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An Overview of the Relapse Prevention (RP) Model[1]

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INTRODUCTION

The Relapse Prevention (RP) Model approach is based on the fundamental principle that a person's drug use has provided a valuable function in their life, even if there are now detriments attached to it (sickness, legal issues, criminalization, loss of significant relationships etc.) which now appear to outweigh its benefits. If the drug user is to attain abstinence and remain abstinent they must hence be able to ascertain and acknowledge the 'pros' of drug use and therefore realistically anticipate the situations in which these 'pros' may appear very alluring and put them at risk of acquiescing to the impulse to use.

People in the midst of substance use disorders face the real possibility of relapse once they have initiated the termination of alcohol or drug use. As a consequence of the complexity of relapse, an ever-increasing emphasis has been placed on the maintenance stage of the change process for individuals with all types and combinations of substance use disorders.

The role of the therapist is to work with the drug user initially in helping them to identify their personal reasons both for using drugs and for wanting to stop using them. Both issues are essential: whilst the 'pros' of the drug use will propose areas of potential difficulty in the challenge to stay drug-free, the 'cons' will reveal the strength of the desire or motivation to make that attempt. Though clients may say that they are 'categorically determined' to give up their drug use, or that drug use ruined their lives', it is essential to help them elaborate on these points, giving as many tangible examples as they can of distinct, specific reasons for their more generalized statements. The rationale for this approach is that the more thought that is given to articulating particular viewpoints; the less easily they are disregarded or forgotten. In the moment of temptation to use drugs, when the 'pros' are to the forefront of the person's awareness, it is very easy merely not to think of the 'cons'. This is all the easier if the 'cons' have not really been processed one by one; the more the client has been encouraged to explore their reasons with real, and intense illustrations, the more likely they are to later recall those arguments against using drugs, and to make a rational and somewhat informed decision regarding the drug use rather than acting purely on impulse.

This paper will provide an overview of the Relapse Prevention model (before specific RP intervention strategies are reviewed, definitions of recovery, lapse, and relapse are explained) and an example of an individual treatment plan for a client is provided; in addition to consideration of treatment outcome studies, surveying the precipitants to relapse, and investigating Cognitive and Behavioral interventions in Relapse Prevention.

The cognitive and behavioral interventions discussed represent the common issues or themes espoused in the various RP treatment models.

Recovery

The A – Z encyclopedia of drug abuse[2] defines recovery as "the maintenance of abstinence from alcohol and / or other drug use by any means" (Nordegren, T. 2002). Recovery from substance use is a process that involves initiating abstinence from the use of alcohol or other drugs use in addition to making intrapersonal and interpersonal modifications to maintain these changes over time. Specific modifications may vary amongst people with substance use disorders and for numerous different reasons. Changes may occur in any of the biopsychosocial areas of functioning. In addition, according to DiClemente, Schlundt, & Gemmell in their 2004 research article "it is largely accepted that recovery tasks are contingent upon the stage or phase of recovery that the individual is in". Recovery is facilitated by the chronicity, complexity and severity of the damage caused by the substance use disorder, the presence of a co-morbid psychiatric or medical illness, and the person's insight, motivation, gender, ethnic or cultural background, and importantly their support system. Whereas some individuals may achieve full recovery, others may only manage to achieve a partial recovery whilst experiencing numerous relapses over time. Recovering from any substance use disorder encompasses gaining information and knowledge increasing self-awareness, developing skills for sober living, and following a structured program of change. The package of change that a person may follow could involve professional treatment sessions, or involvement in self-help or 12 step programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Cocaine Anonymous (CA), SMART Recovery[3], and self-management approaches. In the earlier phases of recovery, the individual will typically rely more upon external support and help from professionals, sponsors, or other members of support groups. As the course of a person's recovery progresses, much more reliance is placed upon the individual to work through any problems and to face the challenges of living a sober lifestyle. The information and skills learned as part of RP offer an excellent mechanism for the person to prepare himself or herself for the maintenance phase of recovery.

Lapse and Relapse

The term 'lapse' denotes the initial episode of alcohol or other drug use following any period of

[2] With more than 30,000 entries The A-Z Encyclopedia of Drug Abuse is one of the most complete and comprehensive reference book in the field of Substance Abuse, and is a useful handbook and working tool for professionals working in the field, or lay persons looking for information.

[3] **SMART Recovery** is a non-profit organization offering support groups and related services for individuals desiring to abstain from any type of addictive behavior (activity or substance). "**SMART**" stands for Self Management And Recovery Training.

abstinence, whereas the term 'relapse' refers to an inability to maintain behavior change over time. Relapse can be viewed not only as the occurrence of resumption of a pattern of substance abuse or dependence, but also as a process in which indicators or cautionary signs regarding lapse or relapse appear prior to the individual's actual substance use.

A lapse may end relatively quickly or may lead to a relapse of varying proportions. In his analysis of relapse following smoking cessation Saul Shiffman reported that sixty three percent (63%) of lapsers who called his Stay-Quit line[4] were smoking 2 weeks later, and thirty-seven percent (37%) were able to stop their lapses (Shiffman, S. 1996). The effects of the original lapse are mediated by the person's affective and cognitive reactions. Whereas many people will travel through a lapse to relapse an out-and-out relapse is more likely with the individual who has a strong sensitivity towards not violating the abstinence rule. Whilst some individuals experience a full-blown relapse and then return to pre-treatment levels of substance abuse, others use alcohol and drugs problematically but they do not return to previous levels of abuse and suffer less harmful effects as a result. Those who relapse vary in the quantity and frequency of substance use as well as the medical and psychosocial schema that accompany a relapse.

Treatment Outcome Studies

High rates of relapse amongst alcoholics, tobacco smokers and drug abusers have been documented throughout numerous reviews of the treatment outcome literature as well as studies of specific clinical populations receiving treatment generally. In 1986 William Miller, and Reid Hester (Miller & Hester, 1986) reviewed more than 26 alcoholism outcome studies and reported that more than three-quarters of subjects relapsed within 1 year of treatment. Between 1950 and 1973 Dr Chad Emrick, MD reviewed a large number of studies of psychologically oriented alcoholism treatments and also reported that most treated clients, at some point relapsed. After review of numerous alcoholism treatment outcome studies by Catalano, Hawkins, Wells, Miller, & Brewer, in 1991 it was noted that similarly high rates of relapse were reported. Catalano et al (1991) also reviewed studies of relapse rates for opioid addicts and found relapse rates ranging from 25% to 97%, the resulting information showed that relapse rates were lowest amongst those opiate addicts who had graduated successfully from a therapeutic community or therapeutic milieu in which they resided for a minimum of 18-24 months. In their review of tobacco dependence interventions Catalano and colleagues' found that relapse rates within one year of tobacco cessation were in the 75-80% range. Hunt, Barnett and Branch in 1971 reported that 65-70% of alcoholics, heroin addicts, and smokers relapsed within the first year of treatment and interestingly mostly within the first 90 day period following abstinence. Simpson, Joe, Lehman and Sells followed a group of 405 opioid addicts 12 years after admission to drug abuse treatment programs. In the twelfth year of this longitudinal study it was found that 26% of those that were followed were again using opioids on a daily basis, 39% were using some opioids, 61% were using marijuana, 47% were using other drugs, and 27% were drinking more than 4 ounces of alcohol per day. However, there was a significant reduction in daily opioid use, from 47% of participants using opioids in year 1 to 26% using opioids at year 12. The Comprehensive Assessment and Treatment Outcome Research (CATOR) group[5] followed 8087 patients from 38 different inpatient programs and 1663 patients

