Chapter 29

Relapse Prevention Therapy

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Synopsis

What follows is the second of two chapters devoted to a cognitive-behavioral approach to the treatment of alcohol abuse and dependence. In Chapter 28, we provided an overview of this therapeutic approach by placing it within a typology of conceptual models, summarizing the main principles of cognitive-behavioral alcohol treatment and reviewing both cognitive and behavioral assessment and intervention techniques that are the constituent ingredients of this empirically-supported form of therapy. The goal of this chapter is to present an overview of a cognitive-behavioral approach to the problem of relapse, relapse prevention therapy (RPT).

The chapter begins by introducing a conceptual model of relapse prevention and discussing the cyclical nature of long-term behavioral change. From this perspective, relapse is a natural part of the process of change and does not represent failure. Rather, lapses or relapses represent opportunities for clients to gain a greater understanding of their unique challenges in changing drinking behavior and to learn new skills to better cope in the future. High-risk situations represent difficult circumstances in which goals of abstinence or moderation may be tested. Common across a range of addictive behaviors, they can be broadly described as interpersonal or intrapersonal situations in which one's sense of control is threatened. The process of relapse, from the experience of high-risk situations to an initial lapse, is then presented. Positive outcome expectancies regarding the effects of alcohol, degree of self-efficacy and the acquisition of effective coping skills all play a role in this process. Additionally, when a lapse occurs there is often an abstinence violation effect, composed of guilty feelings and a sense of inherent powerlessness, which can interact with these other factors and trigger a relapse. A client may unknowingly contribute to a relapse through several covert antecedents that lead him/her to a high-risk situation. For example, the desire for the pleasurable effects of alcohol, a lack of life-style balance, the experience of urges and craving, and cognitive factors such as rationalization, denial and apparently

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irrelevant decisions, all may represent links in the chain leading up to a relapse. A thorough analysis of a relapse experience will reveal these steps and contribute to a greater understanding of the relapse process.

RPT intervention strategies are then discussed. Specific RPT strategies are designed to address the immediate precursors of relapse and include assessment of high-risk situations and coping skills, training of new coping skills, challenging positive outcome expectancies associated with alcohol use, and coping with lapses and the abstinence violation effect. Global RPT strategies are focused on broader issues of life-style balance and awareness of covert determinants of relapse. These include an assessment and emphasis on life-style balance, coping with the desire for indulgence through substitute indulgences, coping with cravings for alcohol and urges to drink, and coping with cognitive distortions to minimize the likelihood of relapse. Finally, two empirical reviews of RPT are discussed. Both support the use of RPT as an effective treatment for alcohol problems.

THE NATURE OF RELAPSE

What is the best way to conceptualize the *maintenance stage* of habit change? One approach is to consider the maintenance stage as a period following treatment and successful abstinence or moderation, during which therapeutic effects wear off over time. In this theory of treatment decay, one would expect the risk of relapse to increase over time as treatment effects wear off. Therefore, booster sessions of alcohol treatment are typically recommended to bolster the lagging effects of the initial therapy. Relapse prevention therapy (RPT) provides an alternative view of the maintenance stage of habit change as an opportunity for new learning to occur. Since drinking is a learned behavior from a cognitive-behavioral point of view, the maintenance stage can be conceptualized as a time to practice "unlearning" old drinking behaviors and replacing these previously dominant responses by experimenting with new learning. Using this theoretical model, one would expect the risk of relapse to decrease over time as clients learn to avoid errors and to acquire and more firmly establish new responses related to alcohol.

In RPT, quitting drinking or exerting control over alcohol consumption is like embarking on an extended journey, with the act of departure (quitting or moderating) only the first of many steps (see discussion of stages of change in Chapter 28). If clients and therapists believe that habit change is successful once drinking has ceased or is moderated, little attention and effort will be placed on the demands of the perilous journey of maintaining change ahead. From a stages of change perspective, after a client has made a successful change in drinking behavior, usually through a series of advances and setbacks, the focus shifts to the stability of the changes achieved. In the maintenance stage, therapeutic gains from the action stage will be consolidated and clients will attempt to identify and implement strategies to avoid relapse. During the first 90 days, when rise of relapse is highest, a client must work hard to maintain his/her motivation and commitment to the ultimate goal of abstinence or sustained moderation. Research has demonstrated that most of the variance in long-term treatment outcome can be attributed to events that occur *after* the action stage, or *after* treatment has been completed (Cronkite & Moos, 1980). This research underscores the need for RPT during both the action and maintenance stages of change and the need for aftercare and social support following the termination of alcohol treatment.

Failure to maintain the changes achieved during the *action stage* of change may lead the client to the *relapse stage*. Although traditionally viewed an indication of treatment failure or the gradual extinction of treatment effects, a cognitive-behavioral view of relapse conceptualizes it as a fluid and dynamic process that is best understood as a natural transition

in the habit change process. Relapse prevention and relapse management strategies are necessary at the action, maintenance and relapse stages in order for habit change to be successful in the long run. Cognitive-behavioral *relapse prevention strategies* are designed to cope with the high-risk situations that precede a slip or lapse and *relapse management strategies* are designed to prevent a slip or lapse from becoming a full-blown relapse.

Since change is a cyclical process, most clients will not be completely successful on their first attempt to alter their drinking behavior. Therefore, RPT is also designed to teach clients not to be demoralized or to view relapse as a failure, but to re-ignite their motivation and commitment to change and to risk beginning the journey again. The lessons learned from each lapse or even relapse may bring clients closer to stable maintenance if they are viewed as opportunities to learn, rather than failures, dead ends, or an indication that the disease of alcoholism is incurable.

HIGH-RISK SITUATIONS FOR RELAPSE

After a client completes treatment, he/she experiences a sense of perceived control while maintaining abstinence from drinking or a moderated level of alcohol consumption. The longer the period of successful abstinence or moderation, the greater the individual's perception of control and self-efficacy is likely to be. Abstinence or moderation will usually continue until the person encounters a *high-risk situation* or *relapse trigger*. A high-risk situation is defined as any internal or external event or factor that poses a threat to the individual's sense of perceived control or ability to cope with the immediate situation or its subjective consequences (e.g. elicitation of negative emotions).

