Chapter ***13***

Maintenance and Relapse Prevention[1]

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INTRODUCTION

After the client has completed the initial stages of treatment, the focus of the counseling process should be on establishing a firm foundation in a maintenance program for the prevention of a relapse. Although client relapse often occurs, this setback can be reframed as a learning experience in the growing awareness of one's limitations and weaknesses. The initial portion of this chapter delves into relapse prevention for addictive behavior, identifies high-risk situations, and examines by case study how seemingly irrelevant decisions play a part in a relapse. We also discuss the abstinence violation effect. The latter portion describes relapse prevention with specific daily maintenance practices as applied within a case study. In conclusion, some of the most recent findings in the field of substance abuse will be summarized to help us better understand the dynamic, complex issues of relapse and maintenance.

RELAPSE PREVENTION FOR ADDICTIVE BEHAVIORS

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[1] We would like to acknowledge the contribution that Jeff Sandoz made to the first edition of this

A relapse is often defined as a return to drug use after a period of abstention. Attempting to determine rates of relapse can be challenging due to many variables. Relapse rates are different depending on the drug, severity of the addiction, length of treatment, and how relapse is defined. Several studies have indicated a relapse as high as 90% for alcoholics (Doweiko, 1990; Orford & Edwards, 1977). A recent government study compared the relapse rates of drug addiction to other chronic illnesses (National Institute on Drug Abuse, n.d.). This study estimated the percentage of people with drug addictions who relapsed as 40% to 60% compared to Type 1 diabetes at 30% to 50%, and both asthma and hypertension at 50% to 70%. Regardless of the many factors involved, both practitioners and researchers agree that most individuals who attempt any significant behavior change will experience lapses and/or relapses.

Alcoholism is a relapsing condition that is found to be no different than other addictive behaviors (Polich, Amour, & Braiker, 1981). What do we mean by "relapsing condition"? In the broader context of medicine, "relapse" might be defined as a return of disease after an apparently full or partial recovery. However, the term is used even more broadly, in everyday life, to refer to falling back into a pattern of habitual (usually negative) behavior. In addiction treatment it can be used in either or both of these senses, but it might best be understood here to refer specifically to a return to a pattern of addictive behavior that had (for a shorter or longer period of time) apparently abated.

Relapse can occur following apparently spontaneous cessation of addictive behavior, self-motivated and deliberate attempts to overcome an addiction, involvement with a self-help (ormu-

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chapter.

tual-help) program of recovery, or following involvement with a formal medical or psychological treatment program. However, for present purposes, it is perhaps best to think of relapse as something that occurs following an intervention or treatment intended to control or eliminate the behavior in question. Thus, a single drink taken by an alcoholic who had been completely abstinent for some months, as a result of engagement in a program of recovery supported by attendance at Alcoholics Anonymous (AA) or Rational Recovery (RR), would count as a relapse. The basic philosophy of such groups is that a relapse is a normal part of the addiction process and it is *not* a part of recovery. Similarly, a return to heavy drinking, by a client seeing a substance abuse counselor who had been assisting her in moderating her alcohol use, would also be a relapse. But a single drink taken by the latter client might not be understood as a relapse at all, as it might have been well within the limits agreed to with her counselor. This distinction immediately raises a series of important considerations.

First, "relapse" can mean different things for different clients engaged in different therapeutic programs. This is not only a question of degree. For example, most 12-step programs aim at abstinence from all mood-altering substances. Thus, consumption of one glass of wine might count as a relapse for a formerly opioid-dependent client attending Narcotics Anonymous, but considered quite immaterial by the counselor of the same client engaged in a purely psychological program of cognitive behavior therapy focused on illicit drug use. Similarly, an alcoholic client who remains completely abstinent from alcohol might begin using tranquilizers in an addictive fashion and thus have relapsed—even though the counselor neglected to tell the client not to use tranquillizers. Such action by the client is referred to within AA circles as the "trading of one addiction in for another."

Second, it will sometimes be necessary to distinguish a "lapse" from a "relapse" (Marlatt &

George, 1984), as a single glass of wine has a different significance for the client enrolled in a controlled drinking program, as compared with a member of AA. Thus, a single glass of wine consumed by one aiming at complete abstinence (whatever program of treatment one is engaged in as a means of achieving that goal) might well constitute a relapse when it is denied, leads to further drinking, or constitutes a breach of terms of employment in a safety-sensitive workplace. However, for another client, where the same behavior leads immediately to a meeting with a sponsor or counselor and thus to a helpful discussion about how it could be avoided in the future, it might be referred to merely as a "lapse." A lapse is thus a technical or modest breach of agreed treatment goals, which allows for learning and therefore eventual achievement of the ultimate aims and objectives of treatment. A relapse is a more serious violation of treatment goals, or a more minor violation in which such learning is not evident.

Third, relapse prevention is an approach to treatment compatible with other treatment models of widely varying philosophy. Multimodal therapies in conjunction with a supportive 12-step program offer the greatest promise for long-term abstinence. But this in turn raises another important question. What is "relapse prevention" in its pure form?

Relapse prevention is difficult to define because it constitutes a range of therapeutic methods applicable to a range of very different addictive behaviors, as well as to habits or behaviors that might not normally be considered "addictive" at all. In each case the aim is to prevent relapse, but like "relapse" the word "prevention" can mean different things. Thus, for example, a program of relapse prevention might be considered successful in the short term if it results in a reduction of the severity or frequency of relapse, even if it does not result in complete elimination of addictive behavior. On the other hand, another program of treatment might achieve complete abstinence in a larger proportion of clients but no reduction at all in those who are not ab-

stinent.

Relapse prevention usually involves training clients in techniques that they will find useful in preventing or eliminating relapse. It is thus, in a sense, a form of “self-help” or self-regulation. However, it is not limited specifically to the realm of addictive behavior. There is reason to believe that overall lifestyle has an important part to play in the maintenance or elimination of addictive behavior; and so relapse prevention can legitimately address itself to matters such as spirituality, diet, exercise, and recreation, as well as to specific issues narrowly concerned with the addictive behavior itself. Furthermore, relapse prevention might involve prescription of pharmacological agents such as acamprosate or naltrexone, which can play a role in supporting or augmenting psychological treatments by reducing the urge or craving to use (Franck & Jayaram-Lindstrom 2013).