[4] Stay-Quit line – A supportive telephone line for people abstaining from tobacco products
[5] Comprehensive Assessment and Treatment Outcome Research (CATOR) group – the largest independent evaluation service for addiction treatment programs in the United States.

from 19 different outpatient programs for 1 year. Sobriety rates at the one-year mark were 60% for inpatient and 68% for outpatient subjects successfully contacted at 6 and 12 months. Even when these rates are adjusted and a 70% relapse rate for missing cases is assumed, sobriety rates at 1 year were reported as 44% and 52% for the inpatient and outpatient cohorts. This research illustrates that in addition to stopping or reducing substance use, many clients receiving substance abuse treatment show significant decreases in post dependence medical care, employment troubles (including absenteeism), working under the influence of substances, traffic violations such as Driving under the influence (DUI), driving while intoxicated (DWI), and other offences. In a 1995 analysis of the alcohol treatment outcome literature, Miller et al reported that there was a "significant" treatment effect on at least one alcohol measure for at least one follow-up point for 146 of 211 studies (69%). Despite relapse rates, many studies show that treatment of substance use disorders has positive effects on multiple domains of functioning.

There is a justifiable need for people using the research to show caution regarding the construction of oversimplifications or generalizations regarding the efficacy of any treatment based entirely on outcome studies or based on the sole criterion of recommencement of substance use. Many practical deficiencies have been noted in numerous outcome studies, and a basic understanding of how to critique a research paper gives readers the opportunity look with more realistic approaches at the outcome studies. Many of the deficiencies noted during research for this paper include lack of standardized measures of relapse or measurable definitions of what constitutes a successful outcome, a number of the studies that were longer in duration suffered with problems of sample selection and selection processes, small sample size, levels of attrition, and length of follow-up interval. The reality of this type of study shows us that many individuals who relapse do not always return to pre-treatment levels of substance use, although the actual quantity and frequency of use may show a dramatic discrepancy. A cocaine or heroin addict that injected large quantities of drugs on a daily basis for many years may return to substance use after treatment, however, this individual may not return to their previous daily use, and the quantity of drugs used may be significantly less than was the pre-treatment level. Since drug and alcohol use is only one outcome measure, an individual may also show many improvements in other areas of their life and functioning despite an actual lapse or relapse to substance use.

Inpatient vs. Outpatient Treatment

Managed care[6] has challenged every drug and alcohol service provider to validate that the treatment they offer is both clinically effective and cost efficient. As a result, over the last number of years we have seen that there is an effort by providers to move away from more intensive and expensive inpatient, residential treatment programs toward less expensive, short-term outpatient programs. The large majority of the literature supports the use of less costly outpatient treatment. For example, in 1985 Helen Annis PhD (Annis, 1985) studied, evaluated and reviewed six well-controlled randomized trials of long periods of inpatient alcoholism treatment versus shorter periods and found no significant advantage for prolonged hospitalization. She also reviewed two well-controlled randomized trials that compared inpatient treatment regimes with day treatment or partial hospitalization and found no significant

[6] The term ***managed care*** or ***managed health care*** is used to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care

advantage that supported inpatient care. Miller and Hester's (1986) review in 1986 of uncontrolled studies and 26 controlled studies likewise showed no significant evidence to suggest an overall advantage for inpatient over outpatient treatment or indeed for more intensive over less intensive interventions for alcohol abuse. In their article Miller and Hester believed that more intensive treatment is beneficial for more severely deteriorated and less socially stable individuals. Dr Edgar P Nace, on the other hand, in 1993 made a suggestion that many negative reports pertaining to inpatient treatment were subjective in nature and based on flawed studies. Dr Nace makes a case in his work for the efficacy of inpatient treatment and defines a number of advantages of inpatient treatment over outpatient or community programs, particularly for clients with severe alcohol dependence or extensive social, psychiatric, or medical comorbidity.

Studies by Thomas McLellan and his colleagues George Woody, Lester Luborsky, Charles O'Brien and Keith Druley showed what many in the profession have believed for many years that the effectiveness of substance abuse treatment with a patient increased significantly when patients were "matched" with the most appropriate level of treatment for their situation. Miller et al, also makes a strong case for matching clients with the appropriate interventions and points out numerous benefits in all biopsychosocial areas, leading to improved outcomes and long term benefits.

Relapse Precipitants

Alan Marlatt has been responsible for many pieces of research in the field of relapse prevention and some of his work (Marlatt, 1978; 1985; 2005) has led to classifying periods of relapse for alcoholics, tobacco smokers, heroin addicts, gamblers, and overeaters of food into two broad categories, namely intrapersonal and interpersonal determinants. This classification scheme has proved to be useful globally. Intrapersonal determinants that contribute to relapse include negative emotional states, negative physical states, and positive emotional states, testing of person's personal control, urges and temptations. According to Marlatts research, the category that most frequently affects relapse of alcoholics, smokers, and heroin addicts was negative emotional states. Marlatt shows that 38% percent of alcoholics, 37% of smokers, and 19% of heroin addicts relapsed in response to a negative affective state or lowering in mood and emotion. Saul Shiffman reported in his work in 1982 that negative affect or stress was a factor in 52% of relapses of smokers who called his Stay-Quit line. In a study examining the post treatment association between panic/phobic symptoms and substance use, Lynda LaBounty and her colleagues Dorothy Hatsukami, Steven Morgan, & Lianne Nelson (1992) found significantly that more anxious clients reported relapsing as a response to negative emotions in order to cope with depression, anxiety, and anger compared to clients who were taking part in matched controls without anxiety problems. Interpersonal precipitants of relapse include relationship divergence, social and peer pressure to use substances, and positive emotional states associated with some type of social interaction with others. Social pressure to use drugs was identified by 36% of heroin addicts, 32% of smokers, and 18% of alcoholics as contributing to their relapses. Barbara Havassy, Sharon Hall, and David Wasserman in 1991 reported that greater social support and spousal support predicted a lower risk of relapse among alcoholics, opiate users, and cigarette smokers completing treatment.