In an analysis of 311 initial relapse episodes obtained from clients with a variety of addictive behavior problems (alcohol, smoking, heroin addiction, compulsive gambling and overeating), three high-risk situations were identified that were associated with almost three-quarters of all the relapses reported: negative emotional states, interpersonal conflict, and social pressure (Cummings et al., 1980). Overall, these high-risk factors can be more specifically divided into *intrapersonal* and *interpersonal* determinants. *Intra*personal determinants refer to those precipitating factors that do not require the presence of another person and include negative emotional states, negative physical states, positive emotional states, testing personal control and urges and temptations. *Inter*personal determinants refer to those precipitating factors that require the current or recent presence of another person and include interpersonal conflict, direct and indirect social pressure, and positive emotional states experienced in social settings.

THE RELAPSE PROCESS: THE PATH FROM HIGH-RISK SITUATIONS TO RELAPSE

If a client has learned and can implement an effective coping response to deal with a high-risk situation (e.g. assertiveness in response to direct social pressure, or relaxation to reduce anxiety and tension), the probability of relapse may decrease significantly (see Figure 29.1). The RPT model proposes that when a person copes effectively with a high-risk situation, he/she is likely to experience an increased sense of mastery and a perception of self-control or self-efficacy. The concept of *self-efficacy* (Bandura, 1977, 1997) refers to an individual's expectation concerning his/her capacity to cope effectively with a specific situation or a particular task. As the duration of abstinence or moderation increases, clients have the experience of coping effectively with one high-risk situation after

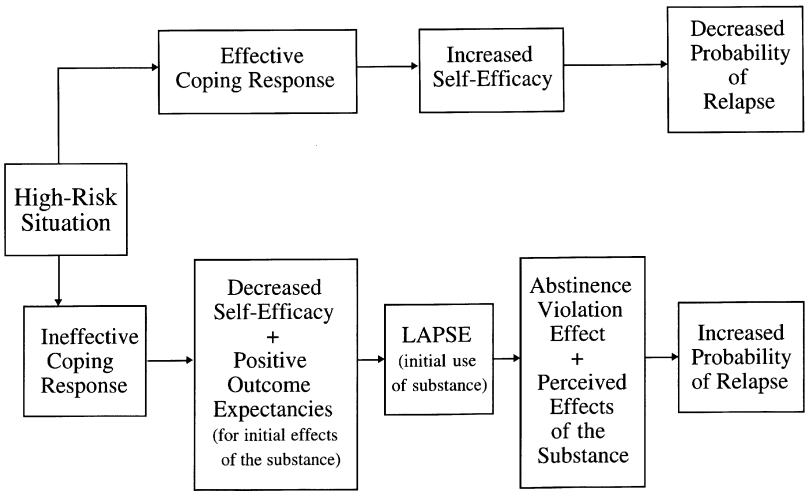

Figure 29.1 A cognitive-behavioral model of the relapse process

another. However, what happens if a client has not learned or cannot execute an effective coping response when exposed to a high-risk situation? The RPT model predicts that failure to effectively cope with a high-risk situation is likely to create decreased self-efficacy and possibly engender a sense of helplessness and powerlessness to cope with other life demands.

As self-efficacy decreases, clients are likely to focus more narrowly on the anticipated immediate positive effects of drinking, especially if they recall that alcohol helped them cope in the past. Attraction to the immediate gratification of excessive drinking becomes dominant in a person's mind and the reality of the delayed negative effects of drinking fade. Research has demonstrated that positive outcome expectancies for the effects of alcohol are potent determinants of excessive use (Marlatt & Rohsenow, 1980). The combination of being unable or unwilling to cope effectively with a high-risk situation, combined with positive outcome expectancies for the effects of drinking, greatly increases the probability of an initial lapse or slip.

After a lapse has been experienced, many clients may experience a further decrease in self-efficacy coupled with the tendency to give up trying to cope and give in to further temptations to continue to drink. To account for this reaction to the transgression of an absolute rule, we have proposed a mechanism called the *abstinence violation effect* (AVE) which is termed the *rule violation effect* (RVE) when applied more broadly to moderation as a goal (Marlatt & Gordon, 1985). The AVE is characterized by two key factors: *cognitive dissonance* (a discrepancy between one's identity as an abstainer and one's current drinking behavior) and an *attribution* of the cause of the lapse to *internal uncontrollable factors* (blaming oneself for lack of willpower). The final factor to be considered concerning the immediate determinants of relapse is the initial intoxicating effects of drinking alcohol experienced by the person following the lapse or slip. It is likely that the immediate outcome of drinking will be a "high" or euphoric state (positive reinforcement) or perhaps a reduction in any negative emotional or physical states (negative reinforcement). These initial effects of the lapse interact with the AVE to further increase the probability of relapse by priming the person to continue engaging in excessive drinking.

