ quase sempre ◯ sempre
Voce tem conseguido controlar a maneira como gasta o seu tempo?	◯ nunca ◯ quase nunca ◯ as vezes ◯ quase sempre ◯ sempre
Voce tem sentido que as dificuldades se acumulam a ponto de voce acreditar que nao pode supera-las?	◯ nunca ◯ quase nunca ◯ as vezes ◯ quase sempre ◯ sempre
Score PSS	______________________ (Soma simples)

Encerramento Do Estudo

Finalizacao do estudo	
Data da inclusao no estudo [date_start]	
Data da ultima visita	______________ (DD-MM-YYYY)
Tempo de seguimento total (dias)	______________ (Campo com calculo automatico.)
Paciente completou o estudo?(SIM quando tempo de seguimento total >= 12 dias)	○ nao ○ sim
Motivo do paciente nao ter completado o estudo	○ Recusa ○ Falecimento ○ Mudanca de cidade / estado sem possibilidade de contato ○ Perda de contato telefonico sem conseguirmos saber o motivo ○ Outro (descrever em comentarios)

Desfechos: Internacao Hospitalar e Obito	
Houve internacao hospitalar?	○ nao ○ sim (Internação hospitalar - para desintoxicação)
Quantas internacoes durante todo o tempo de seguimento?	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Houve obito?	○ nao ○ sim
Data do obito	______________ (DD-MM-YYYY)
Causa do obito	○ Causas cardiovasculares (IAM, IC, arritmias) ○ Embolia pulmonar ○ Acidente vascular encefalico ○ Complicacoes infecciosas ○ Neoplasias ○ Outras causas clinicas ○ Complicacoes cirurgicas ○ Causas externas (trauma, acidente) ○ Causa indeterminada/ desconhecida ○ Informacao nao disponivel
Tempo de sobrevida total (dias)	______________ (Campo com calculo automatico.)

Perdido para Seguimento - Tentativas de contato	
Paciente foi perdido para seguimento?	◯ nao ◯ sim
Quantas vezes foi tentado contato telefonico?	◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 (0 - se o paciente não tiver dado o contato telefônico)
Data da ultima tentativa de contato telefonico	________________ (DD-MM-YYYY)

Comentarios	
Comentarios	____________________

ANNEX

ANNEX

ANEXO 1 - Termo de Consentimento Livre e Esclarecido

(Resolução 466/2012 do CNS)

Prezado(a),

Queremos convidá-lo(a) para participar de nosso estudo denominado “Relacionamento interpessoal breve em enfermagem para equipar usuários de cocaína no manejamento da ansiedade: um estudo de exequibilidade” Esse estudo será realizado no Centro de Atenção Psicossocial Álcool e outras Drogas - Unidade Sé (CAPS AD- Sé), pela pesquisadora Caroline Figueira Pereira. Temos o objetivo de verificar a exequibilidade da intervenção (Relacionamento interpessoal breve em enfermagem para equipar usuários de cocaína no manejamento da ansiedade), por meio de conceitos de aceitabilidade, demanda, praticabilidade e adaptação, de acordo com as percepções dos enfermeiros que trabalham no CAPS AD- Sé, através de grupo focal com os 7 enfermeiros que compõe a equipe do CAPS AD- Sé. Caso aceite, sua participação estará contribuindo para o aperfeiçoamento do manual de intervenção para equipar usuários de cocaína no manejamento de ansiedade.

O relacionamento interpessoal em enfermagem foi proposto pela enfermeira Hildegard Peplau e é dividido em 4 fases sequenciais, claramente perceptíveis durante a interação enfermeiro-cliente, com momentos sobrepostos ou inter-relacionados, são eles: orientação, identificação, exploração e resolução. Essas fases do processo de comunicação têm como significado promover mudanças favoráveis no comportamento dos clientes. Em cada uma dessas fases, o relacionamento enfermeiro-cliente introduz certos comportamentos e objetivos. O enfermeiro usa o relacionamento para avaliar o psicológico, emocional e necessidades espirituais do cliente, por meio do aprendizado de habilidades de comunicação e do entendimento do comportamento humano, o qual será baseado no aprendizado mútuo de ambas as partes, crescimento e desenvolvimento como seres humanos, em uma relação respeitosa, reconhecendo seus papéis sociais, e respeitando os valores culturais e pessoais de cada indivíduo.