Relapse prevention might, ideally, completely remove the underlying causes of addictive behavior. However, in practice it is focused specifically upon the addictive behavior itself. A good outcome is thus defined purely in terms of an observed change in addictive behavior, and not on the basis of hypothesized or actual underlying factors. This is not to say that such considerations are unimportant, but simply that they are not an essential or distinctive component of this approach to treatment. Relapse prevention is sometimes employed in treatment settings where attention to such factors is considered vital; in other cases it is employed as part of a purely behavioral approach, where observable behavior alone is the criterion of success.

While we are mindful of all these various meanings of the term “relapse prevention,” we will use it here to refer primarily to approaches to the rom addictive disorders, which may be taught or learned, with the objective of reducing the frequency and/or severity of relapse. The best possible outcome, of course, is that relapse prevention leads to a total elimination of relapse.

However, no treatment for addictive disorders results in a 100% improvement for all clients. Relapse prevention allows the possibility of a degree of success even where there is not total success. More importantly, it allows the possibility that at least some failures (notably "lapses") can be learning experiences that predict a better outcome in the longer term.

RELAPSE PREVENTION MODEL

The Relapse Prevention (RP) model (Marlatt and Gordon, 1985, Hendershot et al 2011, Donovan & Witkiewitz 2012) is one of the most well-known models used to prevent or manage relapse. It is an approach based upon cognitive behavioral theory and includes aspects of social learning theory. This model has evolved over time, and its proponents describe the relapse process as a complex, multidimensional system (Witkiewitz & Marlatt, 2004).

Counselors using the RP model are interested in understanding the factors which influence an individual to remain abstinent or to relapse. These include both intrapersonal and interpersonal factors. Intrapersonal factors include self-efficacy, outcome expectancies, craving, level of motivation, coping ability, and emotional states. Interpersonal factors involve social support, or the amount of emotional support available to the individual in treatment (Witkiewitz and Marlatt, 2004).

Self-Efficacy

Self-efficacy is defined as the degree to which a person feels capable and competent of being successful in a specific situation (Bandura, 1977). This belief in one's ability is context-specific and often derived from past successes in a similar situation. Self-efficacy level and rate of relapse are strongly related. If clients experience a lapse, their self-efficacy begins to fluctuate, and they have an increased risk of a full-blown relapse (Shiffman et al., 2000). However, if individuals maintain abstinence (e.g. success in smoking cessation), their self-efficacy increases (Gwaltney,

Metrik, Kahler, & Shiffman, 2009).

Melanie was beginning a smoking cessation program. This was her third attempt to quit smoking. She expressed a high level of self-efficacy when discussing her ability to abstain from smoking while she was at work. She knew strategies that helped her resist the urge to smoke on her job, and had successfully used these strategies during the first two attempts. However, she had not been successful in refraining from smoking while out with friends. In this circumstance, she expressed a low level of self-efficacy. What strategies could the counselor use to help Melanie increase self-efficacy for not smoking while out with friends?

Outcome Expectancies

Outcome expectancy refers to the client's beliefs or thoughts about what is going to happen after using a substance. A positive outcome expectancy is associated with increased relapse rates because the individual anticipates positive consequences from the drug use.

Tyler is a college freshman receiving counseling for anxiety and drug abuse. He believes that drinking a couple of six packs of beer will result in him being more popular at the fraternity party because he will have less anxiety. This positive outcome expectancy results in Tyler's lapse. The counselor is hoping to assist Tyler in developing a negative outcome expectancy to increase the likelihood of him remaining abstinent. How could the counselor use cognitive behavioral therapy in this process?

Have you experienced the urge to smoke while trying on a bathing suit? These two events have actually been linked! Because body dissatisfaction leads to negative feelings, young women have

the urge to smoke. These women believe that they will lose weight if they smoke and therefore feel better about themselves in a bathing suit (a positive outcome expectancy), which increases the likelihood of relapse (Lopez, Drobes, Thompson & Brandon, 2008).

Craving

Cravings refer to physiological responses which prepare the individual for the effect of a substance. When an addict is deprived of the substance (during abstinence) and is subject to cue exposure (e.g., seeing a beer advertisement), the individual will experience a craving and this may lead to relapse (Schneekloth et al 2012). If the person believes that the beer is readily available, this increases the craving (Wertz & Sayette, 2001). However, high self-efficacy and effective coping strategies can be the “braking mechanism” to prevent relapse (Niaura, 2000).

Coping

Coping skills refer to strategies that help individuals to effectively manage their behavior, especially in high-risk situations. Many types of coping strategies are used in the field of substance abuse counseling. Behavioral approaches, such as meditation and deep breathing exercises, and cognitive coping strategies, such as mindfulness and self-talk, have proven to be effective in lowering relapse rates for substance abuse.

One of your best coping strategies is your ability to self-regulate. But can your self-regulation “muscle” get tired (Baumeister, Heatherton, & Tice, 1994)? If you’ve been under a lot of stress, resulting in overuse of self-control resources, your self-regulation “muscle” may become exhausted. This fatigue leads to using more ineffective coping strategies, such as drinking more.

Motivation

The level of motivation a person has to change a behavior is one of the most important factors in the efficacy of treatment. The transtheoretical model of motivation (Prochaska & DiClemente, 1984, Norcross et al 2011) described five stages of readiness to change: precontemplation, contemplation, preparation, action, and maintenance. Each stage represents an increase in motivation and readiness to follow through with the change process. Although this model describes a linear progression, there are usually many backward slides as well as forward movement. Levels of motivation depend upon positive and negative reinforcement and can be influenced by situations, life events, moods, social pressure, and numerous other variables.

Think of a time when you've tried to change a behavior. Maybe you're attempting to eliminate junk food from your diet. Did you experience a linear movement from early motivation to reaching your goal? Probably not! Most of us are affected by daily moods, unexpected life events, and changes in our confidence level. So you may have carried out your plan and had no junk food for a few days; then you had a conflict with your boss. After a few days of chips and candy, you re-evaluate and go back to the planning stage!