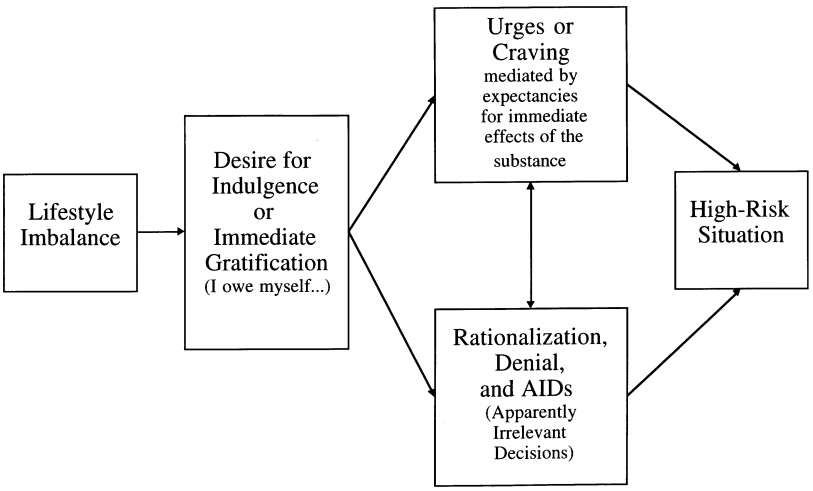

Figure 29.2 Relapse set-ups: covert antecedents of relapse situations

RELAPSE SET-UPS: COVERT ANTECEDENTS OF RELAPSE

In many, perhaps most, relapse episodes, clients report they were not expecting a high-risk situation to occur or were not well prepared to cope effectively with it when it did occur. Usually, after extensive debriefing and analysis of relapse episodes, the lapse or subsequent relapse appears to be the last link in a chain of events that preceded exposure to the high-risk situation itself. It seems as if, perhaps unknowingly, even paradoxically, the client has set him/herself up for relapse (see Figure 29.2).

Why would a person set him/herself up for relapse? The immediate gratification of drinking is a welcome relief from the relative deprivation of abstinence or the restraints of moderation and the individual may believe that it is difficult to cope with life's demands without excessive drinking. For many clients, the instant gratification of excessive drinking may outweigh the cost of any anticipated future negative consequences. Cognitive distortions, such as denial and rationalization, make it easier to set up one's own relapse episode with the added benefit of not having to take responsibility for it.

Research studies and clinical experience suggest that the degree of balance in a person's daily life has a significant impact on the desire for indulgence and immediate gratification. *Life-style imbalance* is the first covert antecedent in a chain of events that can lead to a relapse set-up. A key aspect of life-style balance is the number of daily activities perceived as required by external demands, or *shoulds*, and those activities perceived as engaged in for enjoyment and pleasure, or *wants*. If shoulds are much greater that wants, a client may experience a sense of relative self-deprivation and a corresponding *desire for indulgence* or immediate gratification. More broadly conceived, life-style balance refers to the amount of stress in a person's daily life compared with stress-reducing activities, such as social support, exercise or meditation.

Relapse set-ups are also caused by affective and cognitive processes that mask a client's actual intentions and move the client closer to a high-risk situation. Affectively, the desire for indulgence may be experienced as an urge or craving for alcohol. An urge is defined as

the relatively sudden impulse to engage in a pleasurable act. Craving is defined as the subjective desire to experience the expected effects of a given behaviour. While the disease model of alcoholism views craving as a result of acute withdrawal or an internal physiological need for alcohol, the RPT model recognizes that both craving and urges may also be elicited by conditioned environmental cues associated with withdrawal or past alcohol use and that urges and cravings are mediated by the expectation of immediate pleasure or reduced pain associated with drinking (Rohsenow et al., 1994).

In addition to affective processes, covert antecedents of a relapse episode are influenced by three cognitive factors: rationalization, denial, and apparently irrelevant decisions (AIDs), which are associated with the chain of events preceding exposure to a high-risk situation. A *rationalization* is an explanation or an seemingly legitimate excuse to engage in drinking behaviour. *Denial* is a similar defense mechanism in which an individual will deny the existence of any motive to engage in a drinking and may also deny awareness of the delayed negative consequences of resuming excessive drinking. Both rationalization and denial are cognitive distortions that occur with little awareness and may promote a client's covert planning of exposure to a high-risk situation. AIDs stand for a number of mini-decisions made over time, each of which seems innocent or irrelevant to relapsing in and of itself (e.g. a man decides to visit his old friends at the neighborhood bar) but in combination bring the client closer to exposure to a relapse triggering high-risk situation. One of the primary goals of RPT is to train clients to recognize *early warning signs* that precede exposure to a high-risk situation, and to execute intervention strategies before it is too late to do anything and the temptations in the high-risk situation become too compelling to resist.

RPT INTERVENTION STRATEGIES

RPT intervention strategies represent a menu of treatment alternatives aimed at both the immediate and covert aspects of relapse that can be individually tailored to various clinical populations, to particular addictive behaviors including alcohol dependence, and to different treatment settings. These strategies can be grouped into three categories: coping skills training, cognitive therapy and life-style modification. *Coping skills training strategies* include behavioral and cognitive techniques to effectively cope with high-risk situations and to enhance self-efficacy. *Cognitive therapy* procedures are designed to provide clients with ways of reframing the habit change process (i.e. to view it as a learning process and as a journey), to correcting cognitive distortions and to introduce coping imagery to deal with urges and craving. Finally, *life-style modification* strategies (e.g. meditation, exercise, spiritual practices) are designed to strengthen the client's global coping capacity and to reduce the frequency and intensity of the desire for indulgence and the experience of urges and craving.

Initially, RPT assessment and intervention strategies are designed to teach clients to anticipate and cope with the possibility of relapse. Clients are taught to recognize and cope with high-risk situations that may precipitate a lapse and to modify cognitions and other reactions to prevent a single lapse from developing into a full-blown relapse. Because these procedures are focused on the immediate precipitants of the relapse process, they are referred to collectively as *specific intervention strategies* (Figure 29.3). As clients master these techniques, clinical practice extends beyond a microanalysis of the relapse process and the initial lapse and involves strategies designed to modify the client's life-style and to identify and cope with covert determinants of relapse (early warning signals, cognitive distortions and relapse set-ups). As a group, these procedures are called *global intervention strategies*.

