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Asynchronous Distance Learning Course

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Then when you know better, do better.

— Maya Angelou

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ABOUT THE INSTRUCTOR

Dennis C. Daley, Ph.D., is a Professor of Psychiatry, and Chief of Addiction Medicine Services at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center. He oversees a large continuum of care at Addiction Medicine Services (AMS), which includes over twenty-five treatment, prevention and intervention programs, training programs for psychiatric residents, medical students and graduate students in behavioral health.

Dr. Daley has been or is currently an investigator, trainer and/or consultant on numerous research studies at WPIC sponsored by the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism related to treatment of individuals with substance use disorders and mood disorders. He is currently a trainer and consultant on a NIDA sponsored study of bipolar substance abusers at Harvard Medical School (Roger Weiss, MD, PI). Dr. Daley and colleagues at AMS are currently involved in seven research projects. His research interests are in the areas of addiction, mood disorders and addiction, and adherence to treatment.

Relapse Prevention: Third-Wave Therapies, Digital Tools, and Prediction Science

The relapse prevention framework this course provides — grounded in the Marlatt model and its emphasis on identifying high-risk situations, developing coping strategies, managing cravings, and intervening early in the relapse process — remains the foundation of evidence-based relapse prevention practice. Since this course was written, three developments have expanded the clinical toolkit: third-wave behavioral therapies that add mindfulness and acceptance-based approaches to the traditional cognitive-behavioral framework, digital technologies that extend relapse prevention beyond the therapy session, and emerging prediction science that aims to identify relapse risk before it manifests in behavior.

The third-wave therapeutic approaches that have emerged since this course was published — including mindfulness-based relapse prevention, acceptance and commitment therapy, and dialectical behavioral therapy skills training — were systematically evaluated in a 2026 review of 47 studies (35 randomized, 12 non-randomized) spanning 2014 to 2025. The analysis found that these approaches demonstrated "small-to-moderate benefits on abstinence, craving, and substance use outcomes" with stronger improvements observed in psychological flexibility and emotion regulation than in substance use reduction per se (Calderone et al., 2026). For the cognitive-behavioral relapse prevention framework this course teaches, the third-wave findings do not replace the traditional model but extend it. The Marlatt model emphasizes identifying and coping with high-risk situations — a fundamentally cognitive-behavioral approach. Mindfulness-based relapse prevention adds a complementary mechanism: rather than analyzing and responding to cravings through cognitive restructuring, clients learn to observe cravings without acting on them, treating the urge as a transient mental event rather than a command that requires either compliance or suppression. The clinical implication is that relapse prevention programs that combine traditional CBT strategies with mindfulness techniques may address a broader range of clients — including those who find cognitive restructuring intellectually demanding or emotionally avoidant.

The digital technology dimension of relapse prevention — which this course could not have anticipated — was examined in a 2026 narrative review analyzing literature from 2013 to 2025 on technology-driven interventions for substance use disorders. The review found that effective digital relapse prevention tools integrate evidence-based therapy content, provide personalized feedback, and offer craving-management tools that connect users to support networks in real time. However, user retention remains a critical challenge: many apps experience significant drop-off after initial download. Successful digital therapeutics incorporate gamification, incentive systems, social features, and integration with treatment providers to sustain engagement (Oesterle & Bormann, 2026). For the counseling strategies this course describes — which assume a therapist-client relationship as the delivery mechanism — digital tools represent a force multiplier rather than a replacement. The relapse prevention skills this course teaches (identifying triggers, developing coping plans, managing cravings, building support networks) can now be reinforced between sessions through app-based prompts, real-time craving tracking, and automated check-ins that extend the therapeutic contact from weekly sessions to continuous support.

The evolving science of relapse prediction — moving beyond the clinical judgment model this course describes toward data-driven approaches — was mapped in a 2023 scoping review of 46 articles

examining prediction and prevention strategies. The review identified diverse approaches including cell phone applications that track behavioral patterns, monitoring of biological markers such as transdermal alcohol sensors, and functional neuroimaging of the brain to identify neural signatures associated with relapse vulnerability. While certain strategies show practical promise, the field remains in early stages, with most prediction tools not yet validated for routine clinical use (Carter et al., 2023). For the clinical assessment framework this course provides — which relies on counselor observation, client self-report, and structured relapse prevention planning — the prediction science represents a potential future in which relapse risk can be detected through passive data collection before the client is consciously aware of escalating vulnerability. Programs that incorporate wearable sensors or app-based behavioral monitoring into their relapse prevention protocols may eventually be able to trigger interventions at the moment of greatest risk rather than waiting for the next scheduled session.

The psychological mechanisms that predict relapse — directly relevant to this course's discussion of causes of relapse — were examined in a 2024 study of 200 treated addicted men in a prison setting. Stepwise regression analysis found that experiential avoidance components (distraction, distress endurance, behavioral avoidance, and distress aversion) accounted for 14% of relapse variance, while integrative self-knowledge explained 15% of variance. Among basic psychological needs, the need for meaningful communication predicted an additional 3.8% of variance. The researchers concluded that addiction treatment programs should emphasize reducing avoidant behaviors, enhancing distress tolerance, building self-awareness, and fostering meaningful relationships (Ayaz & Nazari, 2024). For the relapse prevention strategies this course teaches, the Ayaz and Nazari findings identify two specific psychological targets: experiential avoidance (the tendency to escape or suppress uncomfortable internal experiences) and self-knowledge (the capacity to understand one's own motivations, patterns, and vulnerabilities). Clients who avoid emotional discomfort and who lack insight into their behavioral patterns are those most likely to relapse — and these are precisely the capacities that relapse prevention counseling should develop.

The self-care dimension of relapse prevention — which this course addresses primarily through coping skills and lifestyle balance — was comprehensively reviewed in a 2025 scoping review of 30 articles examining self-care practices for individuals recovering from substance use disorders. The review found that effective self-care operates across physical, behavioral, interpersonal, psychological, and social levels. Approaches including mindfulness and cognitive-behavioral therapies were identified as evidence-supported self-care interventions, and the authors emphasized that effective self-care must be personalized and requires ongoing professional support rather than functioning as an independent skill that clients develop once and maintain indefinitely (Folgueiras-Vila et al., 2025). For the relapse prevention framework this course provides, the multi-level self-care model adds specificity to what this course describes as lifestyle balance: self-care is not a single category of activity but a set of practices operating across five distinct domains, each requiring attention in the relapse prevention plan.

Treatment Manuals for professionals

Relapse Prevention Counseling

Strategies to aid recovery from addiction and reduce relapse risk

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Comments about this book or information about clinical workshops on Relapse Prevention can be sent to the first author at daleypublications@yahoo.com.

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Table of Contents: Relapse Prevention Counseling

Dedication to G. Alan Marlatt, PhD

We dedicate this book to a friend and colleague, Alan Marlatt who recently passed away. He was a Professor of Psychology and the Director of the Addictive Behaviors Research Center at the University of Washington in Seattle. Alan was a pioneer in the field of addiction and the first to publish a comprehensive review of Relapse Prevention (RP) and focus on the importance of helping clients learn skills to manage their addiction, change their lives and take action early if they were unable to stay sober. His influence on the fields of addiction and psychology was enormous. Alan stimulated the addiction treatment field with his forward thinking, his research and his teaching on numerous topics related to addiction, treatment, recovery and relapse.

He was a good friend and mentor to many of us in the U.S. and other countries. Alan was well respected for his many contributions to the field, and his book on RP is one of the most highly referenced books in the literature. He received many awards for excellence of his work including the Jellinek Memorial Award (1990), the Combating Substance Abuse Award by the Robert Wood Johnson Foundation (2001), Distinguished Researcher Award from the Research Society on Alcoholism (2004), and the distinguished scientific Contributions to Clinical Psychology Award by the American Psychological Association (2009).

I (dd) first learned about Alan's work in the 1980's when I worked as a therapist in a residential treatment program and read a book chapter he wrote on relapse in addiction. His framework for understanding the multiple causes of relapse and intervention strategies was impressive. In a time before the age of the internet, I called him to discuss his ideas and what I was doing in the area of RP in a treatment program. He was receptive to my call, very helpful and respectful and interested in my clinical work. This led to a long-term relationship. I brought Alan to Pittsburgh on numerous occasions to present on RP. We co-presented at several conferences in the U.S. together. We invited each other to co-author articles and books. And, we talked by phone or email throughout the years to keep up on what each other was doing. In the early years I referred to him as the "grandfather of RP." I told him his emphasis on RP was a major positive influence on the field of addiction treatment.

Many newspaper (such as NY Times) and magazine articles (such as Time) have been written about Dr. Marlatt to share appreciation for his impact on individuals and his field. His good friend and colleague, Dennis Donovan, PhD from the University of Washington (also a friend and colleague of ours) stated that "Alan has been a mentor, friend, and colleague to many of us here at UW, and his network of associates and those whom he has touched personally and professionally is extensive and international in scope. We have lost a true visionary and luminary in the field of addictions. He will leave his prints in our hearts and minds, and there is a cadre of us to carry on the important work that he has championed throughout his career." Another colleague, Dr. Fred Rotgers, the President of the Society on Addiction Psychology said "It is. . .impossible to recount briefly how much Alan has meant to the field of addiction psychology, to addictions treatment and research. . .Alan also had a direct impact on many of us through his friendship, mentorship and genuine humanity."

