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Preventing relapse

Looking at data differently led to today's influential Relapse Prevention Therapy.

BY KATHRYN FOXHALL
***Monitor* staff**

Although the work on understanding and refining Relapse Prevention Therapy is far from finished, it's causing particular excitement for its apparent utility with cocaine abuse, an area where just a few years ago there were no successful treatments.

Maybe one day it will be considered one of the great serendipities of health science: In the 1970s, psychologist G. Alan Marlatt, PhD, and colleagues were studying aversion therapy for people who had problems with alcohol. When people relapsed despite the aversions, the researchers asked them a lot of questions about what happened. The answers revealed common factors that put a person at high risk of relapse.

At the top of that list were negative emotional states. Depression, anger, anxiety, frustration or boredom seemed to catapult the abstinent person back into drinking. The researchers thought that if they could help patients recognize their high-risk situations, they could help prevent relapse. And they had a more revolutionary idea: They might help patients recover from relapses once they happened.

Thus began the gestation of "Relapse Prevention Therapy" (RP) which today is on the short list of scientifically validated psychosocial treatments for substance abuse. Its effect is "pretty potent," says Lisa Onken, PhD, head of the National Institute on Drug Abuse (NIDA) Behavioral Treatment Development Branch, although the work on understanding and refining it is far from finished. It's causing particular excitement for its apparent utility with cocaine abuse, an area where just a few years ago there were no successful treatments.

A system of techniques

The RP model is based on the premise that people who change their behaviors, such as in drug or alcohol abstinence, will at some point run into a high-risk situation. It could be a negative emotional state, interpersonal conflict or social pressure to engage in the behavior --including just being in the presence of people engaging in the behavior. Or it could be positive emotional states or the person's decision to test his or her personal control.

The RP techniques include helping patients recognize their high-risk situations, rehearse strategies for dealing with those situations, self-monitor substance use and deal with cravings--including externalizing them and "surfing" the wave of the urge. It focuses on "lifestyle balance" with the understanding that when the external demands and activities in a person's life (the "shoulds") outweigh pleasurable activities (the "wants"), there's a greater risk the person will indulge in the behavior.

But just as importantly, the therapy helps the person deal with a "lapse," such as an incidence of substance use. The therapist works with the client to keep the feelings of self-blame and uncontrollability from causing the "lapse" to inflate into a "relapse" to former levels of substance use. The client is also encouraged to use the "lapse" as a valuable learning tool, to understand what led up to it and to view it as a chance to renew commitment.

Indeed, says Marlatt, the system has gained wide acceptance in part because it gives therapists a way to work with something that is a constant in substance abuse treatment--relapse--which used to be tallied as a total treatment failure.

RP has also found acceptance because it can be used in conjunction with other treatments, including therapies that use medications, and it can be used as a follow-up to initial treatment or as the entire treatment.

In addition, the theory has been reworked and adapted for different situations, substances and other impulse control problems such as gambling or pedophilia.

Practice makes better?

In the relatively few trials done so far, RP has actually had mixed results when compared to other substance abuse programs and treatments. Nevertheless, the system is intriguing for the effects it does show.

As Marlatt notes, although RP does not result in greater abstinence rates, when people do relapse, "they are able to have shorter relapses and recover sooner."

In just one example, a study showed that of patients with severe cocaine addiction, those treated with relapse prevention have urine screens positive for the drug 28 percent of the time, compared to 47 percent of the time for those who

receive only supportive clinical management.

But what is creating the most interest are the signs that RP may be better than other therapies for maintaining a lower relapse rate at a later point, one year or more after treatment. There is even nascent hope that people continue to improve, even after treatment ends.

Marlatt theorizes that this "delayed emergent effect" means that as people practice the skills of avoiding relapse, they get better at it.

Psychologist Kathleen Carroll, PhD, of the Yale department of psychiatry, a key researcher on this type of therapy, says the effect "has been seen before in cognitive behavior therapy. It is very nice to see it in substance abuse."

"That is a real success story," Onken says, citing the delayed emergent effect as one reason NIDA funds a whole program of research to refine the therapy.

Researching the angles

Current research is focused on whether various components of RP are more effective in particular settings (inpatient or outpatient, group or individual treatment) or when particular substances are targeted, such as nicotine, cocaine, alcohol, heroin or others.

One of the most riveting ideas is the possibility of using the system in conjunction with another therapy that is also showing powerful effects. "Contingency management" is a model that gives the patient rewards, such as vouchers for desired behavior--like having a drug-free urine sample.

Recently Johns Hopkins researchers led by Kenneth Silverman, PhD, showed that placing the right contingencies on behavior--including rewards for coming to class and for providing a clean urine sample, for 15 minutes of appropriate behavior and for other accomplishments--could substantially increase abstinence among cocaine-addicted women who were already in a treatment program. (See February Monitor.)

Now researchers are asking what if programs gave patients contingency management to get them off substances and also relapse prevention therapy to help them stay off the drugs long term?Such a link, Marlatt says, "would seem to be an ideal combination for a comprehensive behavioral treatment program."