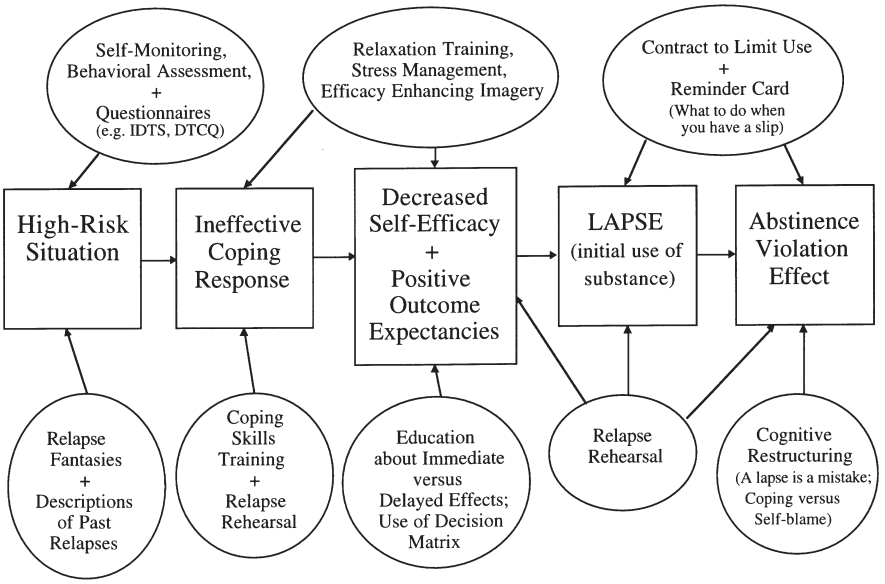

Figure 29.3 Specific relapse prevention therapy intervention strategies

SPECIFIC RPT INTERVENTION STRATEGIES

Assessment of High-risk Situations

Autobiographies

One of the first homework assignments in RPT is for clients to write a brief autobiography describing the history and development of their alcohol problem. Clients are asked to focus on their subjective image of themselves as they progressed through the stages of habit acquisition leading to alcohol abuse or dependence. The following points are emphasized: a description of parental and extended family alcohol and drug use habits, a description of the first episode of drinking to drunkenness, the role of alcohol and drugs in the client's adult life up to the present, factors associated with any increases in the severity of the client's drinking problem, the self-image of the client as a drinker, and any previous attempts to quit or moderate on one's own or with the assistance of treatment. The purpose of this technique is to identify high-risk situations and to get a baseline assessment of the client's self-image while engaging in excessive drinking. Clients are also asked to write a brief essay describing their future as an ex-drinker or a moderate drinker.

Past Relapses

Most clients in treatment will have tried either on their own or in previous treatment to abstain from alcohol or moderate their use. Asking clients to describe past relapses may provide important clues to future high-risk situations and deficits in coping skills. The therapist and the client can classify the descriptions of past relapses into the categories previously presented in order to determine the situational or personal factors that had the

greatest impact. It is also useful to determine the client's attitude toward these past "failures" to remain abstinent or to drink moderately, because many clients develop negative attitudes toward future change attempts, based on attributions that they have a deficit in willpower or self-control. *Cognitive reframing* of past relapses will be necessary to reduce the client's fear of the prospect of yet another failure. The therapist can encourage the client to attribute past relapses as due to a lack of skill or effort, not to immutable internal factors.

Relapse Fantasies

This guided imagery technique involves asking the client to imagine as vividly as possible what it would take to resume drinking. Clients are asked to repeat this technique either in a therapy session or on his/her own as homework for as many possible relapse scenarios as he/she can envision. If a client denies that relapse is a possibility or has difficulty using his/her imagination, the therapist and client can brainstorm together, perhaps using any past relapses as a guide. Questionnaire techniques to be described below can also be used to gain a better understanding of a client's unique profile of high-risk situations.

Self-Monitoring

When clients who are still drinking alcohol or using drugs enter therapy, prior to quitting they are asked to self-monitor their use on a daily basis by keeping track of drinking, the situational context in which it occurs, and the immediate consequences of the behaviour. In most cases, RPT programs are initiated after abstinence or moderation has been achieved by some means. In this situation, self-monitoring of tempting high-risk situations for excessive drinking is a useful technique. Clients are asked to keep track of exposure to situations or personal factors that cause them to have urges or craving to resume drinking excessively.

Questionnaires for Assessing High-risk Situations

The *Inventory of Drug-Taking Situations (IDTS)* developed by Annis, Turner & Sklar (1997b) is a 50-item self-report questionnaire which provides a profile of a client's high-risk situations by measuring those circumstances in which a client has used alcohol heavily in the past year. Clients are asked to indicate their frequency of heavy drinking in each of 50 specific situations. The eight high-risk categories previously described are divided into three areas: *negative situations* (unpleasant emotions, physical discomfort, conflict with others), *positive situations* (pleasant times with others, pleasant emotions), and *temptation situations* (urges and temptations, social pressure to use, testing personal control). Research has documented the utility of the IDTS as a reliable and valid instrument for helping therapists and clients recognize situations in which the client has had alcohol problems in the past and to begin working on acquiring coping skills specific to those situations.

Another excellent tool for assessing a client's specific high-risk situations and coping deficits is the *Substance Abuse Relapse Assessment* (SARA) (Schonfeld, Peters & Dolente, 1993). This structured interview technique based on the RPT model yields the frequency and pattern of substance use for the 30 days preceding the last use of the substance; has the client describe the antecedents of substance abuse including places, activities and companions; assesses coping skills; identifies the most problematic substance in the client's lifetime; identifies the consequences of substance use; and, in a final section, describes the client's responses to previous slips or lapses. SARA also provides the client and therapist with instructions on how to develop an individualized substance abuse behavior chain.

Assessing Coping Skills

The Situational Competency Test (SCT)

The SCT is a role-play technique developed by Chaney, O'Leary & Marlatt (1978), requiring clients to give a verbal response to a series of high-risk situations presented by a narrator on audio tape. The client is presented with a series of high-risk scenarios drawn from the categories of high-risk situations previously described. In the initial use of the SCT, four scoring measures were used: *latency, duration, compliance* and *specification of new behavior*. *Latency* is defined as the elapsed time from the termination of the recorded situation to the beginning of the subject's verbal response. *Response duration* is taken as the frequency of words in the response. *Compliance* is a dichotomous score indicating whether or not the subject gave in to the situation without attempting to engage in an alternative coping response.