Catalano, Howard, Hawkins, & Wells (1988) published an extensive review of rates and determinants of relapse. This review and investigation scrutinized the strength of evidence for

factors associated with relapse to alcohol, tobacco and opiate use according to pre-treatment, active treatment, and post treatment variables. For opiate addicts, the variables most strongly associated with relapse were the degree of impairment caused by the drug use, associated or co-morbid psychiatric impairment, length and modality of treatment, involvement in crime and what type of crime, lack of family and peer support, negative emotional states, and skill deficits. For alcoholics, the factors that were most strongly associated with relapse were lack of family or peer support, negative emotional states, skill deficits, and negative life events. For tobacco smokers, the variables most strongly associated with relapse were negative emotional states and problems in family or peer relationships. Many other pre-treatment, treatment, and post treatment factors either had "some" relationship with relapse or were found to have an equivocal effect on outcome.

Relapse can be understood as something that is the result of an interaction of client, family, social and treatment-related influences including affective variables (e.g., negative or positive mood states), behavioral variables (e.g., coping skills or social skill deficits; impulsive behavior), cognitive variables (e.g., attitudes toward recovery, self-perception of ability to cope with high-risk situations, and level of cognitive functioning), environmental and interpersonal variables (e.g., lack of social family or environmental stability, social pressures to use substances, lack of productive employment or school roles, and lack of involvement in leisure or recreational pastimes), physiological variables (e.g., cravings, protracted and severe withdrawal symptoms. chronic illness or physical pain, or response to medications used for medical or psychiatric disorders), psychiatric variables (e.g., presence of a comorbid psychiatric illness, sexual trauma, a higher global rating of psychiatric severity), spiritual variables (e.g., excessive guilt and shame, feelings of emptiness. a sense that life lacks meaning), and treatment-related variables (e.g., negative attitudes of caregivers; inadequate aftercare services following rehabilitation programs; lack of integrated services for dual diagnosis clients).

OVERVIEW OF RELAPSE PREVENTION (RP)

RP emerged over recent years as a way of helping the person with a substance use disorder maintain change over time. Factors associated with the person achieving aspects of initial change (i.e., abstinence) differ in structure from those that are associated with the maintenance of change over time. RP in general refers to two types of treatment strategies. Primarily, RP may be integrated into any treatment or intervention that is aimed at helping an individual with a substance use problem maintain abstinence once such standpoints are stopped. In a general sense, all psychosocial treatments (e.g., drug counseling or 12-step counseling, supportive-expressive psychotherapy, coping skills training, cue exposure, contingency contracting, cognitive, behavioral, or cognitive-behavioral therapies) and pharmacological treatments (e.g., naltrexone, Antabuse) aim to help the client remain substance free and prevent relapse. Secondly, specific skills-oriented treatments incorporating the major principles and interventions or approaches discussed below may encompass a specific program referred to as relapse prevention. The focus of RP is therefore to address and reduce the risk of relapse by tackling potential precipitants of relapse and high-risk factors.

A variety of models of RP are described in the literature. The more common approaches include Marlatt and Gordon's cognitive-behavioral approach, which has been adapted for other clinical populations in Psychiatry and Mental Health such as sex offenders, food overeaters, and individuals with problems controlling sexual behaviors (In addition for some sexual deviance).

Helen Annis' cognitive-behavioral approach, which incorporates concepts of Marlatt's model with Bandura's self-efficacy theory[7]; Daley's psycho educational approach; and McAuliffe, and Ch'ien's addict aftercare model. Many inpatient healthcare systems and outpatient treatment programs have notably incorporated many aspects of these RP approaches. Some programs now offer more specific "relapse tracks" within their systems that are designed specifically towards those clients who have relapsed following a previous period of sustained recovery. The focus of these programs has been seen to be primarily on those problems and issues that are associated with relapse. Despite their obvious differences, site, skill mix of staff etc. these RP approaches have many components in common in that they focus on the need for individuals with a substance use disorder to cultivate new coping skills for management of high-risk situations and identify and manage their own relapse warning signs; to make lifestyle changes to decrease the need for alcohol, drugs, or tobacco; to increase their ratio of healthy activities and life approaches to diet etc.: to prepare for disrupting lapses so that they do not develop into a full-blown relapse; and to prepare for managing any relapses so that unfavorable consequences may be minimized. All RP approaches emphasize the necessity to have a broad repertoire of behavioral, cognitive, and interpersonal skills and coping strategies to help prevent a relapse. In addition most of these programs and approaches are time-limited or brief in nature, making them more reasonable in the current climate of managed care, and escalating healthcare costs.

Empirical Studies of Relapse Prevention

From the numerous studies reviewed over a number of years I have seen that there is clear evidence that RP does help improve recovery rates and reduce the frequency of relapse. Nevertheless, it should be noted that to date there has been no real superior treatment approach for substance use disorders. Kathleen Carroll and her colleagues Bruce Rounsaville and Frank Gawin conducted a study of outpatient cocaine abusers in which they compared RP to interpersonal psychotherapy (IPT). Carroll et al discovered that RP was more effective than IPT for patients at the more severe end of the continuum of cocaine abuse and, to some extent, for those with higher psychiatric or comorbid disorder severity. In another study of outpatient cocaine abusers, Carroll and colleagues compared the outcomes of 12 weeks of treatment in which patients were randomized to psychotherapy (cognitive-behavioral RP or an operationalized clinical management condition) and regular pharmacotherapy (desipramine hydrochloride or placebo) in a 2 X 2 design. This group of patients was followed for 1 year and Carroll's research team found a significant psychotherapy-by-time effect that indicated to them a delayed improved response to treatment for patients who received RP.

Other published studies have demonstrated RP to be effective in reducing substance abuse but not more effective than a comparison condition. A study by Elizabeth Wells, Peggy Peterson, Randy Gainey, David Hawkins and Richard Catalano which pertained to outpatient cocaine abusers where RP and 12-step counseling (TSC) was compared found that subjects in both treatment conditions reduced their use of cocaine, marijuana, and alcohol use at 6 months post treatment. Conversely, subjects in the TSC condition showed greater improvement in reduction of alcohol use compared to those receiving RP at the 6-month follow-up period. Throughout her

[7] Perceived self-efficacy is concerned with people's beliefs in their ability to influence events that affect their lives. This core belief is the foundation of human motivation, performance accomplishments, and emotional well being (Bandura, 1997, 2006).

work Kathleen Carroll has shown on numerous occasions that there are benefits to RP; she has reported that the strongest evidence for efficacy of RP is with tobacco smokers and also concluded that there is good evidence for RP approaches being successful compared with no-treatment controls. Outcomes where RP may hold greater promise incorporate reducing severity of relapses when they occur, permanence of effects after cessation, and patient-treatment matching. Clients with higher levels of impairment along dimensions such as psychiatric severity and addiction severity appear to benefit most from RP compared to those with less severe levels of impairment. Consequently, RP may be especially helpful for clients with a dual diagnosis. Several studies have included spouses and partners in the RP intervention. A study of the first relapse episodes and reasons for terminating relapses of men with alcoholism who were treated with their spouses found that the relapses of clients receiving RP in addition to behavioral marital therapy (BMT) were shorter than those of clients not receiving the RP. In a study of married alcoholics, Timothy O'Farrell found that in couples assessed to be in "high distress," abstinence rates were highest for those who received BMT in combination with RP. Alcoholics who received RP after completing BMT demonstrated more concurrent days abstinence, fewer days drinking, and reported improved marriages or relationships compared to those who received only BMT.