Emotional States

Both positive and negative feelings have been identified as major reasons for drug use, but negative feelings are thought to be the primary motive. An individual's abstinence self-efficacy, or the confidence in oneself to remain sober, is lowest when the person is experiencing emotions such as sadness, anger, anxiety, or regret. Most clients will experience shame and remorse, which are triggers for relapse. Negative affect has been specifically linked with lapses in alcohol use (Witkiewitz & Villarroel, 2009).

It seems as though traumatic events and disasters are linked to early relapse rates. Following the September 11 tragedy, early relapse rates were reported among smokers attempting to quit. The use of other substances increased, also. Similar behaviors were found after the Oklahoma City bombing. The increased levels of smoking were associated to higher stress levels, worry about safety, and post-traumatic grief (Forman-Hoffman, Riley, & Pici, 2005).

Social Support

In substance abuse counseling, the importance of social support for abstinence cannot be downplayed. Social support can be both positive and negative. Families, spouses, and friends can provide a positive, supportive system that can improve the client's level of self-efficacy and negative mood. However, it is often difficult for a client's family and friends to stay supportive through numerous relapses and subsequent pain and distress. When clients are successful in minimizing negative support, they are more likely to maintain sobriety (Lawhon, Humfleet, Hall, Reus, & Munoz, 2009).

The Value of One — It Can Go Either Way!

The importance of a supportive social network cannot be emphasized enough! Being involved with others and receiving high levels of support from even **one** person prior to treatment leads to better outcomes. But drinkers' social networks include many other drinkers, and having even **one** person in the social network who drinks increases the risk of relapse (Havassy, Hall, & Wasserman, 1991).

Substance abuse counselors have found that clients are more likely to lapse or relapse immediately following treatment. But over time the recovering individuals have a tendency to re-

lapse less as they learn coping strategies and increase their self-efficacy. To help a client stabilize and maintain sobriety, counselors need to be familiar with some common issues. Three of these essential elements in the Relapse Prevention model are: (1) high-risk situations; (2) seemingly irrelevant decisions; and (3) the abstinence violation effect.

HIGH-RISK SITUATIONS

At the heart of relapse prevention therapy is the observation that for every addict certain identifiable sets of circumstances present a high risk of relapse. These high-risk situations (HRS) are key events in relapse, which may pose a threat to one's level of confidence about exercising self-control (Marlatt & Gordon, 1985). The better able a client is to identify his or her own HRSs and to prepare in advance a repertoire of coping strategies designed to manage them without relapse, the more likely he or she is to achieve a good outcome. Marlatt and Gordon (1980) report that most relapses were associated with three kinds of HRS: (1) frustration and anger, (2) interpersonal temptation, and (3) social pressure.

Clients often recognize that they are more likely to drink when feeling negative emotions—anxiety, depression, etc.—but often overlook the fact that emotional highs can also be a problem. One of the coauthors of this chapter (CCHC), engaged in a research follow-up of clients from a 12-step treatment program some years ago, encountered the case of an alcoholic who had been abstinent for a year or more but who died from acute alcoholic poisoning on the night of his first and only relapse of drinking. The relapse was precipitated by his desire to celebrate success in clinching an important business deal. This idea seems to echo the words of Dr. William Silkworth, author of "The Doctor's Opinion" in *Alcoholics Anonymous*. "I have had many men who had, for example, worked a period of months on some…business deal which was to be settled on a certain date, favorably to them. They took a drink a day or so prior to the date, and then the

phenomenon of craving at once became paramount to all other interests so that the important appointment was not met. These men were not drinking to escape; they were drinking to overcome a craving beyond their mental control" (*Alcoholics Anonymous,* 2001, pp. xxvii–xxviii).

Counselors who work with teens may think that an increase in substance abuse is due to conflict with adults or peers, or strong negative emotions. However, a recent study has shown that over two-thirds of adolescents relapse when they are trying to enhance a positive emotional state. In other words, teens use drugs and alcohol in an attempt to increase an already elated mood (Ramo & Brown, 2008).

Interpersonal temptation due to conflict is often recognized as preceding relapse but is easily used by addicts as a way of blaming others for their plight. In relapse prevention therapy this is understood as being an HRS, in which the client is responsible for putting into effect previously planned coping strategies as ways to manage anger, rejection, or conflict without relapse.

Social pressures to drink are often subtle and are pervasive in Western society. However, within given subcultures there are countless pressures to use other drugs, to engage in gambling, overeating, spending beyond personal means, and a variety of other potentially addictive behaviors. Once these pressures are recognized for what they are, it is possible to plan in advance how they will be managed. Many relapses occur simply because addicts do not plan ahead but allow themselves to be caught unawares. As most of us are not able to think up a convincing alternative plan of action at a moment's notice, a long-reinforced and familiar pattern of addictive behavior becomes the inevitable outcome for anyone being pressured to conform to social pressure to drink or use drugs or to engage in other patterns of addictive behavior. This is especially true where friends, family, or respected authority figures exert the social pressure.

Rachel had successfully abstained from drinking for three months but was now dreading going home for the holidays. She explained to the counselor that alcohol was at the center of much of her family's celebration. During counseling sessions, she detailed all of the situations in which she might feel pressured to drink. She and the counselor brainstormed refusal skills and rehearsed behavioral strategies, such as always having a drink (soft drink) in her hand. What other behavioral strategies could the counselor use with Rachel to help her maintain sobriety?

Relapse prevention therapy begins by assisting a client to identify their own HRSs. Keeping a diary of emotional states, social interactions, cravings, and lapses/relapses can assist in this process. A variety of questionnaires are also available to help with this process, such as the Inventory of Drinking Situations (Annis, 1982). Having identified the HRSs that are most difficult for a particular individual to manage, it is then important to consider what the habitual coping strategies for handling these situations might be. Clearly, addictive behavior (drinking, drug use, etc.) is likely to be the predominant pretreatment response. However, other coping strategies a client has used may be ineffective and thus unlikely to help prevent relapse.