Specification of new behavior is also a dichotomous score indicating whether the description of the problem-solving behavior or coping response was given in enough detail for someone else to be able to use the description as a guide to perform the behavior. This technique is a good way to assess coping skills deficits and to begin the process of coping skills training.

Coping Skills Training

Stimulus Control

This behavioral technique is particularly important in the early phase of the maintenance stage of habit change, before self-efficacy has increased and before new, more effective coping skills for handling high-risk situations have been learned. The situational cues previously associated with drinking are likely to create craving, urges and temptations to resume the old pattern of excessive alcohol consumption. Several stimulus control strategies can be easily learned and applied while more extensive coping skills training is under way. The first option is *avoidance* of those high-risk situations that have been identified in the assessment as having the highest problem potential. While this my not be practical in all cases, there are many situations that can be avoided with some forethought and vigilance. Where avoidance is not possible, or when a high-risk situation appears to occur unexpectedly, *escape* is the next best option. Some preparation may be necessary to prepare a client with escape plans for the most probable high-risk situations. Finally, if neither avoidance or escape is possible, *delay* of action may be a final stop-gap measure to buy time until escape is possible.

Coping Skills

Once the high-risk situations have been identified, the client can then be taught to respond to these situational cues as discriminative stimuli ("highway signs") for behavior change. The cornerstone of the RPT approach to maintaining behavior change is *coping skills training* (e.g. Chaney, O'Leary & Marlatt, 1978). For clients whose coping responses are blocked by fear or anxiety, the therapist should attempt to disinhibit the behavior through an appropriate anxiety-reduction procedure, such as systematic desensitization or general relaxation training. For clients who show deficiencies in their coping skills repertoire, however, the therapist attempts to teach them new coping skills, using a systematic and structured approach. The RPT approach combines training in general problem-solving ability with specific skill training focused on the client's unique challenges and resources. Adopting a

problem-solving orientation to stressful situations (D'Zurilla & Goldfried, 1971) gives clients greater flexibility and adaptability in new problem situations, rather than having to rely solely on the rote learning of a number of discrete skills that may or may not generalize across various settings and situations. Coping skills training methods incorporate components of direct instruction, modeling, behavioral rehearsal, therapist coaching and feedback from the therapist.

Relapse Rehearsal

Sometimes a therapist and a client can do coping skills training *in vivo*, in which the therapist accompanies the client while he/she is exposed to high-risk situations in real-life settings. However, the therapist can also make use of imagery or role-plays to represent the high-risk situation. This procedure, called *relapse rehearsal*, is similar to the relapse fantasy technique mentioned earlier. In the relapse rehearsal procedure, the therapist goes beyond the imagined scenario of relapse to include scenes in which the client can imagine or practice engaging in appropriate coping responses. This behavioral procedure, known as covert modeling, can also be used to help clients cope with their reactions to a lapse. Relapse rehearsal can be extended into a role-playing procedure, either in individual therapy or in the context of RPT group work.

Stress Management

In addition to teaching the clients to respond effectively when confronted with specific high-risk situations, there are a number of additional relaxation training and stress management procedures the therapist can draw upon to increase the client's overall capacity to cope. Relaxation training may provide the client with an increased perception of control overall, thereby reducing the stress "load" that any given situation may pose for the individual. Such procedures as progressive muscle relaxation training, meditation, exercise and various stress management techniques are extremely useful in aiding the client to cope more effectively with the hassles and demands of daily life.

Assessing Self-efficacy

The *Drug-Taking Confidence Questionnaire* (DTCQ) (Annis, Sklar & Turner, 1997a) is available to measure a client's confidence in avoiding heavy drinking or drug use across the same eight high-risk categories and 50 specific risk situations included in the IDTS. Clients using the DTCQ are asked to imagine themselves in each of the 50 risky situations and to indicate on an accompanying scale how confident they are that they would be able to resist the urge to drink heavily or use a specific drug. Studies of clients' confidence in coping with risky situations have found that clients are less likely to relapse in situations where they have a high level of confidence in their ability to cope. The DTCQ allows therapists to gauge a client's self-efficacy in coping with high-risk situations at different stages in the treatment process, providing a measure of the client's progress.

Enhancing Self-efficacy

In terms of the relapse prevention model, *self-efficacy* refers to the judgments or expectations about one's capacity to cope with specific high-risk situations. Until a high-risk situation is encountered, there is little threat to this perception of control, since urges and

temptations are minimal or absent. If a coping response is successfully performed, the individual's judgment of efficacy will be strengthened for coping with similar situations as they arise on subsequent occasions. Guided imagery can be used to enhance efficacy in a manner similar to relapse rehearsal. In this procedure, the therapist gently guides the client who is experiencing anxiety or having trouble generating successful coping strategies with subtle prompts that can later be internalized by the client. Efficacy-enhancing imagery is used to augment coping skills training and to assess the client's current level of self-efficacy and coping skills mastery.

Challenging Positive Outcome Expectancies

Positive outcome expectancies for the immediate effects of alcohol play an influential role in the relapse process. As a reminder of its potent effects, this phenomenon is called the *problem of immediate gratification* or *PIG*. The image of a hungry and insatiable PIG provides clients with a vivid reminder of the costs of impulsive consumption. Education about both the immediate and delayed effects of alcohol use may help offset the tendency to exaggerate the positive effects of drinking and to minimize its negative effects. A decision matrix can be an important resource to reduce the PIG phenomenon and the myopia of having outcome expectancies that focus only on the immediate positive effects of drinking. The decision matrix cells concerning both immediate and long-term effects of drinking or not drinking can serve as a potent reminder that alcohol use has its costs.