Para participar do estudo, você será convidado(a) a participar de um encontro de grupo focal com enfermeiros do CAPS AD- Sé durante 45 minutos, com o intuito de avaliar aceitabilidade, no qual você irá analisar se o manual da intervenção é apropriado com o contexto do serviço; demanda, em que você irá reconhecer se há perfil de participantes suficientes para

o desenvolvimento da intervenção com usuários do serviço de saúde; praticabilidade, em que você analisará se há equipamentos, e lugar para o desenvolvimento da intervenção; e adaptação, em que você analisará se o conteúdo e entrega da intervenção necessita ser modificado para melhorar aceitabilidade e implementação da intervenção.

Sua participação envolverá participar do grupo focal, com enfermeiros, acerca da exequibilidade da intervenção. O grupo focal será gravado, para que depois ocorra a transcrição das falas e análise de conteúdo de todas as falas dos enfermeiros durante o grupo focal.

Não haverá riscos relacionados à sua integridade física. Caso sinta desconforto ao relatar suas práticas profissionais com os pares, você poderá falar algo após o término do grupo focal, contatando a responsável Caroline Figueira Pereira, e/ou poderá sair da sala do grupo focal a qualquer momento A sua participação na pesquisa trará benefícios para o aprimoramento do manual da intervenção.

Os dados dessa pesquisa serão publicados em meios científicos, mas os registros de suas falas serão mantidos em confidencialidade.

A sua participação neste estudo será totalmente voluntária. O grupo focal ocorrerá durante o seu horário de trabalho, previamente agendado com o gerente da sua unidade.

A presente pesquisa não representará gastos ou despesas para você. No entanto, caso seja necessário, haverá garantia de indenização diante de eventuais danos decorrentes da pesquisa.

Se você não aceitar participar da pesquisa não sofrerá qualquer tipo de dano, penalidade ou ônus.

Se precisar questionar ou reclamar sobre aspectos éticos desta pesquisa, entre em contato com estes comitês de ética:

Comitê de Ética em Pesquisa(CEP) da Escola de Enfermagem da Universidade de São Paulo, Av. Dr. Enéas de Carvalho Aguiar, 419 – Cerqueira César– São Paulo/SP, CEP – 05403-000. Telefone: (11) 3061-8858, e-mail cepee@usp.br.

Comitê de Ética em Pesquisa da Secretaria Municipal da Saúde de São Paulo– Rua General Jardim, 36, 8° andar, Vila Buarque, São Paulo/SP, CEP–01223-010. Telefone: (11) 3397-2464, e-mail: smscep@gmail.com.

Caso aceite participar do estudo e tenha dúvidas ou necessite de esclarecimentos, você poderá entrar em contato com a responsável pela condução da pesquisa através do telefone listado abaixo, em qualquer etapa da pesquisa com atendimento de 24 horas.

Caroline Figueira Pereira – Tel:(13) 991527262 – email:caroline.figueira.pereira@usp.br - Av. Dr. Enéas de Carvalho Aguiar, 419 – Cerqueira César– São Paulo – Departamento de Enfermagem Materno –Infantil Psiquiátrica- Sala 234.

Este documento deve ser rubricado em todas as suas páginas e assinado nas duas vias, sendo que, o participante da pesquisa receberá uma via do Termo de Consentimento Livre e Esclarecido assinada e rubricada pelo pesquisador.

Esta pesquisa atende todas as especificações da Resolução 466, de 12 de dezembro de 2012 que aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos.

____

Caroline Figueira Pereira

COREn/SP 446.457

Pesquisador responsável

Caso você tenha compreendido as informações e concorde em participar, assine na sequência.

Assinatura do participante:____

São Paulo,___ de __________ de 201__.

ANEXO 2 - Termo de Consentimento Livre e Esclarecido

(Resolução 466/2012 do CNS)

Prezado(a),

Queremos convidá-lo(a) para participar de nosso estudo denominado “Relacionamento interpessoal em enfermagem para desenvolvimento de habilidades no manejo da ansiedade em usuários de cocaína: um estudo de exequibilidade”. Esse estudo será realizado no Centro de Atenção Psicossocial Álcool e outras Drogas - Unidade Sé.