About this Book

This book was written to help clinicians in programs that provide treatment of substance use disorders (addiction medicine and mental health programs) understand and address the problem of relapse. It is written in a brief, succinct manner to summarize strategies to facilitate recovery from addiction and reduce relapse risk. It can be used by clinicians to incorporate relapse prevention strategies into treatment. This book is also a reference on recovery and relapse prevention (see endnotes, references and suggested readings, recovery materials, and web resources).

About the Authors

Dennis C. Daley, Ph.D. is Professor of Psychiatry and Chief of Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center. Dr. Daley has provided services to individuals with addiction for over 30 years. He was one of the first in the U.S. to write interactive recovery materials for clients and authored the *Relapse Prevention Workbook* used throughout the U.S. and other countries. Dr. Daley also authored a recovery video *Staying Sober, Keeping* Straight and a series of 19 interactive videos (*Living Sober I, II, and III)* aimed at facilitating recovery and reducing relapse risk. He a researcher, consultant and trainer on many studies funded by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. Dr. Daley has over 260 publications on recovery from addiction or co-occurring disorders. His materials are used throughout the U.S. and several have been translated to foreign languages. He contributed to the SAMHSA Treatment Improvement Protocol on *Relapse Prevention* that is currently being written.

Antoine Douaihy, M.D. is Associate Professor of Psychiatry, Medical Director of AMS and several clinical programs as well as an HIV clinic. Dr. Douaihy is involved in providing clinical services, teaching and research. He has many publications for professionals and individuals in recovery including recovery journals and workbooks. Both Drs. Douaihy and Dr. Daley have worked together for many years in clinical programs, research, teaching and writing projects. They have been involved in several funded studies on the treatment of addiction.

About Daley Publications

We offer books and manuals for clinicians on treatment of addiction and co-occurring disorders. We also offer materials for clients and families in recovery such as workbooks and journals. These materials are brief, informative, user-friendly and useful for individuals with substance use disorders, psychiatric illness, and/or co-occurring disorders (psychiatric and substance use disorders combined). These materials can be used in addiction medicine, mental health programs and co-occurring disorders programs. Descriptions of materials are available on the webpage: **www.drdenniscdaley.com.**

CHAPTER ONE

Addiction and Recovery

Purpose of Book

Problems with the use of alcohol, nicotine, illicit drugs (heroin, cocaine, cannabis and others) and prescription drugs (for pain, anxiety and other conditions) affect millions of people in the United States. One major community study found over 16% of adults in our country experienced a substance use disorder (referred to as addiction in this book) at some point during their lifetimes with alcohol being the most common substance problem.[1] Many of these individuals have problems with more than one substance.

Addicted individuals are at increased risk for medical, psychological, family, legal, occupational, economic and spiritual problems.[2] Their families experience an emotional and financial burden. Society is adversely affected as addiction costs hundreds of billions of dollars in lost wages and productivity, and the cost of medical care, criminal justice and other services needed as a result of consequences of addiction such as accidents, medical disorders, psychiatric problems, loss of jobs and criminal behaviors.

On a positive and hopeful note, involvement in professional treatment and mutual support programs such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), other 12-Step programs and other mutual support programs helps many of these individuals learn to manage their addiction by engaging in recovery and learning coping strategies to reduce their risk of relapse.[3] A major goal of treatment or involvement in recovery support groups is to prevent relapse or reduce relapse risk. A goal for families is to help them understand addiction, recovery and relapse and how they can help their loved one and themselves. Another goal is to learn how to intervene quickly in the process of a lapse or relapse to limit the damage.

The purpose of this book is to help clinicians understand and facilitate the process of recovery among addicted clients and reduce their risk of relapse. The primary focus is reviewing clinical strategies to help clients reduce relapse risk or intervene early in the relapse process, and describe clinical tools that can be incorporated into individual, group or family sessions. Sources of information for this book are studies of treatment of addiction and relapse, clinical literature, and the authors' experiences and as clinicians and researchers, and developing relapse prevention (RP) programs and materials for addicted individuals and families.

We recently conducted a training needs survey of a large group of clinicians who provide treatment in numerous residential and ambulatory addiction medicine programs. Results showed that a major area of clinical interest was RP. Another result was that clinicians do not read a lot, perhaps because they are busy with work and personal lives. Therefore, this book (an update from a

previous version) was reduced in length to make it more manageable for busy clinicians to read and use in their clinical practice.

This first chapter provides a brief review of addiction, treatment and recovery. It does not provide the symptoms of addiction or other substance use disorders and assumes the reader is familiar with the categories of substance use disorders and symptoms of addiction (dependence).[3]

Chapter two provides definitions of lapse and relapse as they relate to addiction. The multiple factors contributing to relapse and effects of relapse are then discussed.

The third chapter provides an overview of relapse prevention, treatment models that incorporate RP principles, specific models of RP and research support for RP. Readers interested in more in depth review of the RP literature or specific models can consult the references at the end of this book.

Chapter four discusses counseling strategies to aid recovery and reduce relapse risk. These are organized in the following categories, each with specific examples:

1. Treatment adherence
2. Medication-assisted recovery
3. Addiction management skills
4. Psychiatric management skills (since many clients have co-occurring mental health problems)
5. Emotion management skills
6. Relationship skills and support systems
7. Cognitive coping skills
8. Relapse recognition and interruption skills
9. Lifestyle changes

The reader will note the term "skills" used throughout as clients need to learn coping strategies or skills to manage their addiction and engage in a recovery process.

The fifth chapter provides a summary of counseling tools. These can be used to help individuals, groups or family members. They can be incorporated into any type of addiction treatment program (detoxification, residential, ambulatory, narcotic addiction or specialty programs) or mental health program that focuses on co-occurring disorders.

Chapter six provides an overview of relapse prevention groups. It gives details on creating RP groups, formats to use in residential, inpatient and outpatient settings, orienting clients to group and strategies for leaders to use in conducting these groups. This chapter also provides a curriculum on 12 RP group topics that can make up a "core" program for clients.

Chapter seven discusses process therapy or problem solving groups that can focus on a broad range of issues pertinent to ongoing recovery and relapse prevention. This chapter covers the purposes of these groups, objectives and format. It also addresses the problems commonly seen in these types of groups as well as problems encountered in the group process.

An appendix provides references, information about interactive workbooks and journals for clients, and web resources that may be of interest to clinicians, clients and families. The reference section provides an extensive bibliography with a listing of books, papers, studies and recovery guides. The interactive workbook appendix provides brief descriptions of recovery materials that facilitate recovery and reduce relapse risk. Finally, a list of Web Sites provides the reader with additional resources where information on recovery and relapse can be found.

Causes of Addiction

Addiction is a *multifaceted illness or disease* involving *physiological*, *psychological*, and *social or cultural* factors.[4] It is usually a combination of factors rather than just one that leads to an addiction or the continuation of it, and for many it is a chronic disease.[5]

1. *Physiological*: similar to other medical illnesses or psychiatric disorders, addiction runs in families. This means that first degree relatives (children or siblings) are at increased risk for addiction. One of the most potent predictors of addiction for a son or daughter is having a parent with an addiction. The genetic contribution to substance use disorders is complex and involves multiple physiological pathways. Genetic factors are important in determining vulnerability to addiction, but they are not deterministic. Personal and environmental factors play an equally important role. There are also differences in brain chemistry or metabolism of addicted individuals that may distinguish them from non-addicted persons. For example, many individuals with alcoholism develop a high tolerance for alcohol. They can drink larger quantities than others. Even though these individuals drink a lot, they often do not feel high or intoxicated until they have consumed large quantities of alcohol. Whereas social drinkers can read body cues that they have had enough to drink (or too much), alcoholics usually cannot.

2. *Psychological:* these include personality style, psychological defenses and coping mechanisms. Some people have a personality characterized by "risk taking" or "living on the edge." These individuals often (though not always) have a tendency to develop an addiction. Defense mechanisms are psychological processes to protect people from something that causes anxiety. A common defense used by individuals during their active addiction is denial. Denial allows the addicted person to explain away, refuse to believe, or refuse to acknowledge the addiction. How a person handles problems or stresses in life can determine whether or not substances are relied upon to reduce stress, escape problems, or cover up upsetting or difficult feelings such as anger, anxiety, boredom, depression, emptiness, loneliness or guilt. Many people with addiction report that alcohol or other drugs allow a temporary escape from things in life that are unpleasant. Others have co-existing psychiatric disorders that contribute to their addiction or complicate their recovery.[6]

3. *Social or Cultural*: these include influences of the family and ethnic group to which the person belongs, friends, religious practices and the type of community lived in. Friends and siblings influence behaviors, including the use of substances. Norms are the "rules" of a culture or subculture and refer to beliefs that guide an individual's behavior. If a

particular group reinforces getting high or deviant behaviors related to substance use, the individual may be more prone to using substance and eventually becoming addicted.

The features of addiction contributing to its onset and early development may have no bearing on *today's* manifestation of the illness. How or why a person became dependent may be completely unrelated to how or why the addiction continues. Once addicted, no reason is needed for it to continue as it takes on a life of its own. That is, addicted people continue to use alcohol or other drugs regardless of the consequences.

Effects of Addiction

The effects of addiction vary and are not confined to just the person with the addiction. Others, especially the family, are also affected.[7] Some of these effects are obvious while others are subtle and hidden. The effects of addiction are determined by the amount and frequency of alcohol or drug use, how the drug is ingested (i.e., smoking, using needles), age, gender, diet, health and behaviors of the person. The co-existence of serious medical or psychiatric disorders also helps to determine the effects of addiction.