Specific coping strategies must then be considered, planned, and implemented. This process begins with brainstorming—either individually or as part of a group—about what kinds of strategies might be possible for each HRS. After generating a list of as many possible coping strategies as can be imagined, the counselor should assist clients in the process of refining, modifying, combining, and improving upon a selected number of coping strategies. Ideally, these are then rehearsed. For example, there is much to be gained from encouraging alcoholics to role-play drink-refusal skills. The benefit is even greater if the role-plays are videotaped and played back, with discussion of how the client managed the situation. Alcoholics also benefit from recogniz-

ing the ploys that have been used by others to persuade them to join in with "social" drinking. Helpful suggestions in preparing for HRS include the following:

1. Be aware of intrapersonal triggers (thought patterns and related emotions) that lead one to substance abuse (e.g., expectations, anger, fear, resentment, irritation, frustration, disappointment, shame, etc.).
2. Use mnemonic devices to remember countermeasures in a plan of action.
3. Acquire a system of markers (emotional barometers) that will engage the memory to prompt the recall of an action plan.
4. Develop a back-up plan to diffuse emotions, utilizing resources, people, and activities.
5. Use multiple methods of stress relief; specifically, nonaddictive, healthy alternatives such as developing hobbies, meditation, relaxation, and physical exercise.

Have you surfed recently? A group of college students interested in decreasing their smoking habits were encouraged to do some "urge-surfing." If you want to try this, first think of specific urges you experience for an unwanted habit or behavior. Then picture the urges as waves, and imagine riding these waves as they naturally ebb and flow, rather than fighting the urge or giving in to it (Bowen & Marlatt, 2009).

Annis and Davis (1991) offered one of the more comprehensive relapse prevention models. This model, which is designed to initiate and maintain changes in drinking behavior, focuses on building confidence in one's ability and promoting self-efficacy. Procedures for this model include:

1. Develop a hierarchy of substance-abuse risk situations.
2. Identify strengths and resources in the environment and cope with affective, behavioral, and

cognitive issues.

3. Design homework assignments by which the client is able to: (a) monitor thoughts and feelings in specific situations, (b) anticipate problematic situations, (c) rehearse alternative responses to drinking, (d) practice new behaviors within the more difficult situations, and (e) reflect on personal progress and increased levels of competence.

Counselors need to keep in mind specific risk factors that can influence whether or not a person will be successful in maintaining sobriety in the face of high-risk situations. These factors include stressful life events, the loss of family/social support, acute psychological distress, situational threats to self-efficacy, and both positive and negative emotions. Also, some clients have a greater potential for relapse due to a family history of alcoholism or drug addiction, the nature and severity of the addiction, and comorbid psychiatric and substance abuse diagnoses (Donovan, 1996; Shiffman, 1989).

SEEMINGLY IRRELEVANT DECISIONS (SIDs)

High-risk situations are not simply circumstances imposed by other people or the social environment. Sometimes they are the result of an individual's thought processes. These thought processes are varied and diverse and a comprehensive account is not possible here. Where thinking errors and psychological "traps" appear to be a prominent cause of relapse, there may be benefit in gaining specialist help in the form of cognitive therapy. On the other hand, there is much wisdom as to how such processes operate within the world of 12-step groups such as AA. Research in maintenance and relapse prevention indicates that multimodal treatment, along with attendance in a 12-step program, offers the best chance for long-term recovery and abstinence (Inaba & Cohen, 2000). Quite often the 12-step groups will prove to be more accessible and, as they come with the voice of personal experience, advice given there will be listened to more seriously than

that offered by the professional counselor with no personal experience.

"Seemingly irrelevant decisions," or SIDs (also known as "set-ups") are decisions an individual makes that may seem irrelevant at the time, but very often can lead to a relapse. SIDs are perhaps best illustrated by way of an example.

It was a fine day, and John had finished work early after receiving a highly positive annual appraisal from his boss. He decided to walk home from work. He varied his usual route so as to stroll through the local park, enjoying the warm sun, the trees in blossom, and the sounds of children playing ball. He felt good about life, and his days of alcoholic drinking seemed far away. As he walked out of the park he passed a bar where he used to drink. Knowing that he did not want to drink anymore, but remembering that his old friends would be wondering what had happened to him, he went in to see how they all were "just for old time's sake." Once there, they ignored his pleas that he no longer drank alcohol and bought him a "proper man's drink." Telling him they were angry he hadn't called on them for weeks they said that they'd let bygones be bygones if only he joined them for "just one drink." Telling himself that there was nothing else he could do under the circumstances, John gave in. Within only a few hours the barman refused to serve him any more on grounds of his obviously drunken behavior. When he got home his wife was also angry, so he knew that he had "no choice" but to go to the home of another of his drinking friends, where he spent the night consuming yet more alcohol.

Decisions to walk home rather than take a bus, or to choose one route rather than another, are "seemingly irrelevant" to the mental processes of alcoholism. However, with hindsight, such decisions can set in motion an inexorable process of movement toward a relapse due to environmental triggers. Such relapses are often later viewed as "unavoidable." After all, what could John

do once he was back in the bar, with all his old friends insisting that he drank alcohol?

Much of what has been said above is relevant to this example. John could have been aware that his feelings of well-being and success were as much an HRS as any disappointment in life. Had he also rehearsed a range of realistic strategies with which to resist pressures from his drinking friends, he might have been more likely to emerge from the bar without having had a drink. More importantly, he might have recognized that simply going into the bar was an extremely bad idea in the first place. However, the overall problem here was that an unconscious chain of decisions was being forged which made relapse almost inevitable. Because the decisions were seemingly irrelevant, and because their true purpose was partly or completely unconscious, John was able to argue that events caught him off guard. However, having once recognized such patterns of decision making (and most addicts are readily able to think of examples), it becomes extremely difficult to continue engaging in them without making conscious decisions. Once the process has become conscious, SIDs lose much of their power and the client can bring relapse prevention strategies into play.

THE ABSTINENCE VIOLATION EFFECT

One more psychological trap is worthy of mention here, if only because of the controversy it engenders among counselors and clients alike. The basis of this trap is that once human beings have set themselves a rule there seems to be an irresistible temptation to break the rule. Quite apart from the spiritual implications of this, and the responses to it offered by the world's major faith traditions, this observation has important psychological implications for the addictive process. This process is known as the *abstinence violation effect* (Marlatt & George, 1984).