Temos o objetivo de verificar a aplicação do relacionamento interpessoal breve em enfermagem em clientes com ansiedade e que usam cocaína. Caso aceite, sua participação estará contribuindo para a compreensão, e aperfeiçoamento no modelo de assistência da enfermagem em usuários de cocaína com ansiedade.

O relacionamento interpessoal em enfermagem é dividido em 4 fases sequenciais, durante a interação enfermeiro-cliente. Essas fases do processo de comunicação têm como objetivo promover mudanças favoráveis no comportamento dos clientes. Em cada uma dessas fases, o relacionamento enfermeiro-cliente introduz certos comportamentos e objetivos.

Para participar do estudo, você será convidado(a) a comparecer em consultas individuais de enfermagem, nas quais empregaremos o relacionamento interpessoal breve em enfermagem. Essas consultas serão realizadas por uma enfermeira, em 5 encontros. O primeiro terá duração de 30 minutos e os demais de 20 minutos, totalizando uma semana de realização da intervenção. Após uma semana do término da intervenção você será contatado, para realizar a consulta de acompanhamento com duração de 20 minutos.

Será realizado contato, por meio de telefone (mensagem, ligação), para relembrar os dias agendados das consultas de enfermagem com 24 horas de antecedência.

Sua participação envolverá responder um questionário de dados sociais, clínicos e comportamentais; questionários sobre a intensidade da ansiedade, auto- confiança, relacionamentos interpessoais, stress, e abuso de drogas. Você será filmado durante as consultas, com o objetivo de observarmos sinais expressos pelo corpo, como as expressões faciais e movimentos corporais características da ansiedade. Os seus dias de participação serão previamente agendados por uma enfermeira conforme a sua disponibilidade e a do nosso serviço.

Rubrica do pesquisador:______________ **Rubrica do participante:_____________**

Não haverá riscos relacionados à sua integridade física, entretanto com a aplicação do questionário de ansiedade pode-se descobrir níveis altos de ansiedade, o que pode acarretar desconfortos físicos e emocionais ao ficar consciente da mesma. Caso você apresente tal desconforto, será fornecido, por um enfermeiro, estratégias para reduzir a ansiedade apresentada.

Os dados dessa pesquisa serão publicados em meios científicos, mas os registros de sua imagem serão mantidos em confidencialidade, e tanto a sua imagem quanto seus dados de identidade não serão divulgados nem serão utilizados para fins publicitários.

A sua participação neste estudo será totalmente voluntária. Você terá o ressarcimento das despesas em decorrência da participação do estudo, o qual será entregue após a consulta de enfermagem.

Os pesquisadores garantem indenização diante de eventuais danos decorrentes da pesquisa.

Se você não aceitar participar não sofrerá qualquer tipo de dano, penalidade ou ônus, inclusive poderá continuar no tratamento para redução/cessação do uso de cocaína. Se você não quiser continuar no estudo, terá absoluta liberdade de desistir a qualquer momento.

Se precisar questionar ou reclamar sobre aspectos éticos desta pesquisa, entre em contato com estes comitês de ética:

Comitê de Ética em Pesquisa(CEP) da Escola de Enfermagem da Universidade de São Paulo, Av. Dr. Enéas de Carvalho Aguiar, 419 – Cerqueira César– São Paulo/SP, CEP – 05403-000. Telefone: (11) 3061-8858, e-mail cepee@usp.br.

Comitê de Ética em Pesquisa da Secretaria Municipal da Saúde de São Paulo– Rua General Jardim, 36, 8° andar, Vila Buarque, São Paulo/SP, CEP–01223-010. Telefone: (11) 3397-2464, e-mail: smscep@gmail.com.

Caso aceite participar do estudo e tenha dúvidas ou necessite de esclarecimentos, você poderá entrar em contato com a responsável pela condução da pesquisa através do telefone listado abaixo, em qualquer etapa da pesquisa com atendimento de 24 horas.

