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Relapse Prevention

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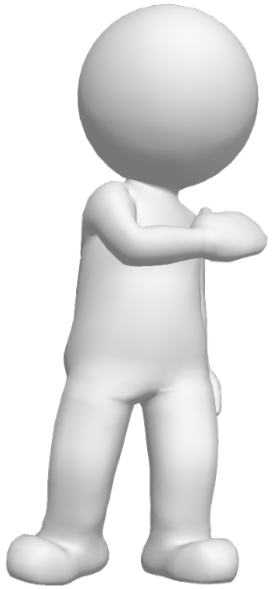
- Points of views or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Learning Objectives

At the end of this session, my goals are that you:



1. Understand the basic features of the Relapse Prevention (RP) model
2. Understand the basics of how RP works to address SUDs
3. Understand some of the strengths and weaknesses of the RP model

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Relapse Prevention (RP) in Context

- At core, all treatments for Substance Use Disorders (SUDs) are designed to prevent relapse
- RP refers to a specific intervention within:
- Cognitive Behavior Therapy (CBT), a psychosocial treatment with an extensive and constantly expanding evidence base across a wide variety of disorders, conditions, and syndromes

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History of RP

- RP was initially developed by G. Alan Marlatt in the 1980s (just one of many wonderful things to come out of the 1980s)
- RP is based on CBT and Bandura's Social Learning Theory

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History of RP, cont.

- RP has become very influential and widely practiced
- Typically when researchers and practitioners refer to CBT approaches to SUDs, they are referring to RP or an approach related to or based on RP

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History of RP, cont.

"RP has in many ways evolved into an umbrella term encompassing most skills-based treatments that emphasize cognitive-behavioral skills building and coping responses."

(Hendershot et al., 2011, p. 2)

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Is RP Evidence-Based?

- RP has a solid record of support in the literature, and the newer Mindfulness-Based RP (MBRP; more on that later) appears to be at least as effective (see Hendershot, 2011 for a review of relevant studies)
- RP may not be as effective with minority populations

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So what exactly is RP?

RP is a skills-based approach to treatment that involves clinicians working collaboratively with their clients to:

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So what exactly is RP?

- Identify specific risk situations and triggers that place clients at greater risk of relapse. These risk situations and triggers are both internal (e.g., self-talk, cravings) and external (e.g., people, places, and things that the client has associated with substance abuse in the past) and to:

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So what exactly is RP?

- Develop specific cognitive (e.g., positive self-talk, reframing) and behavioral (avoiding certain physical environments and individuals) strategies to address high-risk situations, which:

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So what exactly is RP?

- Over time as they result in increasing efficacy, lead to increased confidence and effective coping skills and strategies to handle difficult internal (e.g., emotional) and external (e.g., people, places, and things) experiences without reverting to substance use

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Four Central Ideas* in RP

1. **Relapse is a gradual process with identifiable stages, events, and experiences**

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*Melemis, 2015

Four Central Ideas in RP

2. **Recovery is a process of personal growth and development that, similar to relapse, is also marked by identifiable stages and events/experiences**

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Four Central Ideas in RP

3. **The primary mechanisms for change in RP are CBT methods and, in Mindfulness-Based Relapse Prevention (MBRP), mind-body relaxation**

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Four Central Ideas in RP

4. **The majority of relapses can be explained and understood with reference to a few basic rules, which are the Five Rules of Recovery** (Melemis, 2015)

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Three Stages of Relapse

While Gorski posits 11 phases of relapse, Melemis (2015) identifies three stages:

1. Emotional
2. Mental
3. Physical

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Stage 1: Emotional

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The emotional stage is characterized by:

denial; bottling up of emotions; isolating oneself from others; focusing on others' rather than one's own issues; and poor self-care habits

Stage 2: Mental

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The mental stage is characterized by: ambivalence regarding change; recalling people, places and things associated with using; minimizing bad consequences and glamorizing positive feelings associated with using; lying; looking for opportunities to relapse; and planning a relapse

Stage 3: Physical

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The physical stage is characterized by: an event wherein the individual resumes using – defined as an initial lapse, which when followed by the Abstinence Violation Effect (AVE), transitions to a relapse which is defined as a return to uncontrolled use

The Objective of RP

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- The objective behind RP is to work with clients to help them recognize the early signs and stages of relapse and apply appropriately matched interventions, which are more likely to be successful in the early stages before significant momentum builds up
- RP is not simply saying no just before using; it is an attempt to understand the process of relapse and to institute interventions in the early states of the relapse process

Five Rules of Recovery in RP

1. You have to change your life by creating a new life where it is easier not to use than it is to use (the good lives model old me/new me distinction)
2. Be completely honest with yourself and others
3. Ask for help
4. Practice appropriate and effective self-care routines, such as employing healthy coping responses
5. Don't break these rules!

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How does RP work?

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- RP is necessarily collaborative – the client knows his or her situations, patterns, risks and triggers very well, while the clinician knows how to use this information to understand how they work together and how to use the information to help the client prepare a plan to address them moving forward

How does RP work?