Addiction can produce new or aggravate existing problems in any area of life. The effects range from mild to fatal. Hundreds of thousands of people die every year from the direct and indirect effects of alcohol and drug use, including nicotine.

Following is a brief summary of problems caused or worsened by an addiction:[8]

1. *Medical or Health Problems:* accidents, injuries, overdoses, or diseases can be caused or worsened by substance use disorders. Sometimes, pre-existing illnesses are aggravated. Among women, addiction is associated with complications with the menstrual cycle, pregnancy and childbirth. Drug abusers who use or share needles and equipment with others increase their risk for hepatitis B and C, and HIV/AIDS. Death or serious disability may occur due to vehicular accidents, falls, violence, drug or alcohol overdoses or suicide attempts.

2. *Psychological Problems and Psychiatric Disorders:* addiction affects thinking, emotions, and behaviors. It contributes to psychological or mental health problems such as low self-esteem, aggressive or impulsive behavior, homicidality, suicidality and the development of poor coping mechanisms. In many instances, a co-occurring psychiatric disorder is present, which complicates recovery from addiction. Two major epidemiologic studies conducted in the community and numerous studies conducted among individuals in treatment show that that many individuals have both an addiction and co-occurring psychiatric disorder.

   Individuals with co-occurring disorders often have more problems than those with single disorders.[9] These include financial problems, unstable housing and homelessness, violence, legal problems, incarceration, depression, suicide, family problems, sexually transmitted diseases and HIV transmission or acquisition. The co-occurrence of mental health and substance use disorders worsens the course of both illnesses and compromises treatment response compared to either disorder alone. Individuals with co-occurring

disorders are also more likely to be non-compliant with medications or appointments with their psychiatrist, fail to show for therapy sessions or day treatment programs, drop out of treatment early, fail to transition successfully from inpatient to outpatient treatment, and to be hospitalized multiple times.

3. *Family Problems:* compared to families with no addiction, those in which this problem exists have higher breakup rates from separation or divorce. The family atmosphere is often permeated by worry, fear or conflict. The rates of child abuse or incidents of domestic violence are higher. Violence should be a major concern in treatment and prevention. Other family problems are poor communication and failure of parents to work together as a team. In addition to adverse effects of addiction on the family unit or marriage, individual family members, including children, are also hurt by addiction. These effects include depression, chronic anxiety or worry, feelings of guilt and shame, and substance abuse. Children in these families are at higher risk for developing an addiction themselves. Compared to children in families where there is no addiction, children in addicted families are also more likely to have psychiatric disorders (depression, anxiety, attention deficit disorder, conduct disorder), aggressive behaviors, greater impulsivity, problems with inattention or irritability, lower IQ scores and poor school performance.[10] Families and others close to the addicted individual may contribute to the development and maintenance of substance use. They also play a role in helping the addicted individual to recognize a problem and seek help.

4. *Social and Legal Problems:* addiction harms relationships with family, friends and colleagues. Addicted individuals cause conflicts in, or lose love relationships as a result of their behaviors or the problems created or worsened by their addiction. They are more likely to get involved the criminal justice system because of drunken driving, violence, theft, homicide or other crimes. Jails and prisons are full of people whose criminal behaviors were influenced by their addiction. Impaired judgment due to the effects of a substance could cause a person to engage in a criminal behavior. Or, criminal behavior could result from the need to get money to pay for an expensive addiction.

5. *Job Problems:* these include absenteeism or being a less productive, efficient and responsible worker. Accidents on the job are more common when the person is impaired by substances. Others lose motivation to find work when unemployed. Others are suspended or fired due to poor performance, which often is caused by the effects of addiction.

6. *Spiritual Problems:* some abandon their spiritual beliefs or practices as addiction progresses. They may feel "lost," "empty," or that life is "meaningless." Feeling guilty and ashamed is common. One client described his experience as follows: “I became spiritually bankrupt. My values changed and I did things I never would have done if I wasn’t addicted. I shamed my family and myself. I lost interest in religion and Church.

Treatment of Addiction

There are many evidence-based treatments (EBTs) or practices (EBPs) for addiction. These include behavioral treatments,[11] medication-assisted treatments[12] and combined treatments.[13] Treatment helps addicted individuals engage in treatment, reduce or stop substance use and make positive changes in themselves or their lifestyles. Treatment may contribute to improvements in any domain of functioning: health, psychological, family, social, interpersonal, economic or spiritual. For many, it improves their quality of life.

A continuum of care is needed to meet the varying treatment needs of addicted individuals. This includes detoxification, short and long-term rehabilitation, partial hospital or intensive outpatient programs, outpatient counseling or therapy, and specialized services for pregnant women, clients with co-occurring medical or mental disorders, clients involved in the criminal justice system, or opiate addicts in need of substitution medications. Many clients need and benefit from other services such as medical care, vocational assessment, counseling or training, and legal and social services (housing, welfare, etc.).

While many studies show that treatment of addiction is effective, rates of relapse are fairly high although similar to other medical disorders.[14] The primary outcome of treatment is usually stopping (or reducing) substance use. Other outcomes can relate to improvement in any area of life (medical, psychological, family, social, spiritual, and financial) and increased quality of life. Outcomes can also relate to the process of treatment and include rates of adherence to treatment sessions or completion of an episode of care, and active involvement in mutual support programs such as AA, NA or others.

Often, addicted people benefit from the "cumulative" effects of more than one treatment episode over time. Although some relapse several times, they eventually become abstinent and recover through what they gained from their treatment experiences. We still don't know why one person recovers after a single attempt, while others make several attempts before finally recovering.

Recovery from Addiction

Recovery is a long-term process of change through which an individual achieves abstinence and improves health, wellness and quality of life.[15] While some clients establish and maintain long periods of continuous sobriety, many have periods of remission followed by episodes of relapse. Due to the relapsing nature of addiction, many clients need several episodes of treatment over time, similar to other chronic medical or psychiatric diseases or disorders. Therefore, many clients need to return to treatment to stabilize from periods of relapse. One of the principles of treatment delineated by the National Institute on Drug Abuse is that "*Recovery is a long-term process that frequently requires multiple episodes of treatment."*

Recovery may encompass any area of the addicted person's functioning. While abstinence from drugs and alcohol is the main goal of treatment, personal and lifestyle changes are viewed as needed to improve the chances of abstinence, reduce the risk of relapse and enhance the quality of life.

Recovery as a process may occur in phases according to Dr. G. Alan Marlatt who has written extensively about addiction and RP.[16] The first phase involves making a commitment to change. The client makes an agreement to participate in treatment even if abstinence is not the accepted goal at first. As long as the client acknowledges there is some problem associated with substance use, some commitment can be made. In treatment, clients with weak commitment to recovery will have the opportunity to reassess their situations and develop motivation to change.

The second phase involves stopping drug and alcohol use. While some clients achieve this change relatively easily, most struggle with it and experience multiple lapses and relapses over time. Many do not achieve ongoing abstinence during their first attempt at change. This is not a sign of failure. It implies that addiction is a chronic relapsing illness.

The third phase of recovery is maintenance or relapse prevention. This refers to maintaining behavior change over time after it is initiated. Relapse prevention refers to coping strategies to help clients identify and manage warning signs of relapse and high-risk relapse factors following a period of successful sobriety. RP strategies aim to help clients integrate changes into their daily lives after formal treatment has ended.

Recovery is best viewed as a nonlinear process. Many clients go through ups and downs during their recovery. Some take many steps forward than a step backwards. Struggling or having a relapse not a sign that the treatment has failed or the client has failed as long as clients learn from their experiences.

Recovery is a process, not an event. It is making a commitment to sobriety and changing oneself and one's lifestyle. Recovery is overcoming the problems associated with addiction and developing a balanced and healthy lifestyle in which drugs and alcohol have no place.

Recovery is both learning skills to *abstain from alcohol or other mood altering drugs* (except in cases requiring medication for a medical or psychiatric problem) and *changing oneself and one's lifestyle* to support this abstinence.[17] Each of these processes, abstinence and personal change, affects the other. Someone making positive personal or lifestyle changes is more likely to abstain from using substances; the person who abstains from substances is more likely to make positive personal or lifestyle changes.

Recovery is a *long-term process*. The areas of change during recovery may relate to physical, psychological, social, family, or spiritual functioning[18] Since each addicted person has a different profile of strengths and weaknesses in these areas, each person requires a unique *recovery program* based on these factors.

1. *Severity*: how long has the addiction been a problem? How severe is it in terms of types, amounts, frequency, consequences and methods of use (oral ingestion, snorting, or injecting drugs with a needle or sharing needs or other equipment with other users)?

2. *Demographics*: the age, sex, and ethnicity of the person. There are many subgroups that may have special recovery needs, for example: women, adolescents, the elderly, African Americans, Native Americans, and gays and lesbians.

3. *Magnitude of damage*: serious medical, psychiatric, family or legal problems may require different treatment services and recovery strategies than those less damaged.

4. *Perception of problem*: if the client sees the addiction as an "illness" or "disease," as opposed to a matter of "willpower," it is more likely that professional treatment will be accepted and a program of recovery will be followed.