Caroline Figueira Pereira – Telefone:(13) 991527262 – email:caroline.figueira.pereira@usp.br - Av. Dr. Enéas de Carvalho Aguiar, 419 – Cerqueira César– São Paulo – Departamento de Enfermagem Materno –Infantil Psiquiátrica- Sala 234.

Este documento deve ser rubricado em todas as suas páginas e assinado nas duas vias, sendo que, o participante da pesquisa receberá uma via do Termo de Consentimento Livre e Esclarecido assinada e rubricada pelo pesquisador.

Esta pesquisa atende todas as especificações da Resolução 466, de 12 de dezembro de 2012 que aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos.

____

Caroline Figueira Pereira

COREn/SP 446.457

Pesquisador responsável

Caso você tenha compreendido as informações e concorde em participar, assine na sequência.

Assinatura do participante:____

São Paulo,___ de __________ de 201__.

ANEXO 3 – Parecer consubstanciado do Comitê de Ética em Pesquisa da Escola de Enfermagem da Universidade de São Paulo

USP - ESCOLA DE ENFERMAGEM DA UNIVERSIDADE DE SÃO

PARECER CONSUBSTANCIADO DO CEP

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: Relacionamento interpessoal breve em enfermagem para equipar usuários de cocaína no manejamento da ansiedade: um estudo de exequibilidade

Pesquisador: CAROLINE FIGUEIRA PEREIRA

Área Temática:

Versão: 3

CAAE: 86848418.4.0000.5392

Instituição Proponente: Escola de Enfermagem da Universidade de São Paulo - EEUSP

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 2.712.881

Apresentação do Projeto:

Trata-se de projeto de Doutorado vinculado à Escola de Enfermagem da Universidade de São Paulo na área de concentração "Cuidado em Saúde/Enfermagem Psiquiátrica, sob orientação do Prof. Dr. Divane de Vargas. A pesquisadora propõe o desenvolvimento de uma intervenção breve baseada no Relacionamento Interpessoal em Enfermagem (Peplau, 1997), entre o enfermeiro e o usuário de cocaína, com vistas ao desenvolvimento de estratégias de manejo da ansiedade associada ao uso da droga. Pretende-se avaliar a exequibilidade da intervenção breve, por meio de um grupo focal com os enfermeiros e entrevistas semiestruturadas com os usuários do Centro de Atenção Psicossocial Álcool e Drogas – Sé (CAPSad-Sé). Serão incluídos os usuários de cocaína/crack como droga principal, com idade de 18 anos ou mais, do sexo masculino, que apresentem resultado positivo durante a triagem para ansiedade segundo o instrumento Desordem de Ansiedade Generalizada (GAD-7), e que estejam no período de construção do Plano Terapêutico Singular (PTS), ou seja, o paciente não está em tratamento com outros profissionais de saúde. E serão excluídos os usuários portadores de incapacidade cognitiva que impeça a compreensão dos termos da pesquisa, aqueles intoxicados ou sob o efeito de alguma substância psicoativa e que apresentem patologias que necessitem de internação. Ao todo participarão do estudo 11 usuários de cocaína e 7 enfermeiros. A metodologia proposta para esse tipo de intervenção está baseada no processo de desenvolvimento sistemático do Mapeamento de Intervenção, o qual compreende seis etapas, estruturadas e sequenciais: (1) avaliação das necessidades (modelo lógico do

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UF: SP Município: SAO PAULO
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USP - ESCOLA DE ENFERMAGEM DA UNIVERSIDADE DE SÃO

problema); (2) criação de matrizes de objetivo de desempenho (modelo lógico de mudança); (3) seleção de métodos baseados em teoria e estratégias práticas (desenho do programa); (4) desenvolvimento de programas; (5) adoção e implementação, e (6) avaliação. Os instrumentos que serão aplicados para coleta dos dados dos usuários foram detalhados quanto aos seus objetivos e anexados ao protocolo da pesquisa, bem como o roteiro para o Grupo Focal com os enfermeiros. A proposta apresenta o cronograma de execução com término previsto para abril de 2019. O projeto foi orçado em R$ 3.140,00 e será custeado pela própria pesquisadora.

Objetivo da Pesquisa:

Objetivo geral:

Desenvolver uma intervenção complexa baseada no Relacionamento Interpessoal de Peplau para o manejo da ansiedade em usuários de cocaína.