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Identify high-risk situations (aka triggers)

- People
- Places
- Things
- Internal experiences (e.g., cravings, automatic thoughts, negative emotions)
- Lifestyle factors, patterns, habits, associations

How does RP work?

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Address clients' tendency to focus on the perceived benefits of using rather than the actual negative consequences of substance abuse through a realistic reframing of these experiences – this is a process referred to as cognitive restructuring

How does RP work?

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Work together with the client to develop and implement a new set of coping skills and resources (referred to as interventions) that address specific high-risk situations

How does RP work?

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- Expect emergencies and lapses and work together to develop and implement ways of dealing with them
- Work on increasing perceived efficacy based on “successive approximations” and real-world victories, small and large

RP Techniques

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Cognitive restructuring - confronting cognitive distortions and automatic thoughts as follows:

- Asking what evidence supports specific problematic thoughts
- Asking if there are alternative perspectives that may more accurately represent reality
- Replace the distorted thoughts with the more accurate thoughts

Cognitive Distortions (CDs)

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Examples of common cognitive distortions among persons with SUDs (Melemis, 2015):

- I use because of other people in my life
- I cannot navigate through life without using
- I don't need to stop completely - I can control my use
- I will not enjoy life unless I am using
- People will not like me sober
- I can't resist my cravings
- I can't avoid the people, places, and things I associate with using – they are all I have

RP Techniques

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Role plays

Provide real-world practice

(the B in CBT)

Homework

Provide additional real-world practice:

Journaling, worksheets (e.g., the Daily Record of Dysfunctional Thoughts)

RP Techniques

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Understand each client's unique paths to relapse, including specific internal and external triggers

Develop an individualized RP Plan to address specific triggers with interventions appropriate to the state of relapse (emotional, mental, physical)

Types of Interventions

- Cognitive (changing self talk)
- Behavioral (going to a meeting)
- Relational (talk to your sponsor)
- Environmental (go elsewhere)
- Desperate Measures (whatever you need to do to avoid a relapse)

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RP Terms

- High Risk Situation
- Seemingly Unimportant Decision
- Problem of Immediate Gratification
- Lapse
- Abstinence Violation Effect
- Relapse

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Case Example - Susan

Susan had lap-band surgery nine months ago and has been attending a weekly self-help group and adhering to a very strict diet to address her chronic obesity. She works in a high-rise office building downtown, and commutes via public transportation. Through diligence and hard work she has lost 60 pounds since her surgery. One Monday she arrives at work after a week's vacation to find that there is to be a retirement party for a valued coworker, immediately after work. Each attendee is to bring refreshments. She can't get home or to a supermarket to purchase something healthy. There's a fancy bakery on the corner of her building, which she goes significantly out of her way to avoid whenever she enters or leaves the office building.

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Case Example – Susan, cont.

Susan thinks to herself that the bakery is her only option for refreshments, and that it will only take her 10 minutes to run down to the bakery, pick up a dozen pastries, and return to the office in time for the party. As the end of her workday she goes down to the bakery, where the sights and smells of the pastries remind her of just how much she loves French cuisine. She waits in line, looking at the beautiful pastries, cakes and cookies behind the counter and in all the surrounding display cases. When it is her turn in line, she picks out twelve of her favorites and is told that she gets one more – a true baker's dozen.

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Case Example – Susan, cont.

Susan leaves the bakery and thinks to herself that she can have just one, as nobody will know she got 13 and not 12 pastries. She goes to the courtyard on the ground floor of her office building, finds a shady spot at a bench where she used to eat lunch prior to her surgery, and opens the box of pastries. Susan remembers how good she used to feel while enjoying her favorite foods at this very spot. She picks out her favorite pastry, eats it, and is immediately overwhelmed with guilt and shame. She tells herself that rather than experiencing a failure she ***IS*** a failure. She eats another and another, feeling more ashamed with each pastry she consumes. Susan skips the retirement party, goes home, and experiences a period of relapse that sees her gain back 15 pounds.

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Case Example – Susan, cont.

- Identify Susan's:
  - High Risk Situations
  - Seemingly Unimportant Decisions
  - Problem of Immediate Gratification
  - Lapse
  - Abstinence Violation Effect
  - Relapse

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Case Example – Susan, cont.

- What are some specific RP interventions Susan could have used?
  - Cognitive
  - Behavioral
  - Relational
  - Environmental
  - Desperate Measures

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Newer Formulations of RP

- Mindfulness-based RP (MBRP): adds mindfulness concepts and practices such as meditation to be more aware of cravings and unpleasant emotional experiences, reframe them from being "bad" or signs of failure and not things that must be reacted to
- Reformulated Cognitive-Behavioral Model of Relapse – useful for understanding the dynamic aspects of the relapse process
- Incorporation of genetic and neuroscience findings regarding the relapse process

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Challenges to RP

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Positive approaches (e.g., The Good Lives Model)

- RP is an avoidance model – the focus is on avoiding certain internal and external experiences. We also need approach models for a more holistic approach to meeting our shared motivations and drives.

RP assumes the client is motivated to avoid substance abuse

- This assumption is often not met, at least initially
- Motivation enhancement techniques such as Motivational Interviewing (MI) and specific modules

Resources

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