The trap can present itself in various ways. The most common, and simplest, is that minor infringements of the rule are taken as a justifiable basis for major infringements. Thus, if Jenny

has decided to stick to a diet in which she will not eat cake or candy, and if she finds herself forgetfully accepting a slice of birthday cake at a friend's celebration, she will then decide to go home and binge on cake and candy, because she has already failed. The rule has been broken, so she may as well enjoy breaking it to the full. Of course, in reality, if this is the first piece of cake that Jenny has had for a month she has not failed at all—she is doing enormously well. But, psychologically, she feels as though she has failed and so there is no longer any point in trying to adhere to the rule.

There are many more subtle manifestations of this psychological trap, but the general feature seems to be the transition from seeing the rule as being set by oneself for one's own good, to seeing it as imposed externally in some way and for its own sake (or for someone else's benefit). Circumstances are thus engineered whereby breaking the rule appears to be permissible, or breaking the rule a lot is seen to be no worse than breaking it a little.

From the perspective of relapse prevention, the important consideration is that small violations of the rule ("lapses") need not inevitably progress to major violations ("relapses"). Coping strategies can be learned that prevent this progression and over a period of time, make the behavior manageable. But herein lies the problem: other approaches to addiction therapy emphasize the unmanageability of addictive behavior. Step 1 of the 12 steps of AA states: "We admitted we were powerless over alcohol—that our lives had become unmanageable." (Members of AA are often reminded that "one drink makes one drunk.") The reinforcement of this message of powerlessness is thus criticized by some counselors as making relapse after only a single drink an inevitability, for alcoholics no longer have any reason at all to control their behavior, or any grounds for believing that they might be able to control their drinking if they tried. Alcoholism is a lack of ability to control drinking and therefore one drink will lead immediately, inevitably, and

inexorably back to alcoholic drinking.

It is not possible to review the merits and demerits of these two positions here in full detail. However, some observations are important. First, if clients are involved in relapse prevention therapy based on a model of the psychology of learned behavior, as well as being engaged in a self-help program of recovery, it is better to talk about these apparent conflicts rather than pretend they do not exist. Second, there is not necessarily as much of a conflict as might first appear. Many members of AA, having had a relatively minor "slip," have gone to an AA meeting, or have sought help from their sponsor, and have found help that has prevented the "inevitable" relapse. Equally, a "slip" or "lapse," perhaps following a series of SIDs, can itself present an HRS that was better avoided in the first place—even according to relapse prevention theory. There is much wisdom in both traditions. Third, and finally, when planning relapse prevention therapy counselors should remember that people are all different. What might be possible for one might not be possible for another. However, admitting the impossibility of a certain set of circumstances inevitably presents the risk that when those circumstances are encountered no effort will be made to overcome them.

LIFESTYLE CHANGE

A key issue for many people with addictive disorders is that of imbalance in lifestyle. The dependence syndrome is characterized by salience—a phenomenon which involves the object of addiction assuming greater significance, and occupying more time in life, than it should. This has sometimes devastating consequences. Relationships, work, ethical standards, leisure activities, diet, sleep, health, values, spirituality, and other aspects of life may suffer. However, one way or another, the use of time and energy become seriously distorted, with more attention being given to engaging in (and defending) addictive behavior and less time being given to other things and

people than is conducive to well-being.

Sometimes the lifestyle imbalance may result from the addiction. Sometimes it may contribute to it. Unemployment, for example, may be a consequence of drinking at work, or of the impairment of ability to fulfill obligations at work as a consequence of drinking at other times. However, unemployment may also be one of the contributory stresses around which heavier drinking develops, or may simply allow more time for drinking. Teasing out these cause and effect relationships is rarely productive in practice. What is clear is that a more balanced lifestyle will require less time drinking and more time devoted to constructive activity (such as job seeking, or voluntary work if paid employment is not an option). Practical measures to evaluate and change use of time may therefore be very important as a part of an overall relapse prevention strategy.

A useful exercise can sometimes be the exploration of how an addicted person approaches the "shoulds" and "wants" of life. Often it will be found that much time is devoted to one at the expense of the other. Thus, obligations are prioritized, with relentless disregard for leisure time and personal well-being, until the point is reached at which a relapse is inevitable (because drinking is the only habitual coping strategy employed to deal with the stress that this imbalance generates). Or else, a self-indulgent lifestyle is pursued with equally relentless disregard for relationships or social obligations. Within such a lifestyle drinking (or other addictive behavior) usually features prominently. If it does not, it soon emerges as a consequence of the lack of structure and discipline that such a lifestyle entails.

A 60-year-old male, Stanley, sought counseling after he was forced to take early retirement from a powerful state position. He was currently spending his days idle, remembering the importance

of his life only a short time ago. He described his life after retirement as lonely and boring, and he felt useless and depressed. He realized he had a drinking problem when he “washed down breakfast with a beer” soon after his wife left for work each morning and spent his time finding “creative hiding places” for his liquor. He began attending a 12-step program and did well in the beginning (the meetings gave him a new focus) but relapsed after six months of sobriety. What lifestyle changes may have affected Stanley’s initial drinking and relapse? What changes do you think would benefit him?

Exploration of lifestyle issues usually gets to the heart of what matters to people. How they spend their time, and what they devote their energy to, is usually a reflection of important desires and priorities in life. Once identified, these can provide motivational levers to enable change. For example, a desire to maintain custody of a child may provide motivation to comply with a court-mandated addiction treatment program. However, they also point to core beliefs and priorities which, explicitly or implicitly, are spiritual and/or religious. Identification of these core beliefs and priorities can help in regaining perspective and in identifying a treatment approach which will address the spiritual, as well as the psychological, social, and physical aspects of the addictive disorder. This may entail a 12-step treatment program (see Chapter 12) or a religious program, or it may be a reconnection with religious roots which occurs alongside engagement with a secular treatment program of some kind (Cook, 2009, 2010), or it might involve adoption of a spiritual practice such as mindfulness to support relapse prevention (Mason-John & Groves 2013,Witkiewitz et al 2013a, 2013b) . It is therefore important that counselors are able to facilitate discussion of spiritual and religious matters in an affirming manner, without either proselytizing or undermining healthy religious beliefs which may be different than their own. On the oth-

er hand, some kinds of "pathological" spirituality (e.g., associated with extreme cults or with an addictive pattern of religious behavior) may need gentle challenging (Crowley & Jenkinson, 2009). The balance requires wisdom and a nonjudgmental willingness to explore spirituality from the perspective of what may be in the client's best interests.