Objetivo específico:

Avaliar a exequibilidade da intervenção breve em usuários de cocaína para manejar ansiedade.

Avaliação dos Riscos e Benefícios:

A pesquisadora informou no formulário da Plataforma Brasil que a aplicação do questionário de ansiedade, poderá revelar altos níveis de ansiedade entre os usuários de cocaína, bem como desconfortos físicos e emocionais. Foram explicitadas as condutas que serão adotadas para mitigar o risco dos usuários. Foram descritos no referido formulário e no projeto completo, os riscos decorrentes da participação dos enfermeiros da unidade. Quanto aos benefícios, o desenvolvimento e a avaliação da intervenção proposta para o manejo da ansiedade em usuários de cocaína poderá contribuir no aprimoramento das práticas de saúde e no processo de trabalho da equipe do CAPSad-Sé.

Comentários e Considerações sobre a Pesquisa:

Investigação relevante para a área de estudo.

Considerações sobre os Termos de apresentação obrigatória:

Foram apresentados dois Termos de Consentimento Livre e Esclarecido (TCLEs) dirigidos aos enfermeiros e aos usuários do CAPSad-Sé.

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Continuação do Parecer: 2.712.881

Recomendações:

Não há recomendações.

Conclusões ou Pendências e Lista de Inadequações:

O pesquisador realizou as adequações e atendeu às solicitações quanto às pendências abaixo:

1- Informar nos respectivos formulários e protocolo da pesquisa "Informações Básicas do Projeto", o número de enfermeiros e de usuários em separado, que compõem o universo do estudo;

2- Anexar a carta de autorização institucional do Gerente do CAPSad-Sé ou da Coordenação Regional de Saúde Centro – Supervisão de Saúde Sé da SMS-SP.

3- Manter no TCLE para os usuários: "Você terá o ressarcimento das despesas em decorrência da participação do estudo". Retirar a descrição "Você terá o ressarcimento das despesas relacionadas ao seu transporte público (R$8,00 – ida e volta) do trajeto entre sua residência e o local dessa pesquisa, o qual será entregue após a consulta de enfermagem", pois o valor pode variar de acordo com o local de moradia do participante, bem como com a necessidade de alimentação do mesmo.

Não há óbices éticos.

Considerações Finais a critério do CEP:

Este CEP informa a necessidade de registro dos resultados parciais e finais na Plataforma Brasil. Esta aprovação não substitui a autorização da instituição coparticipante, antes do início da coleta de dados.

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_DO_PROJETO_1105823.pdf	27/05/2018 21:58:29		Aceito
Brochura Pesquisa	Proj_Pesq_Caroline_Autorizacao_CRSCentro.pdf	27/05/2018 21:52:24	CAROLINE FIGUEIRA PEREIRA	Aceito
TCLE / Termos de Assentimento /	tclefinalparticipantes.docx	27/05/2018 21:47:20	CAROLINE FIGUEIRA PEREIRA	Aceito

Endereço: Av. Dr. Enéas de Carvalho Aguiar, 419
Bairro: Cerqueira Cesar **CEP:** 05.403-000
UF: SP **Município:** SAO PAULO
Telefone: (11)3061-8858 **E-mail:** cepee@usp.br

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Continuação do Parecer: 2.712.881

Justificativa de Ausência	tclefinalparticipantes.docx	27/05/2018 21:47:20	CAROLINE FIGUEIRA PEREIRA	Aceito
Cronograma	Grupofocal.docx	28/04/2018 21:11:16	CAROLINE FIGUEIRA PEREIRA	Aceito
Projeto Detalhado / Brochura Investigador	projetofinal.docx	28/04/2018 20:45:38	CAROLINE FIGUEIRA PEREIRA	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	tclefinalenfermeiros.docx	28/04/2018 20:34:14	CAROLINE FIGUEIRA PEREIRA	Aceito
Folha de Rosto	folhaderosto.pdf	03/04/2018 16:51:19	CAROLINE FIGUEIRA PEREIRA	Aceito

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

SAO PAULO, 14 de Junho de 2018

Assinado por:
Márcia Aparecida Ferreira de Oliveira
(Coordenador)