5. *Motivation*: this may be external such as to save a job or marriage, avoid going to jail, or avoid paying a fine. It can be internal such as a person seeking help for himself. At first, the person does not need internal motivation to benefit from treatment of involvement in a recovery program. There are benefits from treatment even if the client is "forced" or "pressured" into it. Eventually, motivation must become internalized if sobriety and personal charge are to continue over the long-term.

6. *Social support*: how adequate and intact is the client's family and social support system? Does she have others upon whom she can rely for help and support with problems? Does she have a confidant with whom she can share thoughts, feelings or problems?

7. *Resources*: what treatment or recovery resources are available to the addicted person? Is there money to pay for professional care? During the past decade, managed care has had a significant impact on the amount of professional treatment services authorized and paid for. For example, years ago a residential rehabilitation program generally lasted at least four full weeks. Insurance companies didn't have to "pre-authorize" or pre-approve care. Today, insurance companies cover many of these programs for only 7-14 days and they must first be pre-approved by the client's insurance company.

Giving up alcohol or drugs can be painful and difficult. Recovery often requires physiological and psychological adaptations that are stressful or uncomfortable at first. Many addicted individuals are unsure if they want to or even can give up the substance they are dependent on. They struggle with accepting their problem or the need for help from others.

Recovery is more than abstaining from using alcohol or drugs. It involves developing new attitudes, motivations, knowledge and acquiring recovery skills. It requires *acceptance* of the addiction and a *plan or program of recovery,* which usually includes professional treatment and/or mutual support programs such as AA, NA, CA, CMA, Women for Sobriety (WFS), SMART Recovery, Rational Recovery, or other mutual support programs. There are no "quick fixes" or "'easy cures" for addiction. Recovery takes time, hard work, and often requires help and support from professionals, other recovering people, family, or friends.

CHAPTER TWO

Causes and Effects of Relapse

Lapse and Relapse Defined

Since addiction is a chronic disease, relapse is common as it is with other medical diseases or psychiatric disorders, especially those chronic in nature.[1] Most addiction relapses occur within the first year of treatment. And within this first year, most relapses occur within the first 90 days. Dropout rates are usually the highest in the first month of treatment. Clients who drop out of treatment are at increased risk for relapse.

Lapse refers to the initial episode of substance use following a period of recovery.[2] A lapse may or may not end up in a relapse. This depends on how the client thinks about and responds to an initial lapse. Relapse is defined relapse from two perspectives: (1) relapse is the *actual event* of substance use; or (2) relapse is the *process* of falling back to unhealthy habits or attitudes that often lead to substance use following a period of abstinence. Warning signs occur before the actual use of substances.[3]

The client in a relapse process usually shows signs of changes in attitudes, thoughts, emotions or behaviors. At this early stage, the clinician can sometimes intervene to help the client prevent a return to substance use. However, this depends on the client's ability to recognize these signs and take action. Recognizing emotional and behavioral signs of relapse are sometimes difficult, however. These signs are often subtle. Then too, different people show different warning signs. A relapse warning sign for one client may be irrelevant for another. Also, since behavior may be unconsciously motivated, the client may actually be unaware of warning signs that are apparent to other people.

Causes of Relapse

There is no simple explanation of why an addicted person relapses to substance use following a period of recovery. Like addiction, relapse itself can defy logic, leaving you puzzled about why someone returns to substance use after doing well, especially for those with long periods of sobriety.

Many causes of relapse have been identified from research, the experiences of recovering individuals, their families and from the work of professionals. Knowledge of relapse precipitants can be used to educate clients and their families, and help them identify their personal high-risk relapse factors as well as strategies to manage these.

Relapse is caused by an interaction of many variables: affective, behavioral, cognitive, environment, relationships, physiological, psychological, spiritual, and treatment-related. Although these variables are separated for discussion, they are often interrelated.[4]

1. *Affective:* the more common emotional states contributing to relapse are anger, anxiety, boredom, depression, and loneliness. In a small number of cases, positive emotional states affect relapse. However, ***it is not the emotional state in and of itself that determines if a relapse will occur, but the client's ability to use active coping skills to manage negative emotional states.***

2. *Behavioral:* clients are more prone to relapse if they have poor problem solving, social, stress management and leisure time management skills. The greater the repertoire of cognitive and behavioral coping behaviors, the more likely the person is to manage the challenges of recovery and maintain abstinence.

3. *Cognitive:* the client's attitudes or beliefs towards substance use or recovery, beliefs about one's ability to cope with difficult situations and expectancies for one's behaviors can contribute to relapse. For example, if a client believes that she can successfully cope with a difficult challenge, such as a drug craving or pressure from friends to use drugs, relapse is less of a threat to recovery. On the other hand, if a client believes recovery is intolerable, not fun or a chore, relapse is more likely.

4. *Environment and relationships:* the availability of substances, social pressures to engage in alcohol or other drug use and major unexpected life changes for which the client is ill prepared. Poor social support systems or networks made up primarily of others who actively abuse substances or have actual addictions themselves, are potentially dangerous to the recovering person. So is a non-supportive, hostile family, or one resistant to becoming involved in recovery when such involvement is critical. This is not to say that others should be blamed for a person's relapse, but to acknowledge that other people and conditions in the social environment affect both recovery and relapse.

5. *Physiological:* these variables include cravings or desires for substances, brain chemistry, diet, physical illness or pain and poor rest and relaxation practices. Medications such as narcotics used to treat pain, benzodiazepines to treat anxiety disorders and other medications used to treat dental or medical problems can contribute to a client's desire to use substances and eventually relapse.

6. *Psychological:* motivation, learned behaviors, personality factors and psychological disturbances stemming from traumas can contribute to a relapse. Addicted clients with psychiatric disorders are at higher risk for relapse especially if the psychiatric disorder is not treated.

7. *Spiritual:* unresolved guilt and shame, and lack of meaning or purpose in life may contribute to relapse. Some clients feel an "emptiness" or "void" when they stop using substances. If this is not filled with meaningful activities, the risk of relapse is greater.

8. *Treatment and recovery related:* a caregiver can directly and indirectly contribute to a client's relapse through expressing negative attitudes, negative feelings or by showing enabling behaviors. Treatment agencies can influence relapse by delaying necessary

services with long waiting lists. An example would be a client who completes a residential rehabilitation program and then is placed on a 3-week waiting list for outpatient services. Even sponsors or other recovering people can do or say things that can contribute a person's relapse. For example, an alcoholic struggling with strong desires to drink was overwhelmed with mixed feelings about staying sober. When she discussed these with a recovering friend, the friend said, "you aren't ready to quit, you haven't hit bottom yet." She was given the message that she was expected to act out her conflicts and go on a binge. Perhaps then she would finally discover that she could not safely drink.

The important point is that many factors can directly or indirectly contribute to relapse. The best way for relapse to be understood is to consider these different variables.

There are some clients who will not care much about recovery or have low motivation to change. While the clinician should not give up on unmotivated clients, it is true that we all have our limitations. Such poor motivation can stem from the addiction, a psychiatric disorder or other psychological problem. However, keep in mind that many addicted people with poor motivation eventually become motivated and recover. Often, this is influenced by clinicians who use motivational interventions and express patience, empathy and compassion.

Effects of a Relapse

Relapse effects differ, depending both on the client and his life situation. Factors influencing the outcomes or effects of relapse are the amount, types, and length of the substance use episode, physical and mental health of the person relapsing, behaviors, beliefs about addiction, recovery and relapse, prior treatment and relapse history and the person's ability to use relapse interruption plans to limit how long a relapse lasts.

There are different "types" of relapses. One type is "the therapeutic" relapse, which helps a person's recovery. For example, Jim, a heroin addict and alcoholic, lazily worked his recovery program and smoked marijuana. Jim argued that he could control marijuana use and not go back to heroin, which was his primary drug of choice. He firmly believed his "days of shooting dope were over" because of how it had wrecked his life. But within a month of smoking marijuana, Jim was shooting dope again. He learned through this relapse that his goal of controlled substance use was hopeless and that "his" recovery plan was not working. From his relapse, he finally accepted the recommendation of his clinician and became involved in regular counseling and the NA program. He adopted a program of total abstinence.

On the other extreme is the "fatal" relapse that tragically ends in death. Louis, a heroin addict, died during his last relapse as a result of a drug overdose. Megan, an alcoholic, died in a car accident after relapsing to alcohol and driving while intoxicated.

Between these extremes are many variations of negative consequences, from mild to very severe. Clinicians should evaluate each relapse individually to determine the actual effects on the addicted person's life and the lives of those close to him. Sometimes, adverse effects of a relapse can help motivate the client to work harder at recovery or improve the recovery plan.

CHAPTER THREE

Relapse Prevention

Treatment Models Incorporating RP Principles

The principles and concepts of Relapse Prevention (RP, also called Relapse Prevention Therapy or RPT) are used with other addictive disorders, impulse control disorders, marital problems, psychiatric illness and co-occurring psychiatric disorders.[1] RP is designed to help the individual with any of these disorders or problems focus on reducing the likelihood of a recurrence of the behavior or symptoms of the disorder. The "maintenance" phase of treatment is important in helping addicted clients maintain their gains.