DEVELOPING A MANAGEMENT PLAN

There are various ways in which relapse prevention might be incorporated into an overall management plan. Amongst these, the 9step approach utilized by Terence Gorski is helpful:

1. **Stabilization**: Following detoxification, at least a few days of sobriety are wise and it is important not to rush in too quickly with much new material that patients will not be able to retain in the immediate post-detoxification period.
2. **Assessment**: This will be a full assessment of psychological, social, physical and spiritual issues pertinent to treatment and recovery, according to usual professional practice. However, Gorski especially emphasizes the need for a life history of alcohol/drug use, including the history of past episodes of recovery and relapse.
3. **Relapse Education**: This is the point at which information about the nature of lapse and relapse is provided. Gorski recommends involving family and friends, as well as 12 Step sponsors, at this stage.
4. **Identify Warning Signs**: Relapse is often preceded by warning signs that can be identified and which can thus allow early intervention and relapse prevention. These signs will be closely related to understanding the nature and identity of high risk situations for each client.
5. **Identify Problem Solving Strategies**: Each identifiable warning sign or high risk situa-

tion should be the focus for identifying a range of coping strategies which will enable coping without alcohol/drug use.

6. **Recovery Planning**: A plan for recovery can now be identified which will include appropriate support groups, professional help, work place support, engagement with 12 Step programs and all other resources that can reinforce and support relapse prevention.
7. **Inventory Training**: It can be helpful for the client/patient to have a regular time each morning and/or evening in which to identify and plan for management of high risk situations that have emerged, or might emerge, during a 24 hour period.
8. **Family Involvement**: Family can be involved in relapse prevention in various ways, but this might be a point at which to encourage involvement in AlAnon, Families Anonymous, or other 12 Step fellowships for families.
9. **Follow-up**: Gorski recommends regular review and updating of the treatment plan: monthly for 3 months, quarterly for 2 years and annually thereafter.

CASE STUDY OF RELAPSE PREVENTION

The latter section of this chapter presents a case study utilizing principles of maintenance and relapse prevention. Both the biopsychosocial model (disease model) and the cognitive-social learning model are used to provide interventions from a multimodal perspective. Although some strategies are associated to a larger extent with a particular model, the necessary strategies for relapse prevention are very similar. These models take into consideration the biological, psychological, and social aspects of substance abuse and use a wide range of counseling techniques to minimize the possibility of relapse. The interventions rely heavily on techniques from behavioral, cognitive, and social learning theories, as well as addressing the client’s physical health and well-

being (Chiauzzi, 1991).

The client for this case study is Thomas, a 27-year-old male currently employed as a salesman, who is married and the father of a 2-year-old daughter. Thomas enters counseling when he realizes his life is out of control. His wife has threatened to leave him, he cannot keep a job for longer than a few months, and his angry outbursts have become more frequent. He has had a couple of anxiety attacks in recent months and has begun to consider suicide, thinking that life is not worth living.

Thomas reports that he has been consuming alcohol since high school. He reports drinking approximately a case of beer daily, the amount depending on his stress level. He often switches to bourbon and spends many weekends with his friends in a drunken state. His dependency on alcohol consumption has become more self-evident as the consequences of his drinking have become increasingly serious.

Thomas's initial treatment to stabilize his condition included several visits to his physician to regulate antianxiety and antidepressant medications. During therapy, he is taught the importance of remaining on these medications and following the prescribed dosage. With Thomas's previous history of anxiety and depression, maintaining sobriety may be partially dependent upon his consistent use of these medications.

In the recovery phase, after withdrawal and stabilization, the relapse prevention counselor has several treatment goals. First of all, Thomas needs to be able to identify HRSs; he must then develop strategies to cope with these situations. Also, the counselor must help Thomas identify (and possibly establish) support systems. These may include positive social support networks such as AA, church, supportive friends, and family members. Additional goals include learning about the nature of addictions, and identifying and managing warning signs of relapse. Finally,

goals must include exploration of multisystemic issues related to Thomas's life—his relationships, environment, health, recreation, and family—and an evaluation of where positive change is needed.

Self-Assessment of High-Risk Situations

Initially, Thomas is taught to self-monitor HRSs. He is instructed to keep track of when, where, and why he wants to use alcohol. Thomas is given a chart on which he can track the risky situations, his thoughts and feelings at the time he has urges, and the coping strategies he uses to avoid substance use or to limit the amount consumed. Because substance use becomes habitualized after years of use and seems to be an automatic response, the self-monitoring strategy forces him to be consciously aware of his actions (Marlatt & Gordon, 1985).

When Thomas meets with his counselor, they use the chart as both an assessment tool and an intervention strategy. After examining the chart together, the counselor helps Thomas to see that the cues are centered mostly on stressful events, such as pressure to meet a quota on his sales job or a difficult argument with his wife. Thomas believes he deserves a reward (in the form of a drink) for making it through the situation, or that he must have a drink to relieve the stress. He is experiencing severe anxiety regarding his wife's threats to leave him and thinks a drink will help relieve his stress and give him more courage. His feelings often include nervousness, anger, or disappointment.

Self-Monitoring Chart

Date	Time	Situation	Thought(s)	Feeling(s)	Action
June 1	8:30 AM	Late for work; boss seems	I'm probably going to get fired; he always seems	Anxiety and disappointment	Get prepared for first client.

		agitated	down on me. I need a drink.	in self	
June 1	5:30 PM	Driving for 1½ hours in traffic	I am so mad at those stupid drivers. I deserve a drink when I get home. What a day!	Anger, frustration	Listen to upbeat music.
June 6	7:30 PM	Confrontation with wife	I don’t know what I’ll do if she leaves me. I won’t be able to go on. If I could only have a drink, I would have more confidence to convince her to stay.	Sadness, desperation	Go outside, walk around, and prepare what to say.