Endereço: Av. Dr. Enéas de Carvalho Aguiar, 419
Bairro: Cerqueira Cesar **CEP:** 05.403-000
UF: SP **Município:** SAO PAULO
Telefone: (11)3061-8858 **E-mail:** cepee@usp.br

ANEXO 4 – Parecer consubstanciado do Comitê de Ética em Pesquisa da Secretaria Municipal da Saúde de São Paulo

SECRETARIA MUNICIPAL DA SAÚDE DE SÃO PAULO - SMS/SP

PARECER CONSUBSTANCIADO DO CEP

Elaborado pela Instituição Coparticipante

DADOS DO PROJETO DE PESQUISA

Título da Pesquisa: Relacionamento interpessoal breve em enfermagem para equipar usuários de cocaína no manejamento da ansiedade: um estudo de exequibilidade

Pesquisador: CAROLINE FIGUEIRA PEREIRA

Área Temática:

Versão: 3

CAAE: 86848418.4.3001.0086

Instituição Proponente: COORDENADORIA REGIONAL DE SAÚDE CENTRO-OESTE

Patrocinador Principal: Financiamento Próprio

DADOS DO PARECER

Número do Parecer: 2.789.403

Apresentação do Projeto:

O objetivo deste estudo será descrever o uso do mapeamento de intervenção no desenho de uma teoria e intervenção complexa baseada em evidências, para desenvolver habilidades em torno do manejo da ansiedade para usuários de cocaína em tratamento ambulatorial de dependência na cidade de São Paulo. Métodos: O estudo irá utilizar seis etapas da abordagem do mapeamento de intervenção, que são a avaliação de necessidades; criar matrizes de objetivo de desempenho; selecionar métodos e estratégias práticas; desenvolvimento de programas; adoção e implementação; e avaliação.

A teoria que será utilizada para o modelo conceitual será a Teoria das Relações Interpessoais de Peplau e serão selecionados alguns métodos de outras teorias para alcançar determinados resultados da intervenção.

Todos os métodos serão baseados na teoria e as aplicações práticas serão desenvolvidos no nível individual, atuando no contexto comportamental, interpessoal, organizacional e comunitário.

Objetivo da Pesquisa:

Objetivo Primário:

Desenvolver uma intervenção complexa baseada no Relacionamento Interpessoal de Peplau para o manejo da ansiedade em usuários de cocaína.

Objetivo Secundário:

Endereço: Rua General Jardim, 36 - 5º andar
Bairro: Vila Buarque **CEP:** 01.223-010
UF: SP **Município:** SAO PAULO
Telefone: (11)3397-2464 **E-mail:** smscep@gmail.com

SECRETARIA MUNICIPAL DA SAÚDE DE SÃO PAULO - SMS/SP

Avaliar a exequibilidade da intervenção breve em usuários de cocaína para manejar ansiedade.

Avaliação dos Riscos e Benefícios:

Riscos: Durante o grupo focal, os enfermeiros da unidade podem sentir desconforto ao relatar suas práticas profissionais com os pares; poderão falar algo após o término do grupo focal, contatando a responsável pela pesquisa, e/ou poderá sair da sala do grupo focal a qualquer momento.

Os usuários de cocaína/crack que participarem do estudo não estarão sujeitos a riscos relacionados à sua integridade física, entretanto com a aplicação do questionário de ansiedade pode-se descobrir níveis altos de ansiedade, o que pode acarretar desconfortos físicos e emocionais ao ficar consciente da mesma.

Caso o participante apresente tal desconforto, serão fornecidas, por um enfermeiro, estratégias para reduzir a ansiedade apresentada.

Benefícios: Aprender estratégias de como manejar ansiedade, e consequentemente diminuir o nível de ansiedade sentida, e utilizar menos cocaína.

Comentários e Considerações sobre a Pesquisa:

A pesquisa é relevante e bastante interessante.

A metodologia está adequada aos objetivos. Foi apresentado o instrumento de coleta e análise de dados.

A condição de risco/desconforto ao sujeito da pesquisa foi apontada em relação à ansiedade e o possível desconforto de responder quanto a doenças prévias.