Coping with Lapses and the AVE

The occurrence of a lapse, while not a catastrophe, cannot be viewed as a totally harmless event. It is a moment of crisis that combines both danger and opportunity, with the most dangerous period immediately following the slip. There are several recommended strategies, or *relapse emergency procedures*, to employ whenever a lapse occurs. These can be presented to clients in summary form by the use of a *reminder card* that should be kept handy in the event that a lapse occurs. Since specific coping strategies will vary from client to client, therapists may wish to help a particular client prepare an individualized reminder card that fits that person's unique set of vulnerabilities and resources.

The following strategies for coping with lapse and the AVE are adapted from *relapse prevention* (Marlatt & Gordon, 1985):

1. *Stop, look and listen.* The first thing to do when a lapse occurs is to *stop* the ongoing flow of events and to *look* and *listen* to what is happening. The lapse is a warning signal indicating that you are in danger.
2. *Keep calm.* The first reaction to a lapse may be one of feeling guilty and blaming oneself for what has happened. This is a normal reaction and is to be expected. Give yourself enough time to allow this reaction to arise and to pass away, just like an ocean wave that builds in strength, peaks at a crest, and then ebbs away.
3. *Renew your commitment.* After a lapse, the most difficult problem to deal with is motivation. You may feel like giving up. Think back over the reasons why you decided to change your behavior in the first place. Renew your commitment.
4. *Review the situation leading up to the lapse.* Don't yield to the tendency to blame yourself for what happened. Instead, look at the slip as a specific unique event. Ask yourself the following questions. What events led up to the slip? Were there any early

warning signals that preceded the lapse? What was the nature of the high-risk situation that triggered the slip?

5. *Implement your plan for recovery*. After a slip, you must turn your renewed commitment into a plan of action to be carried out immediately. First, get rid of all alcohol or other stimuli associated with drinking. Second, remove yourself from the high-risk situation if at all possible. If necessary, find an alternative means of gratifying your need for satisfactions.
6. *Ask for help.* Make it easier on yourself if you find that you need help: ask for it! Ask your friends who are present to help in any way they can. If you are alone, call your therapist or AA sponsor and seek out their assistance and support. If you know about a crisis center, give them a call for assistance.

After the lapse has occurred, the client should be reassured that the therapist or RPT group will not censure or blame him/her for the mistake, as often occurs in traditional programs. Instead, clients should receive compassion and understanding, along with encouragement to learn everything possible about how to cope with similar situations in the future through a thorough debriefing of the lapse and its consequences. Clients are taught to review the details of the of the events and thoughts that led to the high-risk situation, to develop and practice new coping responses that are likely to be more effective in future situations, and to reframe their reactions to the slip as an error that is correctable with effort on their part and not as a sign of failure or moral weakness.

GLOBAL RPT INTERVENTION STRATEGIES

Providing clients with behavioral coping skills training and cognitive strategies to effectively cope with high-risk situations and lapses is vital to the success of any relapse prevention program. However, simply teaching clients to cope with one high-risk situation after another is not enough for long-term success in habit change. Even if every situation could be identified, teaching the client to cope effectively with each situation is likely to be time consuming and inefficient. In addition, the coping skills training and cognitive therapy procedures previously described are, by necessity, specific to the situations encountered and their unique cognitive and emotional consequences. In order to develop a more comprehensive and effective program of habit change, it is necessary to: (a) help the clients develop a more balanced life-style in order to increase their overall capacity to cope with stress, as well as incrementally to increase self-efficacy; and (b) teach clients how to identify and anticipate the early warning signals that preceded exposure to high-risk situations and to implement coping strategie*s* designed to reduce the probability of a lapse or a relapse (Figure 29.4).

Assessment of Lifestyle Balance

As stated earlier, the degree of balance or imbalance in a person's daily life has a significant impact on the desire for indulgence and immediate gratification. The first step in applying global RPT intervention strategies is to assess the client's quality of life with a focus on areas of life-style imbalance. A good place to start assessing life-style balance is by paying attention to the areas of life previously mentioned by the client. Areas to explore include, but are not limited to: physical health, including chronic illness; exercise and nutrition; psychological health, including co-occurring psychological conditions, such as DSM-IV Axis I disorders and DSM-IV Axis II disorders; interpersonal factors, including family

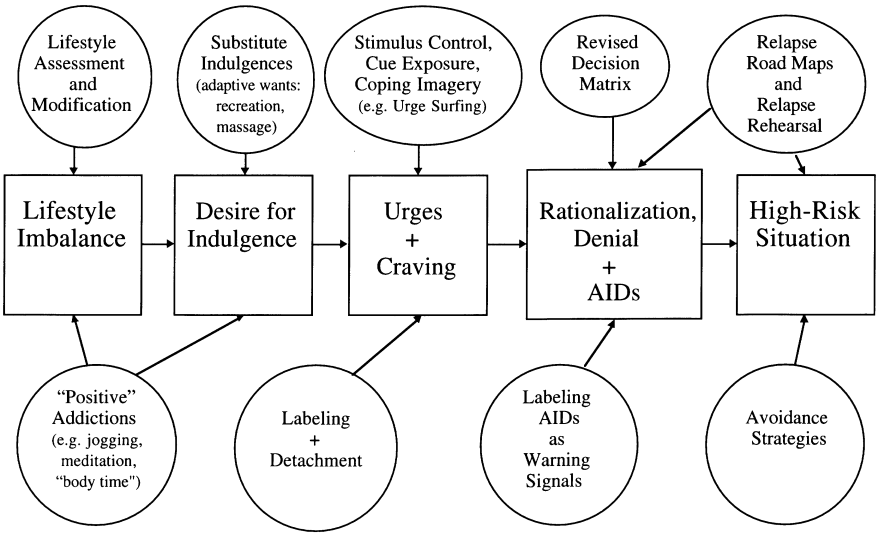

Figure 29.4 Global relapse prevention therapy intervention strategies

dynamics and the extent and quality of other social support; employment, including job satisfaction and security; the client's current financial situation, including savings and debt; and the client's spiritual beliefs and practices. In addition to clinical interviews, two life-style questionnaires designed for use in substance abuse treatment are available: *The Health and Daily Living Form* and the *Lifestyle Assessment Questionnaire* (Murphy & Impara, 1996). Both instruments can be used as therapist-administered structured interviews or as self-report questionnaires.