The goal of addiction treatment is usually to help the client initiate abstinence, improve functioning and prevent relapse. RP for substance use disorders generally refers to three types of clinical interventions: (1) a specific program focusing primarily on relapse issues and the maintenance stage of treatment; (2) any individual or group psychosocial treatment aimed at helping clients reduce or stop substance use, prepare for recovery and coping with high-risk relapse factors, and reduce the likelihood of relapse; and (3) medication-assisted treatment that helps clients with more severe forms of addiction. Examples include:[2]

1. Cognitive-Behavioral or Coping Skills Therapies
2. Community Reinforcement Approach
3. Contingency Management (Motivational Incentives)
4. Motivational Interviewing
5. Marital and Family Therapies
6. Group Drug Counseling
7. Individual Drug Counseling
8. MATRIX Model for Stimulant Addiction
9. Recovery Management Checkups
10. Relapse Prevention (also called Relapse Prevention Therapy)
11. Twelve-Step Facilitation Therapy
12. Medication-Assisted Treatments (mainly for alcohol, opioid or nicotine dependence)

Clinicians can incorporate RP into their individual, group or family work. Exposing clients to the major issues and principles of RP can aid their ongoing recovery and reduce relapses. Many of the clinical models listed above focus on RP as one area of focus during the treatment. For example, the Cognitive-Behavioral Coping Skills Therapy approach developed by Kadden, Monti and colleagues used in the NIAAA sponsored Project MATCH study aimed to help clients develop coping skills to manage cravings and thoughts of drinking alcohol, refuse offers to drink, cope with a lapse to prevent it from leading to a full-blown relapse, and understand how 'seemingly-irrelevant-decisions' can impact on relapse. [3] The Twelve-Step Facilitation Therapy model developed by Nowiski and Baker used in Project MATCH aimed to reduce relapse risk by helping clients understand and actively use the AA program.[4]

The Individual Drug Counseling (IDC)[5] model developed by Mercer and Woody, and the Group Drug Counseling (GDC)[6] model developed by Daley, Mercer and Carpenter for a NIDA sponsored large-scale, multi-site clinical trial of cocaine dependent individuals placed considerable attention to issues of relapse and RP. Both IDC and GDC provided specific sessions on RP issues as well as the opportunity for clients to discuss close calls, lapses, relapses and strategies to re-establish abstinence if substances were used.

RP has also been added to Behavioral Marital Therapy (BMT).[7] This BMT approach focuses both on relationship issues within the marriage as well as issues affecting relapse.

The MATRIX model of structured outpatient treatment developed by Rawson and colleagues in the treatment of cocaine or methamphetamine dependence includes considerable focus on RP in both individual and group sessions.[8] This program offers stabilization, education, RP, family and phase II therapy groups. Topic oriented RP groups are a central component of this model. The general goal of RP is to help addicted clients understand relapse and learn strategies to reduce the likelihood of a relapse occurring. Each RP group session involves the presentation of material relevant to relapse followed by a discussion of this material. Clients then have the opportunity to discuss recent problems or issues, which could impact on relapse. Sessions use informational and interactive handouts as well to help clients personalize the information. There are 19 topics in the RP module, which address issues such as relapse warning signs, relapse justification, lifestyle balance, and keeping a distance from relapse.

Models of Relapse Prevention

A variety of RP models are described in the literature, several of which have been adapted for use in clinical trials.[9] Most RP models incorporate principles or clinical strategies from Marlatt's original conceptualization of relapse. Despite any differences in theoretical underpinnings, philosophy of treatment or intervention strategies, models of RP have several components in common. They focus on the need for clients with an addiction to:

1. Have a broad repertoire of cognitive and behavioral coping strategies to draw upon for identifying and managing high-risk situations and warning signs of relapse.

2. Make lifestyle changes to decrease the need for addictive substances.

3. Increase healthy activities and pleasures.

4. Prepare for interrupting lapses to minimize damage and prevent these from becoming full-blown relapses; and learn to intervene quickly should a relapse occur.

Following is a brief review of three RP models. The reader can consult the references if interested in any of these or other specific models of addiction treatment or approach to RP.

Addict Aftercare Model (N.I.D.A.)

This RP model was developed through the collaboration of researchers in the United States and Hong Kong.[10] They adapted an aftercare model used in Hong Kong to treating opiate addicts in the U.S. Goals were to reduce relapse with drug abusers by developing aftercare treatment aimed at promoting lifestyle change. One result of this project was a descriptive manual that gives instructions on how to carry out a structured aftercare program that systematically addresses the need for lifestyle changes. This model presumes that besides being a disease, addiction is a way of life within a distinct subculture. Recovery requires the addicted person to stop drug use and develop a new way of life. Developing a new way of life requires learning new skills.

This model states that the addict faces a number of "recovery challenges" and needs “skills” to avoid relapsing. To remain sober, the client must learn to:

1. Handle drug cravings
2. Socialize differently in order to build a new social network
3. Adjust to drug-free activities and satisfactions
4. Cope with physical pain or stress without returning to drug use
5. Initiate and sustain relationships to meet intimacy needs
6. Refuse drug use offers
7. Respond to "slips" to prevent a full-blown relapse

This program consists of recovery training sessions, fellowship meetings, drug-free social and community activities, and a network of senior ex-addicts. Each of these components is discussed in detail in the treatment manual describing this RP approach. Like other RP models, this one addresses the reality of relapse, recommending that clients discuss this possibility before trouble arises. Honest reporting of actual drug-use episodes is encouraged. Problems should be confronted directly and the members should be aware of signs of trouble. Assessing actual relapses and discussing these in group sessions helps the person develop strategies to stop drug use. Honest sharing can help the entire group learn from the experience of individuals who relapse frequently.

All of the group session topics fall into one of the following four categories.

1. *Being clean*. The seven topics of this section deal with the most direct threats to abstinence and issues of drug use. The topics include: de-addiction and craving; your

dangerous situations; a drink, a toke--risks and limits; saying no; coping with pain and prescription medication; relating to active drug users; and tips about slips.

2. *Highs and lows*. The three topics of this section offer help with stressful events and anxieties associated with finding new pleasures in the first year or two of abstinence. The topics include: having good times without drugs; preparing for stressful situations; and coping with pain and prescription medication.

3. *Social relations*. Nine topics help recovering clients explore the social problems that are likely to confront them, including: assessing your social life; making a new friend; a more open recovery; love and intimate relations; issues of the recovering family; the goals of group membership; having the best group we can; relating to active drug users; recovery and community service.

4. *Work and growth*. The six topics on work and growth help the recovering person consider how performing certain roles in a straight world affects recovery. Topics include: phases of recovery; presenting your past for employment; a job that meets your needs; handling on-the-job problems; recovering and community service; looking ahead--plans, goals, and dreams.

Although this manual was developed for an aftercare program for opiate addicts, the topics lend themselves to easy adoption by rehabilitation, halfway house, therapeutic community and outpatient programs for any type of substance addiction. These topics are also adaptable to both individual and group sessions. There are many ways the clinician can use his or her experience and creativity to accomplish this.

Research showed that aftercare group members had better rates of abstinence or "rare" uses of opioids at the one-year follow-up period compared to members of the control group. This program also helped some of the unemployed participants find jobs.

Cognitive Behavioral Model (Marlatt and Colleagues)

Dr. G. Alan Marlatt from the Addictive Behaviors Research Center at the University of Washington was the first researcher to address the problem of relapse and propose RP strategies for clinicians, as well as integrate "mindfulness" strategies popular in today's treatment environment into an iteration of RP called "Mindfulness-Based Relapse Prevention (MBRP)".[11] His work resulted in one of the most comprehensive theoretical and clinical models of RP, which influenced many researchers and clinicians over several decades. This model has been adapted and applied to disorders such as impulse control problems and impulsive aggressive acts in addition to addictive disorders. This work is described in many publications, including the classic book entitled *Relapse Prevention: A Self-Control Strategy for the Maintenance of Behavior Change*. This is one of the most widely cited references in the literature on relapse. Dr. Marlatt is considered by many as a leading authority on RP (see figure 1).

Relapse prevention is a "self-management program" to help a person maintain changes such as abstaining from alcohol or other drug use (or gambling or other addictive or compulsive

behaviors). This approach engages the client as a co-therapist, giving her the primary responsibility for change. Recovery is a "learning task" that involves acquiring new skills.
This model of RP is predicated on key assumptions about behavior change. The first assumption is that the causes of an addictive habit and the process of behavior change are governed by different principles. Second, stopping addictive use of alcohol or other drugs involves three stages:

1. Making a commitment and becoming motivated to change
2. Implementing the change
3. Long-term maintenance of change

Marlatt identified multiple determinants of relapse. These fall into one of the two general categories, *intra*personal and *inter*personal factors. Examples of *intra*personal factors are negative emotional states, motivation, coping, outcome expectancies, craving, and self-efficacy. Examples of *inter*personal factors include social pressures to use substances, and conflicts in relationships.

The rationale behind such a categorization is to help addicted people identify which of these factors is "high risk" or threaten their recovery. A high-risk situation is defined as "any situation which poses a threat to the individual's sense of control and increases the risk of potential relapse." Someone may fail to cope with high-risk situations because coping skills are lacking, fear and anxiety inhibit a positive coping response, or the situation was not recognized early enough. Relapse episodes often follow *unexpected* high-risk situations, or those the client is unprepared for. Sometimes the person may "set-up" the relapse in which the relapse is the last link in a chain of events.

Assessing high-risk situations involves two stages. First, the clinician helps the client identify situations posing future relapse risk. Self-monitoring records such as the *Daily Drinking Diary*, self-efficacy ratings, autobiographical statements and a review of past relapses can be used to assess risks. The second stage involves assessing the client's coping skills through naturalistic observation of the client in an actual problem situation. Simulations and role-playing can also be used to assess these skills.