There are several limitations found regarding studies on RP. Firstly some studies have used RP as the single treatment intervention for cessation of drinking rather than for maintenance of change once alcohol consumption was stopped. Secondly, studies usually do not differentiate between subjects who are motivated to change substance use behaviors and those who have little or no motivation to change. Thirdly, in some studies, sample sizes are very small and there is not enough statistical power to detect differences between experimental and controlled conditions. Fourth, many of the studies found do not always use random assignment or operationalize the therapy being compared against RP, which makes it difficult to determine what factors contribute to treatment effects. And lastly, the follow-up period in many studies is often short-term (6 months or less). Despite these limitations, however, I would propose that there is ample empirical evidence to show that RP strategies enhance the recovery of individuals with substance use disorders.

COGNITIVE AND BEHAVIORAL INTERVENTIONS

This segment reviews a selection of practical RP interventions that can be utilized in multiple treatment contexts. These interventions reflect the approaches of numerous clinicians and researchers who have developed detailed models of RP produced written client-oriented RP recovery materials in addition to the authors' experience treating patients with alcohol and drug dependence, including those patients with a co-morbid psychiatric condition. The interventions discussed include cognitive and behavioral interventions. Whereas the patient can use some of these interventions themselves as part of a self-management recovery program, other interventions involve gaining support or help from family or significant others. The reviewed literature emphasizes tailoring RP strategies to the individual, taking into account chronicity, complexity and severity of substance use, gender, personality functioning, and socio-cultural environment. The use of experiential learning (e.g., role-playing, behavioral rehearsal, use of workbooks, interactive videos, and homework assignments) as in Kaskutas, Marsh, & Kohn (1998) has been highly recommended in order to make learning an active experience for the patient for a long time. The use of these types of action techniques can have increase in the effect of enhancing self-awareness, decreasing defensiveness, and encouraging behavioral

changes. In treatment groups, action techniques can provide plentiful opportunities for the clinician or counselor to elicit feedback and support for individual patients identify common themes and issues related to RP, and put into practice specific interpersonal skills. The encouraged use of a daily inventory is also recommended. Recording of a daily inventory aims to get clients to continuously monitor their lives so as to identify relapse risk factors, recognize relapse warning signs, or significant life problems that could contribute to a relapse.

Summary of Important Premises in Relapse Prevention

1. Support patients in the identification of their high-risk relapse factors; and develop strategies to deal with them.

The necessity for a patient to be able to recognize the risk of relapse and the high-risk factors or situations is a crucial component of RP. High-risk factors, or 'critical incidents'[8], typically are those situations in which clients used alcohol or other drugs prior to treatment. High-risk factors usually involve intrapersonal and interpersonal situations. Annis (1990) suggests that the circumstances in which the client used any substances during the year preceding treatment all represent high-risk situations following cessation of substance use. There are a sizeable number of clinical aids have been developed by researchers and clinicians that enable counselors etc. to support clients in the identification and prioritization of their individual high-risk situations and the development of individual care plans and coping strategies to aid in their recovery. Some of the clinical aids are; Helen Annis' Inventory of 'Drinking Situations and Inventory of Drug-Taking Situations', Denis Daley's 'Identifying High Risk Situations Inventory', Kathleen Carroll's 'Substance Abuse Problem Checklist', Terence Gorski's 'High Risk Situation List' and 'High Risk Situations Worksheet', and Arnold Washton's 'Staying Off Cocaine' workbook.

For a number of patients, identifying high-risk factors and developing new coping strategies for each is not achievable, because they may identify sizeable numbers of risk factors. This patient group needs assistance in taking a more global approach to their recovery and may need to learn specific problem-solving skills. Marlatt, for example, suggests that in addition to teaching clients 'specific' RP skills in order to help them develop the ability to deal with high-risk factors, the clinician should also utilize more 'global' approaches such as skills training strategies (e.g.. behavioral rehearsal and assertiveness training), cognitive reframing (e.g., coping imagery and reframing reactions to lapse or relapse), and lifestyle interventions (e.g., meditation, exercise, mindfulness). Skills training and stress management approaches have been found to increase the effectiveness of treatment. Figure.1 summarizes one paradigm for conceptualizing high-risk

[8] A critical incident can be described as one that makes a contribution—either positively or negatively—to an activity or phenomenon – In this case a relapse.

factors.

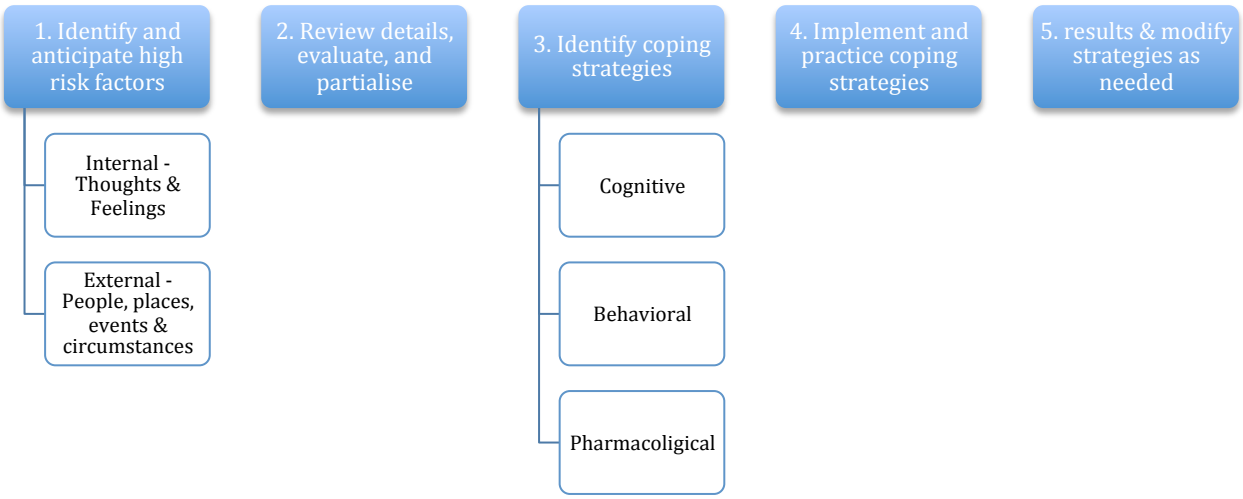

Figure 1: Summary of high risk factors associated with RP – Jackson 2013

2. Help patients understand relapse as a process and as an event.

Patients are much better prepared for the challenges that recovery puts in front of them if they are cognizant of the fact that relapse ensues within a 'context' and that clues or warning signs typically precede any actual lapse or relapse to substance use. Though a relapse may be the result of an impulsive act on the part of the recovering individual, more often than not, issues such as biopsychosocial, and/or behavioral fluctuations typically manifest themselves preceding the actual ingestion or consumption of any substances. An individual's clues or warning signs can be conceptualized as links in a relapse chain. Many patients that I have worked with that have relapsed have reported that in reality their warning signs appeared days, weeks, or even

longer before they ingested substances.