Increasing Life-style Balance

Once life-style imbalance has been assessed and its implications have been thoroughly discussed with the client, a comprehensive self-management program to improve the client's overall life-style and to increase his/her capacity to cope with the experience of more pervasive stress factors is begun. Life-style modification procedures are designed to identify and circumvent the covert antecedents of relapse that set-up exposure to high-risk situations and to promote life-long habit change to create greater mental, emotional, physical and spiritual well being.

The specific life-style modifications recommended in the RPT approach depend on the client's unique needs and abilities. A program of exercise, meditation, enhanced social activities, or weekly massages to reduce muscle tension are among the many possibilities. Some clients are simply encouraged to create some time and space in their daily routine for discretionary activities to reduce stress and enhance pleasure.

Coping with the Desire for Indulgence: Substitute Indulgences

As life-style imbalance is likely to create a desire for indulgence, one effective strategy is to search for activities that might be *substitute indulgences* that are not harmful or

addictive. In this regard, Glasser (1974) has described behaviors such as excessive drinking and drug abuse as negative addictions that initially feel good, but produce long-term harm. Conversely, Glasser describes "positive addictions" (e.g. running, meditation, hiking, hobbies) as producing short-term discomfort or even pain while creating long-term benefits to physical health and to psychological well-being. Positive addictions often become wants as clients begin to gain mastery and look forward to engaging in these activities as a source of pleasure. An added benefit of positive addictions is that they often involve developing new skills and social relationships, which may increase a person's self-efficacy and create social networks with peers who model and support a healthy life-style.

Coping with Craving for Alcohol and Urges to Drink

Stimulus Control

Despite one's best attempts to modify life-style and to learn and practice positive additions and substitute indulgences, occasional urges and cravings do arise. Quite often, urges and craving are conditioned responses triggered by external cues, such as the sight of others engaged in drinking. The frequency of these externally triggered urges and craving can be reduced by using *stimulus control techniques* designed to minimize exposure to these cues. In some circumstances, simply avoiding the situation is the best strategy. Using a highway metaphor for habit change, avoidance strategies can serve as an *emergency detour* allowing the client to escape exposure by a last-minute defensive maneuver. Later, when coping skills are better learned and more effective, it may be less dangerous to venture down that high-risk road. In any case, viable avoidance strategies may serve a person well for a time and enhance his/her sense of self-efficacy and personal choice while more sophisticated coping strategies are being learned.

Cue Exposure

Stimulus control techniques such as avoidance are at best short-term solutions to the challenges posed by urges and craving. Eventually, the client will have to learn and master effective techniques to cope with these tempting situations. One emerging approach in this regard is *cue exposure* (Drummond et al., 1995). Traditional treatment programs do everything they can to minimize or eliminate all tempting stimuli from the protected environment of the therapeutic setting. Without preparation or warning, exposure to cues associated with addictive behaviors can be an overwhelming and discouraging experience and is often interpreted by the client as an indication that the treatment has failed or that treatment effects have worn off. Cue exposure treatments administered in either analog situations or *in vivo* can assist clients to avoid lapse when they cannot avoid drinking cues.

Coping Imagery

In addition to contemporary approaches, such as cue exposure, it is often helpful when teaching clients to cope with urges and craving to emphasize that the discomfort and agitation associated with these conditioned internal sensations is expected and natural. Most people have the mistaken idea that once an urge or craving begins, it will increase in intensity until drinking occurs. In helping clients to cope with the seemingly overwhelming power of growing urges and craving, it is helpful to teach them that these conditioned responses will rise in intensity, reach a peak, and then subside. In this respect, urges and craving can be compared to waves on the ocean; they rise, they crest, and then they fall, in a repeated

cycle. *Urge surfing* uses the wave metaphor to help clients gain control over these seemingly unmanageable events. The client is taught to label these urges or craving as an ocean wave that reaches a peak, crests, and then subsides. Clients visualize learning to "ride the wave" through the peak experience of craving to its eventual decline. Clients are initially taught the urge surfing technique through guided imagery and then encouraged to try it on their own whenever they are exposed to alcohol cues.

Self-monitoring

Another way to foster detachment and disidentification with urges and craving is to have clients use *self-monitoring procedures* to keep track of these experiences. The *craving diary* is a technique used in a number of RPT programs to gain information and to help cope with craving. The client is asked to keep track of the internal and external cues that stimulated a craving, his/her mood, the strength of the craving, how long it lasted, coping skills used, and how successful or unsuccessful these coping strategies were.

Craving Cards

Just as a reminder card is used to automate the client's emergency response to a lapse, *craving cards* are designed to help clients cope with intense urges and cravings at a time when they may have trouble generating adaptive thoughts and behavioral coping skills. These cards include both general and specific suggestions for how the client can survive an urge and craving emergency without a lapse. A sample card might include tips on recognizing and labeling cravings, brief instructions for relaxation techniques, positive self-statements that encourage continued abstinence, tips on how to use distraction and incompatible responses, an abbreviated decision balance sheet, and emergency escape directions, including phone numbers of individuals willing to offer social support.

Coping with Cognitive Distortions

Urges and cravings usually do not operate at a conscious level, but are likely to be masked by the cognitive distortions and defense mechanisms described in the discussion of covert antecedents of high-risk situations. As such, these dimly perceived sensations and strong emotions fueled with forbidden desires set-up the possibility of relapse by allowing for *apparently irrelevant decisions* (AIDs) to bring the person closer to exposure to a high-risk situation. Teaching clients to become vigilant for these early warning signals and to engage in explicit self-talk that questions their motivations and intentions can help them to recognize and acknowledge the direct relevance of these AIDs to the increased risk of relapse. By acknowledging to oneself that these mini-decisions actually represent urges and craving to return to excessive drinking, one is better able to recognize them as early warning signals on the road to relapse. Deliberately labeling the true nature of urges and craving before they motivate apparently irrelevant decisions is a good way to foster detachment and a stronger sense of self-efficacy.