Three cognitive factors interact in the relapse process. These are self-efficacy, outcome expectancy and attribution of causality.

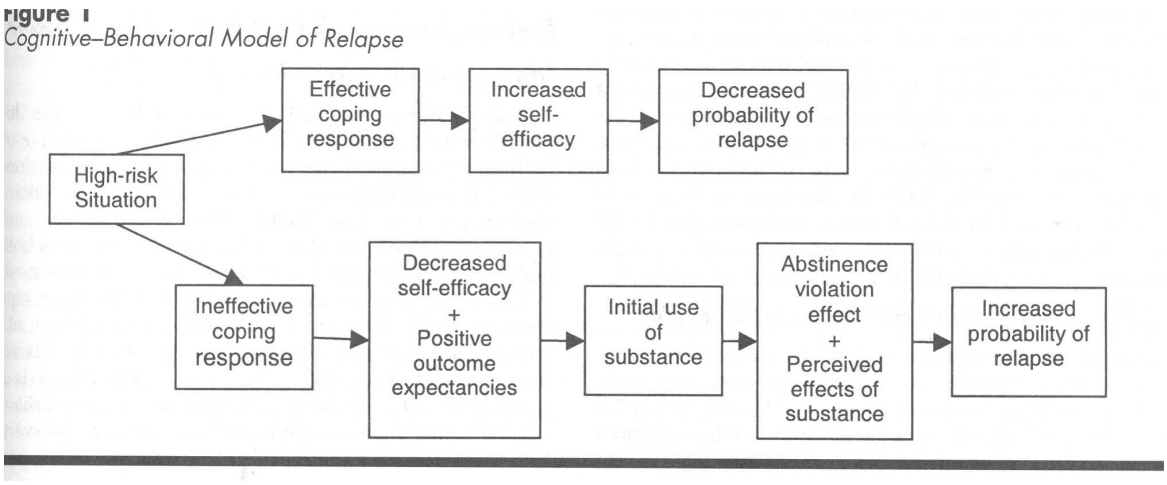
1. *Self-efficacy* is the client's judgment about well he deals with difficult, stressful or high risk situations.
2. *Outcome expectancies* are the anticipated outcomes of a given behavior. If a client expects the outcome of substance use to be positive the probability of relapse increases.
3. *Attribution of causality* refers to the client's perception of whether substance use was caused by internal or external factors. This has an impact on subsequent behavior. For example, if a client uses substances one time and believes he has lost control of his disease rather than accepting that a mistake was made, he is more likely to continue drug use.

Recovery strategies can address each client's unique high-risk factors. The clinician should strive for a balance between verbal and non-verbal techniques such as imagery, meditation and exercise. This model stresses the need for both specific and global RP strategies such as skill training, cognitive reframing strategies and lifestyle interventions. Cognitive or behavior coping skills to deal with "high-risk" relapse situations can be taught in individual or group situations. If these new skills are learned, then the probability of relapse decreases. Since teaching addicted clients explicit skills or cognitive strategies to cope with high-risk situations is not always enough to prevent relapse, clinicians need other "global" or self-control strategies such as positive addictions, substitute indulgences, exercise, relaxation, meditation, self-hypnosis and learning to develop a "balanced" daily lifestyle. Modifying one's lifestyle is critical in overcoming an addiction.

A broader purpose of RP is to ease changes in personal habits and lifestyle to reduce the risk of physical disease or psychological stress. The aim is to teach the client to prevent unhealthy habits by balancing work and play, and by developing positive habits. Achieving this requires a balance between the external demands or "should" activities, and those the person "wants" to engage in for pleasure or fulfillment.

The clinician can assess sources of stress in the client's life and the client's health status, exercise habits, relaxation practices, use of drugs or medications including caffeine, interpersonal activities and religious beliefs. Based on the assessment of these areas, the clinician can help the client develop a program for lifestyle change. This RP approach advocates teaching clients moderation when approaching lifestyle changes.

The person's reaction to an initial lapse as a crucial determinant of whether a "full-blown" relapse will occur. Initially using a substance after a period of abstinence is seen as a "lapse," or a "transitional process," that may lead to a return to previous levels of substance use. The client who lapses can be compared with a person at a "fork in the road,: one path leading to the former problem level of substance use and, the other path leading toward positive change. A lapse can represent an opportunity for growth, a useful learning experience. Therefore, clinicians should teach clients to anticipate and cope with "slips" or lapses to prevent full-blown relapses.



Psychoeducational (Daley)

This RP approach evolved from my (DD) review of the empirical and clinical literature, extensive treatment experiences and designing and conducting groups in addiction treatment programs.[12] This model operationalizes many of Marlatt's concepts and includes an interactive workbook for clients (*Relapse Prevention Workbook).* This workbook helps clients personalize information reviewed and develop a plan to address potential relapse factors.

Although this model was initially developed for use in a residential rehabilitation program, other clinicians adapted it in detoxification, therapeutic community, halfway house, intensive outpatient, outpatient and aftercare settings. Conducting this program in group sessions provides an opportunity to use the group process so that clients can give and receive feedback from peers and learn from each others. RP groups are "task-oriented" and involve brief lectures and discussions, and the use of dyads (two clients) or small groups to complete tasks that focus on a specific RP topic. However, all of these RP strategies can be used in individual sessions.

The goals are to educate clients about relapse, help them learn coping strategies to manage relapse risk factors and warning signs, and help them learn how to interrupt an actual relapse should one occur. This model views addiction is a biopsychosocial illness with multiple etiologies, adverse consequences, and manifestations. Recovery is viewed as a long-term process of abstinence and change, which can be difficult and painful in the early stages. The recovery needs of each client depend on: the length and severity of the addiction; age, gender, and ethnicity; and the degree of damage resulting from the addiction. Relapse is a multifaceted process resulting from a combination of affective, behavioral, cognitive, interpersonal, physiological, psychological, spiritual, and treatment-related variables. For many, relapse is part of the total recovery journey. Relapses often can be learning experiences and help recovery.

RP groups are designed to actively involve the participants in lectures, discussions, role-plays, and small task-oriented activities. The *Relapse Prevention Workbook* provides the content for the sessions. Homework tasks are sometimes assigned between group sessions. Sessions can last one to two hours. Chapter 6 of this book provides an overview of RP groups and provides a group curriculum for the following 12 sessions:

1. The process and domains of recovery
2. Cravings and urges to use substances
3. Managing anger
4. Managing boredom
5. Refusing substance use offers
6. Establishing a recovery support system
7. How mutual support programs aid recovery and reduce relapse risk
8. Identifying and managing relapse warning signs

9. Identifying and managing high risk situations
10. Maintaining recovery by using tools in daily life
11. Setbacks: managing a lapse or relapse
12. Creating a balanced lifestyle

Research Support for Relapse Prevention

As stated earlier, all treatment of addiction aims to reduce the risk of relapse. Outcome studies show that many behavioral, medication and combined treatments are effective in doing this even though many clients relapse once or more due to the chronic nature of addictive disease. And, many treatments of addiction incorporate strategies from the RP literature.

However, there is also a clinical and research literature specific to RP. Literature reviews, meta-analyses of multiple studies show that RP is effective in improving recovery and reducing relapse rates of individuals with an addiction.
Following is a brief summary of research findings:

1. *Review of randomized trials*:[13] Carroll reviewed 24 randomized controlled clinical trials of RP among smokers, alcohol abusers, marijuana abusers, cocaine abusers, opiate addicts, and other drug abusers. She reports that RP is superior to no-treatment control groups, especially with smokers. Carroll also reports that RP holds the greatest promise in helping the addicted individual maintain gains after stopping substance use and reducing the severity of relapses when they occur. Clients with higher levels of psychiatric and addiction severity appear to benefit most from RP. Thus, RP may be especially helpful for clients with co-occurring psychiatric disorders.

2. *Meta-analysis of clinical trials*:[14] Irvin and colleagues conducted a meta-analysis of 26 clinical trials on RP with a total sample of almost 10,000 participants. The RP approach used in these studies was consistent with Marlatt's cognitive-behavioral approach to RP. Irvin found that the strongest treatment effect for RP was with patients who had problems with alcohol or polysubstance use. They also found that individual, group and marital modalities appeared to be equally effective, and that medication is very helpful in reducing relapse rates, particularly for the treatment of alcohol problems.

3. *RP delivered in groups*:[15] Several studies found that RP administered in groups is as efficacious as RP delivered in individual sessions. McKay and colleagues randomized cocaine users to standard group or RP individual sessions, and found that those who endorsed a goal of total abstinence when entering treatment had better treatment outcomes in RP than those in standard group counseling.

4. *RP including spouses*:[16] Several studies included spouses in the RP intervention. Maisto and colleagues study of the first relapse episodes and reasons for terminating relapses of men with alcoholism who were treated with their spouses found that the relapses of clients receiving RP in

addition to behavioral marital therapy were shorter than those of clients not receiving the RP. In a study of married alcoholics, O'Farrell found that in couples assessed to be "high distress," abstinence rates at 12-months were highest for those who received behavioral marital therapy (BMT) in combination with RP. Alcoholics who received RP after completing BMT had more abstinent days, fewer days drinking and, for those with the poorest functioning at baseline, improved marriages compared to those who received only BMT.