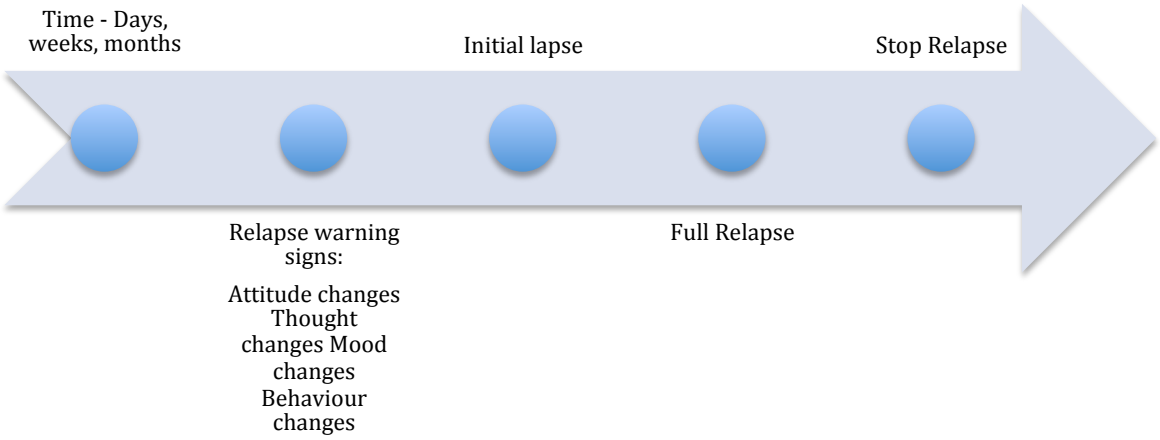

Figure 2: Relapse Process – Jackson 2013

Patients in a treatment program for the first time can benefit from reviewing common relapse warning signs that have been identified by others experience and in group settings in recovery. There have been many occasions when it has been found to be beneficial to have patients with experience of relapses examine their experiences in depth so that others can learn the connections between cognitions, emotions, circumstance, environment, and relapse to substance use.

3. Help patients understand and address alcohol or drug cues as well as cravings.

There is a increasing body of research such as Douglas Bernheim, and Antonio Rangels 2004 work 'Addiction and cue-triggered decision processes' (2004) that suggests that alcoholics', drug addicts', and tobacco smokers' desire or craving for alcohol or other drugs can be 'triggered[9]' by exposure to environmental cues associated with a patients prior use. Cues such as the sight or smell of the substance of abuse may trigger cravings that become evident in cognitive (e.g., increased thoughts of using) and physiological (e.g., anxiety) changes.

The advice given in groups such as AA, NA, and CA for alcoholics and addicts to avoid people, places, and things that may be associated with their prior substance abuse was developed as an approach to minimizing the persons exposure to cues that may trigger cravings that can for each person be so overwhelming that they contribute to a relapse. A practical suggestion is to encourage clients to remove from their homes any substances as well as any paraphernalia

[9] A relapse trigger is any person, place, thing, or situation that reminds a person of their drug and alcohol use. Article Source: http://EzineArticles.com/2088664

(pipes, mirrors, needles, etc.) used for taking drugs. This may be more difficult for tobacco smokers, however, since most relapse crises occur in association with food or alcohol consumption. Cue exposure treatment as per Cynthia Conklin and Stephen Tiffany in Cue Exposure Treatment. Addiction recovery tools: A practical handbook, 2001, is one method used to help reduce the intensity of the patients' reactions to cues. This treatment involves exposing (with the support of a clinician) the client to specific cues associated with substance use. Cue exposure also aims to enhance coping skills as well as the client's confidence in his or her ability to resist the desire to use. Because it is virtually impossible for patients to avoid all the cues that are associated with their substance use, the clinician can teach the client a variety of practical techniques to manage their cravings. Patients should learn information about cues and how they have the effect of triggering cravings for alcohol or other drugs. Monitoring and logging cravings, related thoughts, and outcomes can help patients become more attentive and prepared to cope with them. Beneficial cognitive interventions for managing cravings include working towards changing thoughts about the craving or desire to use, challenging euphoric recall talking oneself (Self commentary) through the craving, thinking beyond the positive effects of the substance (The High) by identifying the negative consequences of using (immediate and delayed) and positive benefits of not using, using AA/NA/CA recovery slogans and delaying the decision to use. Behavioral interventions include avoidance, changing the environment by leaving a place that produces a trigger, or changing situations that trigger or worsen a craving, redirecting activities or getting involved in pleasant activities, getting help or support from others by admitting and talking about cravings and hearing how others have survived them, attending self-help support group meetings, or taking medications such a disulfiram or naltrexone (for alcoholics). Shiffman and colleagues recommend that ex-smokers carry a menu card that lists various ways to coping with a craving to smoke, a strategy that can also address alcohol or other drug cravings. Figure #3 below is can help clients understand triggers, cravings, cues etc.

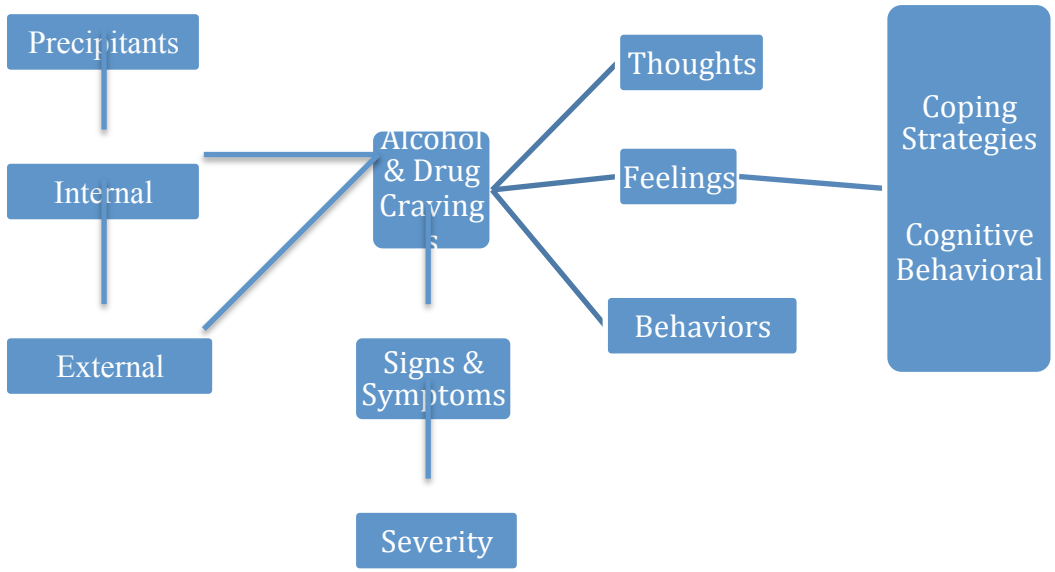

Figure 3: Understanding and managing cravings for patients – Jackson 2013

4. Help patients understand and deal with social pressures to use substances.

An assortment of direct and indirect social pressures can contribute to a relapse. Social stresses often lead to amplified thoughts and desires to use substances, as well as anxiety regarding one's ability to refuse any offers to drink alcohol or use other drugs.