EMPIRICAL SUPPORT FOR RELAPSE PREVENTION THERAPY

In this section, we will described two recent reviews which provide evidence for the therapeutic efficacy of treatments derived from the RPT model in their ability to effectively help clients overcome alcohol dependence and other addictive behavioral problems.

Carroll (1996) reviewed more than 24 randomized controlled trials evaluating the effectiveness of RPT as a psychosocial treatment for substance abuse. Her selection criteria included "only those randomized controlled trials that evaluated a treatment approach defined as *relapse prevention* or evaluated a coping skills approach that explicitly invoked the work of Marlatt" (Carroll, 1996, p. 46). After reviewing these studies, Carroll concluded:

> Across different substances of abuse, there is evidence for the effectiveness on substance use outcomes for relapse prevention over no-treatment control conditions, mixed findings when compared with attention and discussion control conditions, and findings that relapse prevention appears comparable, but not better than, other active treatments. (Carroll, 1996, p. 51).

In her review, Carroll (1996) discusses three areas that emerged as having particular promise for the effective application of RPT. First, Carroll notes that while RPT may not always prevent relapse better than other active treatments, several investigations suggest that RPT is more effective than available alternatives in relapse management (i.e. reducing the intensity of lapse episodes if they do occur). Second, numerous studies, especially those comparing RPT to other psychotherapies, have found RPT to be particularly effective at maintaining treatment effects over long-term follow-up measurement. In addition, Carroll's review suggests the presence of what she calls "delayed emergence of effects for relapse prevention", in which clients actually improve in coping ability over time (Carroll, 1996, p. 52). Finally, Carroll (1996) suggests that relapse prevention may be most effective "for more impaired substance abusers, including those with more severe levels of substance abuse, greater levels of negative affect, and greater perceived deficits in coping skills" (Carroll, 1996, p. 52).

Narrative reviews of substance abuse treatment studies, such as the one by Carroll (1996), serve a useful purpose for both researchers and clinicians, but conclusions from descriptive analysis are not readily quantified and may be subject to various interpretations. On the other hand, *meta-analytic reviews* of treatment outcome studies use statistical techniques to measure and quantify treatment effects, allowing more precise comparisons and conclusions regarding the relative effectiveness of different treatment alternatives (Lipsey & Wilson, 1993). A meta-analytic review of the efficacy of Relapse Prevention Therapy has been recently completed and will be summarized below.

Irvin, Bowers, Dunn & Wang (1999) selected 17 controlled studies with 72 hypotheses in order to evaluate the overall effectiveness of RPT as a substance abuse treatment and to identify moderator variables that may reliably impact the outcome of treatment. Six moderator variables were studied: treatment modality; theoretical orientation of prior therapy delivered before relapse prevention; treatment setting; type of outcome measure used to determine effectiveness; medication as an adjunct to relapse prevention; and finally, type of substance use disorder treated by the RPT interventions.

In their discussion of the results of the meta-analytic review of RPT outcome studies, Irvin et al. (1999) conclude that "relapse prevention is highly effective for both alcohol-use and substance-use disorders". They go on to say that the effect size for this finding was significant and the available evidence indicates the overall effectiveness of RPT as a substance abuse treatment for both habit cessation and maintenance. Additionally, relapse prevention appears to be most effective when applied to alcohol or poly-substance use disorders, combined with adjunctive use of medications, and when evaluated immediately following treatment using uncontrolled pre–post tests (Irvin et al., 1999). These two treatment outcome reviews provide encouraging evidence on the effectiveness of RPT as a treatment for alcohol problems. Overall, RPT appears to be a promising intervention for use in alcohol and substance abuse treatment.

KEY WORKS AND SUGGESTIONS FOR FURTHER READING

Marlatt, G.A. & Gordon, J.R. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*. New York: Guilford.

Part I of this book presents a detailed exposition of the relapse prevention model that forms the basis of RPT. Part II presents application of RPT with specific addictive behaviors such as alcohol, smoking, and weight control. This is still the most complete presentation of RPT in print.

Wanigaratne, ••, Wallace, ••, Pullin, ••, Keaney, •• & Farmer •• (1990). *Relapse Prevention for Addictive Behaviors: A Manual for Therapists*.

This manual is a practical introductory guide to conducting RPT with any type of addictive behavior. Written in a clear and engaging style, it presents an overview of the relapse prevention model as well as descriptions of how to implement both specific and global RPT interventions for individuals or groups.

Annis, H.M., Herie, •• & Watkin-Merek, •• (1996). *Structured Relapse Prevention: An Outpatient Counselling Approach*.

A treatment manual and videotape developed by Helen Annis and her colleagues at the Addiction Research Foundation that presents a systematic protocol for use in outpatient settings. The five major components of SRP include assessment, motivational interviewing, treatment planning, initiation of change and maintenance of change.

Annis, H.M., Turner, N.E. & Sklar, S.M. (1997). *IDTS: Inventory of Drug-Taking Situations*.

Toronto: Addiction Research Foundation of Ontario. This manual provides guidelines for using the IDTS, which assesses a client's most problematic triggers for relapse based on the taxonomy of high-risk situations developed by Marlatt. The IDTS is available as a paper and pencil questionnaire or as computerized software.

Swanson, •• & Cooper, •• (1994). *The Complete Relapse Prevention Skills Program*.

This program based on the RPT model offers clinicians and clients a package of user-friendly yet sophisticated tools to prevent and manage relapse. The program includes an integrated set of clinician's guides as well as client pamphlets, workbooks and videotapes.

Roberts, ••, Shaner, •• & Eckman •• (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*.

A therapist manual with accompanying video offering a step-by-step approach to RPT with clients presenting with co-occurring substance use and mental disorders. The best resource currently available for RPT coping skills training.

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