Considerações sobre os Termos de apresentação obrigatória:

A Folha de Rosto está corretamente preenchida, foram identificadas instituição proponente e coparticipante, autorização para realização da pesquisa foi adequadamente apresentada pela Coordenadoria Regional de Saúde Centro.

TCLE, Cronograma, Orçamento detalhado e fonte financiadora estão adequados.

Conclusões ou Pendências e Lista de Inadequações:

Sem pendências ou inadequações.

SECRETARIA MUNICIPAL DA SAÚDE DE SÃO PAULO - SMS/SP

Considerações Finais a critério do CEP:

Para início da coleta dos dados, o pesquisador deverá se apresentar na mesma instância que autorizou a realização do estudo (Coordenadoria, Supervisão, SMS/Gab, etc).

Salientamos que o pesquisador deve desenvolver a pesquisa conforme delineada no protocolo aprovado. Eventuais modificações ou emendas ao protocolo devem ser apresentadas ao CEP de forma clara e sucinta, identificando a parte do protocolo a ser modificada e suas justificativas. Lembramos que esta modificação necessitará de aprovação ética do CEP antes de ser implementada.

De acordo com a Res. CNS 466/12, o pesquisador deve apresentar a este CEP/SMS os relatórios semestrais. O relatório final deverá ser enviado através da Plataforma Brasil, ícone Notificação. Uma cópia digital (CD/DVD) do projeto finalizado deverá ser enviada à instância que autorizou a realização do estudo, via correio ou entregue pessoalmente, logo que o mesmo estiver concluído.

Este parecer foi elaborado baseado nos documentos abaixo relacionados:

Tipo Documento	Arquivo	Postagem	Autor	Situação
Informações Básicas do Projeto	PB_INFORMAÇÕES_BÁSICAS_DO_PROJETO_1158835.pdf	25/07/2018 14:35:22		Aceito
Outros	Respostadoparecerv2.docx	25/07/2018 14:33:06	CAROLINE FIGUEIRA PEREIRA	Aceito
Cronograma	Cronogramaatualizado030718.docx	03/07/2018 12:37:51	CAROLINE FIGUEIRA PEREIRA	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	tclefinalparticipantes020718.docx	02/07/2018 16:21:02	CAROLINE FIGUEIRA PEREIRA	Aceito
Brochura Pesquisa	Proj_Pesq_Caroline_Autorizacao_CRSCentro.pdf	27/05/2018 21:52:24	CAROLINE FIGUEIRA PEREIRA	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	tclefinalparticipantes.docx	27/05/2018 21:47:20	CAROLINE FIGUEIRA PEREIRA	Aceito
Projeto Detalhado / Brochura Investigador	projetofinal.docx	28/04/2018 20:45:38	CAROLINE FIGUEIRA PEREIRA	Aceito
TCLE / Termos de Assentimento / Justificativa de Ausência	tclefinalenfermeiros.docx	28/04/2018 20:34:14	CAROLINE FIGUEIRA PEREIRA	Aceito

SECRETARIA MUNICIPAL DA SAÚDE DE SÃO PAULO - SMS/SP

Situação do Parecer:
Aprovado

Necessita Apreciação da CONEP:
Não

SAO PAULO, 29 de Julho de 2018

Assinado por:
SIMONE MONGELLI DE FANTINI
(Coordenador)

Anexo 5 – Certificate of english editing

CERTIFICATE OF ENGLISH EDITING

This document certifies that the paper listed below has been edited to ensure that the language is clear and free of errors. The edit was performed by professional editors at Editage, a division of Cactus Communications.The intent of the author's message was not altered in any way during the editing process. The quality of the edit has been guaranteed, with the assumption that our suggested changes have been accepted and have not been further altered without the knowledge of our editors.

Title Of The Paper

INTERPERSONAL THEORY OF NURSING TO ANXIETY MANAGEMENT IN PEOPLE WITH SUBSTANCE USE DISORDERS (ITASUD).

Authors

Caroline Figueira Pereira

Job Code

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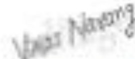
Signature



Vikas Narang,
Senior Vice President,
Operations-Author Services, Editage

Date of Issue
March 04, 2019

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