Figure 4 below offers a framework for one scheme for helping clients understand and deal with social pressures. The first step is to identify any high-risk relationships (e.g. living with or dating an active drug abuser or alcoholic) and situations or events in which the client may be exposed to or offered substances (e.g., social gatherings where people smoke cigarettes or drink alcohol). The next step is to evaluate the consequences of these social pressures on the thoughts, feelings and behaviors of the client. Planning, practicing, and implementing coping strategies is the next step. These coping strategies include avoidance and the use of verbal, cognitive, or behavioral skills. Utilizing role-playing to rehearse the ways to decline offers of drug or alcohol in an assertive but sensitive way is one very practical and easy- to-use intervention. The final step of this process involves teaching the client to evaluate the results of a given coping strategy and to modify it as needed

In many instances, pressures to use alcohol or other drugs result from relationships with active drug users or alcoholics. The client needs to assess his or her social network and learn ways to limit or end relationships that represent a high risk for relapse.

5. Help Clients Develop and Enhance a Supportive Social Network

Several authors have addressed RP from a wider viewpoint that involves the family or significant others. Daley has concluded that familial involvement in RP is mutually beneficial to both the patient and the family. In 2012 Jan Klimas and her colleagues Catherine-Anne Field, Walter Cullen, Clodagh SM O'Gorman, Liam G Glynn, Eamon Keenan, Jean Saunders, Gerard Bury, and Colum Dunne modified Marlatt's cognitive-behavioral model of RP and applied it to couples in recovery. Gorski's model of RP places strong emphasis on the need for relapse-prone people to involve meaningful individuals in their lives in a RP network. In 1993 Timothy O'Farrell and his colleagues Keith A. Choquette, Henry S. G. Cutter, Elizabeth D. Brown, and William F. McCourt developed a RP protocol for clinicians use in combination with behavioral marital therapy (BMT). Stephen Maisto and his colleagues Timothy O'Farrell, Gerard Connors, James McKay, and Margorie Pelcovits found that alcoholics who were treated with their spouses with RP in addition to marital therapy had shorter and less severe relapses than clients not receiving RP.

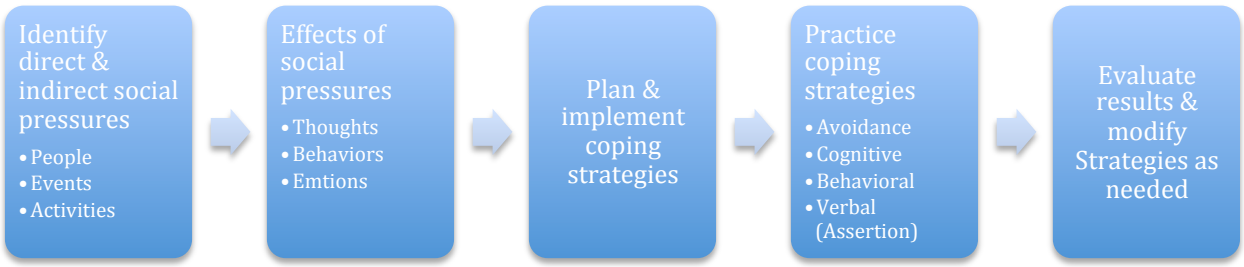

Figure 4: Framework for helping patients to understand and manage social pressures based on the care planning and nursing process – Jackson 2014

Numerous reports have confirmed a positive correlation between abstinence from alcohol, drugs, and tobacco and the presence of strong family and social supports. Families are more likely to support the process of recovery if they are involved in the process and have opportunity to heal from the emotional pain that they have experienced. This is more likely to occur if the family member with the substance use disorder understands the impact of substance abuse on the family and works with the family on some the previously adverse effects on the family.

Involvement and connection of immediate families or significant others in the recovery process provides the family with an opportunity to deal with the impact of substance use on their lives as well as their own issues (e.g.. enabling behaviors, preoccupation, feelings of anger, shame and guilt). Families are then in a much better position to support the recovering family member. Indications that the family has not had an opportunity to deal with their own issues or heal from their emotional pain may be seen in a multiplicity of overt and covert ways in the sabotage of the recovery of the affected family member.

In addition to family or significant other involvement, patients can be stimulated to get involved in any of the support groups such as AA, NA, or other support groups. Sponsors, others that are in recovery and personal friends, and employers may become part of a person's RP network. Patients generally should not try to recover in isolation, particularly during the early stages of recovery.

Following are some suggested steps for helping clients develop a RP network. First, the patient should identify whom to involve in or exclude from their RP network. Others who abuse substances, or harbor extremely strong negative feelings toward the recovering person, or generally are not supportive of recovery usually should be excluded from this network development.

The patient should then determine how and when to ask for support or help. Behavioral

rehearsal has shown that it can assist the patient in practicing ways to make specific requests for support. Rehearsal also helps increase confidence and assertive conversation, as well as clarifying thoughts and feelings regarding reaching out for help. Many patients, for example, feel a sense of guilt or shame when asking for help and question whether or not they deserve support from others. Yet others have such strong feelings of pride that the thought of asking others for support is very challenging to accept. Rehearsal may also clarify the client's ambivalence regarding their continuing recovery, and it helps better understand how the person being asked for support may respond. This prepares the patient for addressing potential negative responses from others. However, patients should be counseled that recovery is ultimately their responsibility.

Action plans can then be created, practiced, executed, and adapted as needed. Some patients find putting their action plan in writing so that all of those involved have a specific document to refer to is exceedingly useful. The action plan can address many of the following issues: how to communicate about and deal with relapse warning signs and high-risk situations; how to disrupt a lapse; how to intervene if a relapse occurs; and the importance of exploring all the details of a lapse or relapse after the patient is stable so that it can be used as a learning experience. Having a plan can have the effect of helping the recovering person and family feel more in control even if they are faced with the real possibility of an actual relapse. Additionally, it helps everyone take a proactive approach to recovery rather than to passively wait for problems to occur. The authors' clinical experience has been that clients and families who are involved in such discussions and planning are much more likely to intervene earlier in the relapse process than those not involved in these discussions.