Coping Strategies

The self-monitoring chart also helps Thomas become aware of the critical times when he makes a decision to drink and the alternative responses that help him resist. Thomas and his counselor brainstorm alternative behaviors for different high-risk situations and together determine several effective coping strategies for each. During future sessions, the counselor sets up a variety of situations and has Thomas rehearse these strategies.

For example, Thomas becomes aware that the stress of driving in rush-hour traffic usually results in an overwhelming urge to have a drink. After brainstorming alternatives, Thomas realizes that he could use this time to unwind after his work by listening to music that produces a good mood. In addition, his counselor helps him to recognize his dysfunctional thinking during this

situation. He has a tendency to blame the other drivers ("He cut me off on purpose. These stupid drivers need to get out of my way"), which increases his stress. He is helped to change to a healthier, less stress-inducing way of thinking, such as "All the drivers are trying to get home just like me. They didn't single me out to cut off." Thomas practices these strategies during counseling sessions by visualizing driving in traffic, listening to upbeat music, and thinking the more rational thoughts. This process teaches him to recognize his triggers, develop coping strategies, and use cognitive-behavioral techniques to change his dysfunctional thinking to minimize relapse (Gorski, 1993).

Lapse and Relapse Prevention Techniques

Also during the initial stage, the counselor teaches Thomas about lapses (single episode of use) and relapses (return to uncontrolled use). Although told that lapses and relapses are common, he is encouraged to use the knowledge gained from lapses to identify precipitating events and better coping strategies. In this way, lapses are reframed as learning experiences that can help prevent relapses. This view reduces the guilt, anxiety, and doubt that are often felt after a lapse and eliminates any moral injunctions against the client (Lewis, Dana, & Blevins, 1994).

The reframing of lapses as a learning experience can also help Thomas to dispute the "all or nothing" belief. Many times people with addictive behaviors have the irrational belief that if they slip one time then their situation is hopeless and they might as well give up, which leads to a total relapse. This was referred to previously as the abstinence-violation effect (AVE) where the client believes that absolute abstinence and complete loss of control are their only options. When viewing lapses as a normal part of the recovery process from which he can learn, Thomas realizes that he can regain control. This sense of control then leads to self-efficacy, enabling him to believe that he can have control in similar future situations.

At this time, the counselor provides several strategies to help in reducing lapses. Thomas is given a therapeutic contract to sign, which states that he agrees to leave the situation when a lapse occurs (Marlatt, 1985). This gives him a “time out” and limits the extent of alcohol use at the time of the lapse. Also, the counselor and Thomas work together to construct reminder cards of specific steps to take, as well as a list of support people to call (including their phone numbers). The cards may also include positive statements, such as “Remember, you are in control,” “This slip is not a catastrophe. You can stop now if you choose,” and “Visualize yourself in control.” Thomas commits to using these strategies immediately following a lapse.

A counseling session soon follows during which Thomas reports a lapse and describes the situation. He describes his week as being extremely difficult, with problems at work as well as a major argument with his wife. He leaves his house Saturday morning, still angry after the disagreement on Friday evening, and decides to visit one of his friends. Thomas admits knowing this was a dangerous thing to do as the friend was one of his “drinking buddies.” He states that his feelings of anger and frustration were overwhelming and “it just didn’t matter.” After a few beers, while Thomas was alone in the restroom, he remembered the card. He read the positive reminders and remembered the long-term versus the short-term consequences of drinking. He thought about the consequence of possibly losing his wife if he continues to drink and remembered the contract he has signed to leave immediately after the lapse. Thomas then tells his friend one of his rehearsed excuses and makes a quick exit. At the end of the session, the counselor helps Thomas to explore what he learned from this event and encourages feelings of self-efficacy.

Afterward, the counselor examines the situation for treatment gaps. She realizes that Thomas needs more work in handling negative emotions. During subsequent sessions, they return to

the brainstorming stage so that he can learn (or be reminded of) coping strategies to use when he is angry, agitated, or depressed. Also, his support system is re-examined to determine the best person or group to go to for help when he is experiencing intense emotions.

Support Systems and Lifestyle Changes

Thomas and his counselor further examine his support system. Thomas has attended a 12-step program for several months, and although these meetings have provided him with a way to meet nonusing people, it is essential that he have a system of support outside the meetings. With a system of nonusing friends and family, the possibility of relapse is much less likely.

Thomas's wife has been supportive of him since he entered treatment and has attended a family treatment program independent of Thomas's program. Although emotionally disengaged in the beginning, she has made gains in reconnecting with Thomas, as she sees him showing a commitment to maintaining sobriety. Also, because Thomas reported that communication was a major problem in his marriage, he and his counselor have worked on developing skills and role-playing communication between him and his wife.

(It is important to mention here that although the involvement of the family is critical in relapse prevention, the process is not simple. The principle of family homeostasis must be considered when working with close family members. Central to this principle is the idea that when one member of the family experiences change, the other members will be affected and adjust in some manner [Jackson, 1957]. Boundaries, roles, and rules will need to be reorganized to establish a new sense of balance.)

Thomas's wife had taken on the role of main provider and was seen as the strong person in the family. Emotional roles were present, also, with Thomas being the angry one and his wife being the sullen, stoic one. Rules revolved around communication and sexual activity. Since

Thomas's wife had become emotionally disengaged, she limited both communication and sex with him so as to avoid any sense of intimacy. As Thomas practiced sobriety and the will to be committed to his program, his wife was able to gradually become somewhat more open to both communication and sexual activity. However, the fear of being hurt again continues to cause her to withhold herself to some extent.

The issue of having a system of nonusing friends is important to Thomas not only for support but for companionship in recreational activities. Because Thomas's drinking has taken precedence the past few years, his only friends have been his drinking friends, and he has cultivated little interest in any activities outside of work. The counselor helps Thomas to establish a list of activities he thinks he would enjoy and would like to pursue. At the top of his list is working out at the gym. Since he and his wife have a family membership, he is able to begin right away and finds that working out actually produces a feeling of accomplishment and well-being. He establishes a friendship with a trainer who works at the gym, as well a couple of men who attend the gym at the same time.