5. *Delayed effects of RP among cocaine abusers and smokers*:[17] Carroll and colleagues compared cocaine abusers receiving RP to those receiving interpersonal psychotherapy (IPT). RP was more effective than IPT for clients with more severe cocaine problems and to some extent for those with higher psychiatric severity. In another outpatient study of cocaine abusers, Carroll and colleagues compared RP to an operationalized clinical management condition and medication condition (desipramine: a tricyclic antidepressant or placebo). At one year follow-up, they found a delayed improved response to treatment for patients who received RP. Rawson and colleagues found a similar "sleeper effect" for RP with cocaine addicts. Goldstein and colleagues also found a significant delayed effect for an experimental RP condition compared to an educational support control condition at six months for smokers treated in a 10 week group program. These findings of *delayed effects* of RP are consistent with the idea that learning new ways to cope with high risk situations takes time for the client with a substance use disorder.

6. *RP with alcohol problems*:[18] Saunders and Allsop found that male subjects receiving RP returned to problematic alcohol use at a rate of four to seven times less rapidly than subjects in a discussion control group at the six-month follow-up period. Chaney and O'Leary compared subjects receiving RP skills training to those receiving a discussion control group at 12-months. They found that subjects receiving RP drank less, had fewer episodes of intoxication, experienced less severe lapses for shorter periods of time, and stopped drinking significantly sooner after a relapse compared to clients in control condition. The mean number of "days drunk" and "total number of drinks" were significantly lower in the RP condition. Koski-James found that there was greater treatment adherence and satisfaction, reduced lengths of inpatient treatment, and fewer alcohol related arrests among clients receiving RP compared to clients receiving other treatment modalities. Ito and colleagues found that hospitalized alcoholic clients receiving RP drank on fewer days, drank less alcohol, were more likely to complete a course of aftercare treatment, and had a slightly higher rate of continuous abstinence at 6-month follow-up compared to clients who received interpersonal therapy.

7. *Medication combined with counseling*:[19] Kranzler assessed the effects of the antidepressant fluoxetine as an adjunct to RP in alcoholics and found that both fluoxetine and placebo groups decreased their number of drinking days and drinks per drinking day six months after treatment. Since there were no significant differences between the fluoxetine or placebo groups, the conclusion of Kranzler was that RP was a factor in improved drinking outcomes. O'Malley found that patients who received RP and naltrexone were less likely to relapse to heavy drinking after a lapse when compared to a control group.

8. *Findings from the Relapse Replication and Extension Project (RREP)*:[20] This was a multisite replication and extension study of Marlatt's RP model funded by the National Institute on

Alcohol Abuse and Alcoholism. The RREP addressed the relationship between a high-risk situation and relapse to alcohol use. Several changes were recommended to the taxonomy of high-risk situations as well as increased emphasis on factors that make some people more vulnerable to relapse regardless of the relapse situation. Broad categories of high-risk situations account for the factors originally proposed by Marlatt, with negative emotional states, social pressure to drink, physical withdrawal, craving, urges and substance-related cues as the most common high-risk situations for relapse. The availability of coping skills is a protective factor against relapse, and the use of ineffective coping is a consistent predictor of relapse. The availability and use of adequate coping skills and higher levels of self-efficacy are associated with preventing a crisis situation from turning into a relapse. Combinations of relapse precipitants operate in the context of a relapse event. Relapse factors that take place closer in time to a relapse (e.g., conflict with spouse) account for a substantially greater amount of variance in subsequent outcome than the relapse factors that are identified at intake (e.g., family history of substance use disorder). Also, the type of relapse that may occur in the future is not necessarily related to the type of the most recent relapse.

Limitations to Studies and Reviews of RP

While RP may not always be better than another behavioral treatment it is compared to, results of studies show it is often as good as these other treatments. This suggests that many treatments are effective and help reduce relapse rates among clients receiving treatment, including RP. As experienced clinicians know, treating addiction is a challenge due to the complexity of problems presented by clients, varying levels of motivation and degrees of social support.

There are several limitations to studies and reviews on RP. First, there is no consensus on when or how to define or measure relapse. For example, should this be measured during active treatment, at specified follow-up points in time (e.g., 3, 6, 12, 24 months)? Many clinical trials have short follow-up periods of less than 6 months so long-term outcome is not studied. Also, should the "primary" substance represent the main relapse outcome measure? In terms of how to measure relapse some of the possibilities include: time to first lapse or relapse; time to "heavy" or "regular" use of a substance (note: it is easier to define "heavy" alcohol use compared to drug use), days of substance use, amount of substance use, etc.

Second, some studies have used RP as the single treatment intervention for cessation of substance use rather than for maintenance of change once substance use was stopped. In the real world of clinical care, RP is usually integrated into the overall treatment plan. The interventions discussed in this book may be delivered at different stages of treatment.

Third, studies usually do not differentiate between subjects who are motivated to change substance use behavior and those who have little or no motivation to change (e.g., they may enter treatment due to external pressure from the legal system, an employer, or a family member). Clinicians understand that clients vary in their level of motivation to change. They also know that motivational strategies are often needed in the early stages of recovery to help engage clients in treatment and influence their desire to deal with their substance problem.

Fourth, in some studies sample sizes are small and there in not enough power to detect statistical differences between experimental and control conditions. Meta analyses that combine results from multiple studies are one way to use data from multiple studies, including those with small sample sizes.

Fifth, studies do not always use random assignment or operationalize the therapy being compared against RP making it difficult to determine what factors contribute to treatment effects. In more recent clinical trials, comparison groups (usually called "usual care" or "treatment-as-usual") are used against which to compare clients receiving the intervention.

And last, the follow-up period to study relapse following a period of treatment is often short-term. Clinicians would prefer longer term follow-up periods (several years), but the high cost of conducting studies often limits follow up periods to a year or less.

Despite these limitations, the literature shows that RP strategies enhance the recovery of individuals with substance use disorders and improves substance use outcomes.

Conclusions

A variety of clinical treatment models and RP approaches have been developed to reduce relapse risk and improve psychosocial functioning and the quality of life. Many of the cognitive and behavioral interventions described in these RP approaches can be adapted for use with clients who have other compulsive disorders, impulse control disorders, or co-occurring psychiatric illnesses.

RP interventions aim to help clients maintain change over time and address the most common issues and problems raising vulnerability to relapse. RP also aims to help clients make broader lifestyle changes that reduce stress and facilitate personal growth and satisfaction.

Studies indicate that RP has efficacy in reducing both relapse rates and the severity of lapses or relapses. Clinical RP strategies can be used throughout the continuum of care. In addition, family members can be included in educational and therapy sessions and involved in the development of RP plans for members with substance use disorders. Medication-assisted treatment added to RP is also helpful to some clients.

Many of the RP approaches described in the literature are short-term or brief treatments, and can be provided in individual or group sessions, making them attractive and cost effective. The majority of clinical models of RP are supported by user-friendly, interactive recovery materials such as books, workbooks, videos and audiotapes. These supplemental materials provide additional information and support to clients who can learn to use self-management techniques of RP on their own, following completion of formal treatment.

CHAPTER FOUR

Counseling Strategies to Reduce Relapse Risk

Introduction and Overview of Chapter

This chapter describes clinical strategies that reflect the approaches of researchers and clinicians who have developed models of RP and written client oriented recovery materials.[1] These strategies can be used in individual or group sessions. Some can be used with families.

The use of experiential learning or action techniques such as role playing or behavioral rehearsal, monodramas, bibliotherapy, use of workbooks, a daily inventory, interactive videos and homework assignments makes learning an active experience. Such techniques can enhance the client's self-awareness, decrease defensiveness and encourage positive behavioral change. In RP groups, action techniques provide the opportunity to elicit feedback and support for clients from their peers, identify common relapse themes and issues related, and practice specific cognitive or interpersonal skills. For example, the group leader sets up a role-play in which a male cocaine addict in recovery is offered cocaine by another addict who is not in recovery. Other group members are instructed to imagine that they are also in this situation and to pay close attention to their thoughts and feelings as they observe the role-play. Although the client refuses the substance offer during the actual role-play, the post-role play discussion reveals several interesting facts. First, the client's body language and affect during the role play are viewed by observers as giving mixed messages to the other addict offering the drug, thus opening the door for the person to continue to pressure the addicted person to use drugs. Group members believe that ambivalence about sobriety is easily perceived by other addicts offering substances. Second, although the client refuses the offer to use the drug, his internal dialogue is much more ambivalent and strong thoughts of getting high on cocaine emerge. This takes the client by surprise because he feels his commitment to abstinence is strong. And finally, when other group members share their reactions regarding what it is like imagining being in this situation, it becomes apparent that the majority feel that such interpersonal encounters tap the "addicted part" of them that still wants to use substances. While some clients are not surprised by this, others are. Such experiential learning often leads clients to look beneath the surface and examine internal thoughts, feelings and desires. Once clients are aware of these, the clinician can then help them explore, develop and practice strategies to manage social pressures they expect to face.

The strategies discussed in the remainder of this chapter are adapted from the various models of RP as well as other treatment models that incorporate relapse issues into treatment. Several clinical examples are provided throughout this discussion. Strategies are clustered in the categories of treatment adherence, illness management, relapse prevention and intervention skills, emotional management skills, relationship skills and support systems, cognitive coping skills and lifestyle issues.