6. Help Clients Develop Methods of Coping With Negative Emotional States.

Negative affective states are regularly associated with relapse across the gamut of addictions. Several investigators reported that depression and anxiety were major factors in a substantial number of relapses. Zackon, McAuliffe, & Ch'ien (1993) believe that addicts frequently relapse as a result of joylessness in their lives. Shiffman and colleagues (1982) found that coping responses for high-risk situations were less effective for smokers who were depressed or had mood alterations. Other negative affective states associated with relapse include anger, anxiety, and boredom. The acronym 'HALT'[10] used in AA and NA speaks to the importance of the recovering substance abuser not allowing themselves to get too angry or lonely. These two emotional states are seen as high-risk factors for many. Interventions for helping patients acquire appropriate coping skills that enable them to manage negative emotional states vary, depending on the foundations, expression, and consequences of the emotions. For example, strategies for addressing a depression that accompanies the realization that addiction caused havoc in one's life may contrast from those for dealing with depression that is part of an endogenous or major depressive illness that becomes apparent after the patient is substance-free and creates significant personal distress.

Interventions to help the patient who intermittently becomes angry and seeks comfort in drugs, tobacco, or alcohol vary from those needed to help the patient who shows almost chronic anger at themself and others. The former may need help in expressing their anger appropriately rather

[10] HALT - Don't get too **H**ungry, **A**ngry, **L**onely, or **T**ired – Alcoholics Anonymous, Narcotics Anonymous

than assistance in suppressing it. The chronically angry individual, instead, may need to learn how not to express anger, since it is often expressed impulsively and inappropriately and often is not even justified. With this type of presentation, a patient may benefit from cognitive techniques that teach the individual to challenge and change angry thoughts that are not justified or helpful. For those patients who recognize in themselves that their anger must be the demonstration of a character flaw Psychotherapy or the use of a 12-step program of AA and NA are appropriate interventions to help modify such an ingrained belief. Interventions for clients who report feelings of chronic boredom, emptiness, or joylessness similarly depend on the specific nature of the emotional state. The client may need help in learning how to use free time or how to fill their life with a more productive pastime than with a drug or alcohol use. Similarly, the client may need help in identifying and developing new values and new relationships or in finding new activities that provide a sense of meaning in their life. Many clients can be helped to alter their beliefs regarding fun, excitement and what is important in their life. The author has encountered many cocaine addicts across a number of years who have reported that being drug-free was boring compared with the high provided by the drug or behaviors associated with getting the drug or 'living on the edge.' In such cases, the client may recognize a need to change not only behaviors but also beliefs and attitudes.

7. Assess Clients for Psychiatric Disorders and Facilitate Treatment if Needed.

Numerous studies of community samples, psychiatric treatment populations, and substance abuse treatment populations show evidence of high rates of 'Dual diagnosis'[11]. According to Kranzler, & Rosenthal (2003) clients with a dual diagnosis are at a significantly higher risk for substance use relapse than those with only a substance use diagnosis resulting from the effect of psychiatric symptomology on motivation, judgment, and functioning indeed it is a very easy argument to defend following on from the experience of many other contributors to the subject. In addition, clients with a dual diagnosis who resume substance use frequently fail to adhere to their psychiatric treatment and are noted to comply poorly with pharmacotherapy, psychotherapy, and self-help program attendance. In a previous short term quality assurance/improvement study conducted in 1997 by one of the authors regarding 25 substance abusers with mood disorders and 25 substance abusers with schizophrenia who were re-hospitalized as a result of significant worsening of their psychiatric condition, it was found that a relapse of substance or alcohol abuse played a significant role in 60% of the psychiatric relapses.

RP strategies can be modified and tailored to the specific difficulties and symptomology of the client's psychiatric disorder. Monitoring target moods or behaviors, participating in pleasant daily activities, developing routine and structure in activities of daily life, learning to cope with persistent psychiatric symptoms associated with chronic or recurrent forms of psychiatric illness, and identifying early warning signs of psychiatric relapse and developing appropriate coping strategies are helpful interventions for clients with a dual diagnosis.

Negative mood states that are part of an affective disorder (major depression, bipolar disease, etc.) or anxiety disorder (phobia, panic, etc.) may require pharmacotherapy interventions in

[11] **Dual diagnosis** (also called **co-occurring disorders**, COD) is the condition of suffering from a mental illness and a comorbid substance abuse problem - http://en.wikipedia.org/wiki/Dual_diagnosis

addition to consistent psychotherapy and involvement in self-help programs. Clients taking medications for these or other psychiatric disorders may also benefit from developing assertiveness strategies for addressing issues pertaining to others encouraging them to reduce or stop their medication regime due to a perception that it is prolonging the substance abuse, and slowing down the process of recovery.

8. Facilitate the transition to follow-up outpatient or aftercare treatment for clients completing residential or hospital-based treatment programs.

Numerous clients make substantial gains in many structured, hospital-based or residential substance abuse treatment programs only to have these gains negated due to an inability to adhere to ongoing outpatient or aftercare treatment. Interventions that are used to enhance treatment entry and adherence that lower the risk of relapse may include the provision of a single session of motivational therapy prior to discharge from inpatient treatment, the use of telephone or Email reminders of initial treatment appointments, and providing the client with positive reinforcement for appropriate participation in treatment activities or for providing drug-free samples of urine (should that be part of a treatment or follow up package). In a pilot study conducted in one of the authors' treatment programs in the UK, a single motivational therapy session that was provided to hospitalized substance abusers with a comorbid depressive illness led to a nearly 50% increase in the show rate for the initial outpatient appointment. Whilst this was a small and informal study with a small number of clients the evidence would suggest that the non-attendance rate at outpatient appointments might be reduced simply by the provision of this one session, prior to discharge. Anecdotal evidence suggests that clients who attend for their initial appointment and successfully 'enter' outpatient treatment have a reduced risk of not completing a treatment program and subsequent psychiatric and/or substance use relapse.

9. Help Clients Learn Methods to Cope With Cognitive Distortions[12]

Psychiatrist Aaron T. Beck began the study of these distortions, and David D. Burns continued research on the topic. Burns' 1989 book, *The Feeling Good Handbook* presented information on these thought patterns along with a proposal of how to eliminate them. Cognitive distortions, or errors in thinking are associated with a wide variety of mental health and substance use disorders. These distortions have also been connected with relapse to substance us. Many twelve-step programs refer to cognitive distortions as 'stinking thinking' as recognized originally by members of Alcoholics Anonymous, and suggest that all recovering individuals need to alter their thinking if they are to remain alcohol and drug-free. Teaching clients to identify cognitive errors and automatic negative thoughts[13] (e.g., black-and-white thinking, over generalizing, selective abstraction, catastrophic thinking, or jumping to conclusions) and then to evaluate how these thought errors affect the relapse process is often extremely helpful. Clients can then be taught to counter these thoughts and to challenge their faulty beliefs or their specific negative thoughts. In practice clinicians should provide clients with the skills to help the client learn to challenge thoughts that may lead to relapse. Clients should be able to recognize a thought that

[12] **Cognitive distortions** are exaggerated or irrational thought patterns that are believed to perpetuate the effects of psychopathological states, especially depression and anxiety.
[13] Automatic negative thoughts are the negative thoughts that are elicited in people when faced with anxiety-provoking situations that normally elicit feelings of anxiety and are part of a CBT approach to Psychotherapy

may be negative or related to a potential relapse, for example 'relapse can't happen to me', 'I'll never use alcohol or drugs again', I can control my use of alcohol or other drugs', 'a few drinks, joints, pills, lines won't hurt', 'recovery isn't happening fast enough', 'I need alcohol or other drugs to have fun', 'my problem is cured', the client should then be able to distinguish the error in that thought, and create a new thought or statement.