These friendships provide social modeling for Thomas, who sees their interest in health and fitness as something he wishes to emulate. Social modeling can often be a strong motivator in changing individual behavior. Thomas perceives these individuals as having positive traits he wishes to acquire, and their personal encouragement helps him to develop an improved self-concept.

Along with the need to acquire healthy relationships and activities is the need to change old friends and unhealthy environments. This becomes an important focus during treatment. Thomas has several friends he refers to as his "drinking buddies" who often call and attempt to persuade him to meet them at their favorite bar. After an outing to the bar results in a 2-month relapse,

Thomas realizes that he can no longer keep these friends and stay sober. During counseling, refusal skills are rehearsed, and Thomas and his counselor role-play different situations that Thomas previously encountered with his friends.

In addition, the counselor helps him explore other environments in which external cues prompt cravings and urges. He learns that being exposed to these cues often leads to a feeling of deprivation and an urge to use. Thomas is instructed by his counselor to determine which cues he can avoid, as well as which ones are more difficult or impossible to avoid. Social outings where others are drinking prove to be a major trigger, or cue, for Thomas. He learns that taking care of himself and maintaining his sobriety is his current priority and that he can decline these invitations without feeling guilty. The counselor also instructs him to remove as many cues as possible from his daily environment to decrease the frequency of his urges and cravings. One such change was as simple as taking a different route home from work so that he did not have to pass his favorite bar.

For unavoidable situations, Thomas is taught other strategies, including body awareness cues and mnemonic devices. Through body awareness techniques, he is able to identify the onset of physical urges to drink. The counselor has Thomas visualize a time when he feels a craving to drink and to give a detailed description of what is occurring in his body. He reports that he first feels his heart rate increase, then his hands start trembling and his mind begins to race. The counselor instructs Thomas to use the onset of these physical signs as a cue to identify an HRS.

At that time, the counselor explains the use of a mnemonic device, or memory aid, to help Thomas recall what he needs to do. An acrostic is given, using the word STOP. His instructions are to use each letter to evoke a reminder of his plan. “S” stands for “situation”—be aware of the high-risk situation; “T” stands for “think”—think about what I need to do; “O” is for “options”—

recall the different options or strategies I've rehearsed for this situation; "P" is for "plan"—proceed with plan.

Other Lifestyle Changes

All areas in a client's life that could possibly lead to relapse need to be approached eventually during therapy. From the beginning, Thomas indicates that his job as a salesman is a major stressor. The pressure of having to reach a quota is often a cue for him to have a drink, and he thinks of himself as unsuccessful and inadequate. He and his counselor explore his options, and Thomas decides he needs to find work where he experiences less pressure. He finds an assistant manager position with a different company and, though he takes a salary cut, is relieved that he does not have the stress of meeting a quota.

Because of his employment record and past spending habits, Thomas has financial problems, leading to a huge amount of stress. For once in his life he is attempting to be responsible and remain sober, but creditors are harassing him and he has no money to pay for a broken furnace. Without financial assistance, the likelihood of a relapse is high. Thomas seeks help from his local bank; by consolidating his debt and getting a small loan, he feels capable of getting out from under his financial difficulties.

THE REALITY OF RELAPSE PREVENTION

When reading about the multitude of strategies and interventions involved in treatment of substance abuse, maintaining and preventing relapse may appear to be an overwhelming task. This chapter condenses a case study so that the interventions appear to be introduced at a rapid pace, but in actuality the case extends over many months. Although the counselor had a long list of the lifestyle changes needed to prevent relapse, these changes were prioritized and broken down into small, achievable steps.

To prevent clients from feeling overwhelmed, counselors must present the interventions at a pace at which clients can experience success and build self-efficacy. Realistic goals must be established, and the counselor has to be aware of the danger of having too many “shoulds” on the client’s plate (Fisher & Harrison, 2000). Starting out slowly and finding a balance is important. The stress of clients trying to build their lives too quickly and taking on too much can lead to relapse. The “shoulds” need to be balanced with fun and pleasure. Feelings of resentment and shame are slowly replaced with gratitude and forgiveness (C. Wildroot, personal communication, January 12, 2010).

Counselors and therapists also need to recognize the challenges and complexities of working in this field and should be prepared for responding appropriately to the transference and counter-transference issues that will arise. Sometimes, feelings of anger, frustration, inability to help, or even despair, can be indicators of psychological issues projected by the client, and may provide important clues to how others close to the client (family, friends, colleagues) are also feeling. The best advice is always to have good supervisory support, whether as a treatment team or on a one to one basis, so that the counselor/therapist has space in which to reflect on these issues and respond constructively to them.

Summary and Some Final Notations

Relapse prevention and maintenance are complex and dynamic processes. All clients have their own individual risk factors. Multiple influences contribute to high risk situations—years of dependence, family history, social support, comorbid psychopathology, and physiological states (physical withdrawal). Cognitive factors also affect the risk of relapse, including the abstinence violation effect, level of motivation, self-efficacy, and outcome expectancies. When a person re-

lapses, there is probably not one single distinct cause but rather a multitude of internal and external factors (Marlatt & Gordon, 1985).

In the Relapse Prevention model, cognitive behavioral strategies are taught and practiced. Counselors help clients identify more effective coping strategies to use during high-risk situations. Relaxation skills and mindfulness meditation (Marlatt, 2002) are practiced, and lifestyle changes encouraged. A supportive social network is stressed.

When an individual relapses, the goal of relapse prevention is to lessen the length and severity of the relapse and to decrease the amount of time it takes for the client to stabilize and return to maintenance. An integrated, multifaceted approach (Knack, 2009) provides the tools for the most effective treatment in preventing relapse—including medication, 12-step programs, and cognitive behavioral models. Although there is a high rate of relapse, the good news is that the longer clients maintain sobriety, the less likely they are to relapse.

Useful Web Sites

The following Web sites provide additional information relating to chapter topics:

About.com: Alcoholism & Substance Abuse

http://alcoholism.about.com/od/relapse/Relapse_ Prevention.htm

Addiction Alternatives

http://www.addictionalternatives.com/philosophy/relapseprevention.htm

Dual Recovery Anonymous

http://www.draonline.org/relapse.html

Information for Individuals and Families

http://www.addictionsandrecovery.org

Website of Terence Gorski

http://www.tgorski.com/

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