Many of the AA and NA slogans were devised to help alcoholics and drug addicts alter their thinking and tolerate desires to use substances. Slogans such as 'this, too, will pass', and 'one day at a time' often help the individual work through thoughts of using either alcohol, or other substances.

10. Help Clients Work Toward a Balanced Lifestyle.

In addition to recognizing and managing factors for relapse, recovering individuals frequently need to construct more global changes to restore or achieve a healthy homeostatic[14] balance in their lifestyle. The development of a healthy lifestyle (diet, exercise etc.) is seen by many healthcare professionals as extremely important in reducing the stress that makes a client more vulnerable to a relapse. The client's lifestyle can be assessed by evaluating patterns of daily activities, sources of stress, stressful life events, balance between the desirable (activities engaged in for pleasure or self-fulfillment) and the necessities (external demands), health and exercise patterns, relaxation patterns, interpersonal activities, and religious beliefs. Facilitating a client's development of positive habits or substitute indulgences for substance abuse can help to balance their lifestyle.

11. Consider the use of a pharmacological intervention as an adjunct to psychosocial treatment.

Pharmacological interventions to attenuate or reduce cravings for alcohol or other drugs, or to enhance motivation to stay sober, and increase confidence in their ability to resist relapse do have positive effects for many clients and some find success with this additional support. Several studies provided preliminary evidence that naltrexone[15], for example, is helpful for alcoholics. Joseph Volpicelli and his colleagues' Arthur Alterman, Motoi Hayashida, and Charles O'Brien conducted a 1992 study of 70 male alcohol-dependent clients that were participating in a 12-week, double-blind, placebo-controlled trial of naltrexone. Volpicelli et al found that 23% of subjects taking naltrexone met the criteria for relapse, which compared with 54% of treatment subjects that took placebos. The primary effect of naltrexone was that subjects were much less likely to continue drinking following the initial use of alcohol compared to the control subjects. In a study of naltrexone combined with coping skills and/or RP training (N+RP) or supportive therapy (N+ST), Stephanie S. O'Malley, PhD; Adam J. Jaffe, PhD; Grace Chang, MD; Richard S. Schottenfeld, MD; Roger E. Meyer, MD; Bruce Rounsaville, MD found that N+RP subjects who returned to drinking were less likely to experience a relapse to heavy drinking compared to N+ST subjects. As was mentioned in the previous discussion around the issues of a dual diagnosis, any treatment of psychiatric symptoms with appropriate medications has important

[14] **Homeostasis** - literally means "same state" and it refers to the process of keeping the internal body environment in a steady state.
[15] **Naltrexone** is an opioid receptor antagonist used primarily in the management of alcohol dependence and opioid dependence.

implications for recovery. Henry R. Kranzler, MD, and his colleagues Joseph A. Burleson, PhD; Frances K. Del Boca, PhD; Thomas F. Babor, PhD; Patricia Korner, RN; Joseph Brown, PhD; Michael J. Bohn, MD conducted a randomized, 12-week, placebo-controlled trial of buspirone[16] in 61 anxious alcoholics who also received weekly RP therapy. Clients receiving the buspirone protocol showed greater retention in treatment at a 12-week timeframe in addition to presenting with reduced anxiety, a slower return to heavy alcohol use, and fewer drinking days compared to those receiving placebo. In a randomized controlled double blind clinical trial of 100 alcoholic patients. Mark L. Kraus, M.D., and his colleagues Louis D. Gottlieb, M.D., Ralph I. Horwitz, M.D., and Mitchell Anscher, M.D. found that among the 57 high-risk patients reporting cravings for alcohol at baseline, relapse rates were 90% for patients receiving placebo compared with 65% for those receiving atenolol[17]. This study by Mark Kraus, M.D and colleagues also found that poor levels of treatment adherence were strongly associated with the adverse outcome.

12. Help Clients Develop a Plan to Manage a Lapse or Relapse.

A search of the literature shows us that for most alcoholics, smokers, and drug addicts a lapse or relapse is likely at some point in the recovery process. Consequently, it is categorically advocated that clients have an emergency plan to follow if they do find themselves at risk of a lapse, so that a complete relapse can be avoided. If an out-and-out relapse occurs, however, the client needs to have strategies to break it. The specific intervention strategies should be based on the chronicity, complexity and severity of the client's lapse or relapse, coping mechanisms, and the clients prior history of relapse.

Helpful interventions include self-talk or behavioral techniques to stop a lapse or relapse, asking family for support, connecting or re-connecting with sponsors, friends, or professionals for help; carrying an emergency card with names and phone numbers of others who can be called on for support or carrying a reminder card that gives specific instructions on what to do if a lapse or relapse occurs is a useful tactic that can be extremely useful when the clients mind may not be able to focus on next steps. Marlatt recommends developing a relapse contract with clients that outlines specific steps for the client and the therapist to take in the event of a future relapse. The aim of this contract is to formalize or reinforce the client's commitment to change and the support that accompanies that commitment.

Analyzing lapses or relapses is a valuable process that can aid ongoing recovery. This helps to reframe a "failure" as a "learning" experience and can help the individual prepare for future high-risk situations.

CONCLUSION

A large variety of RP clinical treatment models and specialized programs have been developed for clients with alcohol, tobacco, or other drug problems over the years. Various portions of the cognitive and behavioral interventions that are described in these RP approaches can be

[16] Buspirone is an anxiolytic medication, which is prescribed for short periods of time to help ease symptoms of anxiety.

[17] **Atenolol** is a selective β_1 receptor antagonist Atenolol is used for a number of conditions including: hypertension, angina, acute myocardial infarction, supraventricular tachycardia, ventricular tachycardia, and the symptoms of alcohol withdrawal.

adapted for use with clients who have additional problems, such as compulsive disorders, impulse control disorders, or comorbid psychiatric illnesses. RP interventions objective is to help clients maintain change over time and to address the most common issues and problems raising vulnerability to relapse. Studies indicate that RP has efficacy in reducing both relapse rates and the severity of lapses or relapses. RP strategies can be used throughout the continuum of care in primary rehabilitation programs, partial hospitalization or halfway house programs, or therapeutic milieu and community programs, as well as in outpatient and aftercare programs. In addition, family members can (and many would say should) be included in educational and therapy sessions and involved in the development of RP plans for members with substance use disorders. Many of the RP approaches described in the literature can be considered short-term or brief treatments and can be provided in individual or group sessions, making them attractive and systemically cost effective. User-friendly, interactive recovery materials such as books, workbooks, DVD's and internet based support programs support most clinical models of RP. These supplemental materials provide additional information and support to clients who can learn to use self-management techniques of RP on their own, following completion of formal treatment.

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