1. Treatment Adherence

Incorporate Strategies to Improve Adherence

A friend of mine told me that Woody Allen was quoted as saying "80% of success is showing up!" This speaks to the importance of adherence. Poor adherence to treatment services or recovery activities is a major factor in relapse. On the other hand, good adherence increases the odds of recovery and decreases the chances of a relapse. If the client shows up, you can help! Even if the client is struggling with motivation to change, using substances or having other problems, you can help them if they attend their sessions. For example, I had a client who I was seeing in outpatient treatment (following a rehab program) for alcohol dependence. After our fifth weekly session he told me "I didn't tell you the truth last week when you asked if I had drank any alcohol. I drank twice in the past two weeks." I thanked him for sharing this with me and we used it to discuss several important issues: factors that contributed to his alcohol lapse, how to stop this lapse now, what it is like for him to share the truth and how being open about any episodes of use is necessary for treatment to work. He could have chosen not to come to sessions, but he didn't. By adhering to his scheduled sessions, we were able to address his lapse. I believe this was a critical point in our therapy as he told me later he was watching closely for my reaction to his use of alcohol and wondering if I would confront him. Following completion of individual (and some marital sessions) treatment he continued in AA and the last I heard he had over five years of continuous sobriety and was still active in AA.

Many studies show that clients who adhere to treatment show better outcomes and lower relapse rates compared to those who do not adhere to treatment, miss sessions or drop out early. The following strategies can help you improve adherence to treatment among your addicted clients.[2]

1. *Motivation*: accept as normal the client's ambivalence regarding treatment participation or change, accept and appreciate small changes he makes, anticipate non-adherence at various stages of treatment, discuss any prior history of poor adherence and discuss motivational struggles and adherence problems immediately. Use strategies from Motivational Interviewing to help enhance a client's motivation to change and engage in treatment or recovery.

2. *Therapeutic relationship*: understand the importance of your relationship with your client (and group), express empathy and concern, convey helpfulness in your attitudes and behaviors, encourage the client to discuss the counseling process and the client-counselor relationship. If you conduct groups, periodically ask the members how the group is doing, what they find helpful and what changes they would like to see in the group.

3. *Treatment preparation*: explore the client's hopes and expectations for treatment, any resistance or barriers to treatment, discuss pros and cons of treatment from the client's perspective, and prepare the client for what occurs in various forms of treatment (e.g., group therapy, an intensive outpatient program, medications or a specific form of counseling). I have spoken with many clients who told me they were assigned to an intensive outpatient program without knowing much about what went on other than the general idea that they would be in group sessions with others recovering from an addiction. I think preparation for

group is important as you can set the stage for the client to listen and learn, self disclose personal feelings and problems and give and get support from peers.

4. *Treatment plan development*: negotiate rather than dictate the treatment plan, emphasize to the client that it is her responsibility to change, review goals and progress regularly, discuss pros and cons of abstinence as a goal, and provide options regarding treatment (i.e., no one type of treatment is appropriate for all clients). If a client does not accept the optimal treatment that you recommend at this time, negotiate a plan in which the client agrees to this treatment in the future if the plan currently chosen does not work. For example, I worked with a nurse who had an addiction and serious depressive illness that I thought required medication. She initially refused to consider medications for her mood disorder. However, she agreed to reconsider this option if her mood did not improve over the next several weeks. Despite getting and staying sober from alcohol, her mood improved only slightly over a period of two months. She then reluctantly agreed to see our program psychiatrist and take an antidepressant that was prescribed, which lead to a significant mood improvement. As her mood improved she reported her recovery from alcoholism went better and she felt her life was so much better.

5. *Treatment process*: use evidenced-based practices, change treatment frequency or intensity as needed, give the client feedback about her problems and progress, discuss her reaction to this feedback, provide reinforcement for treatment adherence, and address social anxiety regarding group participation if client is attending a residential, intensive or other group oriented program (including mutual support programs). For example, we had an elderly woman (one of the few clients who cussed me out in my office over the years) with chronic social anxiety and depression that was dependent on alcohol and benzodiazepines. Once our outpatient treatment team was able to wean her off the benzodiazepines and get her on an SSRI (Zoloft®) to help her depression and anxiety, she became more stable and able to use therapy. As her social anxiety decreased as a result of medications and our work in therapy, she was able to join a treatment group and attend AA meetings. Several years after she moved to another State to be closer to her family, she called to update me. She was still taking medications and seeing a therapist and psychiatrist for maintenance treatment each several months and active in AA.

6. *System strategies*: develop a clinic or program philosophy on adherence, provide easy access to treatment for clients, provide flexible appointment times, use prompts or phone reminders regarding appointments, reach out to poorly adherent clients, use case management services for more chronically impaired clients, establish program and clinician benchmarks for acceptable levels of client adherence to scheduled treatment sessions and conduct regular satisfaction surveys with clients and families. For example, one of our clinics established an acceptable show rate for outpatient appointments and had clinicians review adherence rates with a supervisor regularly. This led to a greater awareness of adherence problems and changes in the clinic such as calling to remind new clients of their appointments, and clinicians following up with clients who missed appointments. A result was improved adherence rates.

7. *Use motivational incentives to reward adherence to treatment sessions*: motivational incentives is very robust in the effects on clients.[3] Incentives are usually used to reward

abstinence from alcohol or other drugs. However, incentives can also be used to reward adherence to treatment sessions. For example, in one of our acute partial hospital programs for clients with addiction (including those with a co-occurring psychiatric disorder), clients earned draws from a fishbowl for each day of program attendance and extra bonus points for attending the program on consecutive days. At the end of each week, clients drew slips from a fishbowl; about half had an encouraging saying written on them (good job; keep coming back; etc) and the other half listed small, medium or large prized. Small prizes were valued at $2 of less; medium prizes at about $5; and large prizes at $10 or more. The result of using incentives was that attendance increased by 60%, a significant improvement as a result of providing incentives to clients for attending the treatment program.

Facilitate the Transition Between Levels of Care

Clients can make significant gains in residential or hospital treatment programs only to have these negated due to failure to adhere to ongoing residential, ambulatory or aftercare treatment. Interventions used to enhance treatment entry and adherence that lower the risk of relapse include the provision of a single session using a motivational approach prior to discharge from inpatient treatment, the use of telephone or mail reminders of initial treatment appointments, and providing reinforcers for appropriate participation in treatment activities or for providing drug free urines. Connecting with a staff member from the program the client will be attending can help too, but this is often hard to offer due to logistics (programs in different physical locations).

In one of our quality improvement surveys, we found that a single Motivational Therapy (MT) session provided to hospitalized psychiatric patients with co-occurring substance use disorders led to a nearly two-fold increase in the show rate for the initial outpatient appointment. A study by Swanson and colleagues found that inpatients with schizophrenia and substance use disorders who received a single motivational session prior to hospital discharge more than doubled their initial aftercare entry rates. Clients who show for their initial appointment have a reduced risk of treatment dropout and subsequent psychiatric and/or substance use relapse. Therefore, the transition between inpatient and ambulatory care is an important area upon which to focus clinical interventions.[4]

2. Medication-Assisted Recovery

Offer Medications with Psychosocial Treatments

Prolonged substance use can cause alternations in brain chemistry, which can be helped with medications. Medications for addiction may disrupt the reward provided by alcohol or drugs or affect the dysregulation of brain chemistry caused by substances. The use of medication-assisted treatment reduce the client's use of substances, decrease the risk of transmitting or acquiring hepatitis B or C or HIV, increase retention in treatment, and enhance the health of this individual. For pregnant mothers, medication can lead to improved birth outcomes for babies.

Medications should be combined with therapy or a psychosocial treatment program. They can be especially helpful for clients with a history of multiple relapses to alcohol, opioids or nicotine. Medications are also a necessary for more severe and chronic mental health disorders such as bipolar illness, recurrent major depression, psychotic disorders and certain anxiety disorders.

You can help your client by providing information about medication-assisted treatment, facilitating a medication evaluation for clients who want or you believe may benefit from combined treatments based on current problems and past experiences with treatment. Some clients need help in overcoming their reluctance to consider medications either for an addiction or a psychiatric illness so it may take time to persuade them to consider medications. Following is a review of medications used with clients.

1. *Alcohol dependence*:[5] medications that benefit clients with ongoing recovery from alcohol dependence include disulfiram (Antabuse®), naltrexone (oral form is Revia®, Depade®; injectable extended release form is Vivitrol®) or acamprosate (Campral®). Disulfiram interrupts the metabolism of alcohol and creates an unpleasant and sometimes dangerous reaction if the client drinks with this drug in his system. Since this medicine can remain for up a week or more in the body after the last dose this may can influence the person not to drink while the medication in still in his system. By the time the medicine clears, the client's desire to drink may have lessened or stopped. Naltrexone occupies and blocks the mu opioid receptor sites and decreases the pleasant effects of alcohol, often leading to less alcohol consumption by the client taking this medication. Acamprosate improves the regulation of the neurotransmitters GABA and glutamate (associated with physiological craving) and is believed to decrease cravings for alcohol by normalizing these transmitters.

   In addition to attenuating or reducing cravings for alcohol, these medications may also enhance motivation to stay sober, increase confidence in the ability to resist substance use and reduce the severity of lapses or relapses. A review by Garbutt and colleagues of 41 studies found that naltrexone and acamprosate were the most helpful pharmacologic adjuncts used with alcoholics.[6] Clients taking naltrexone were much less likely to continue drinking following the initial use of alcohol compared to control subjects. O'Malley and colleagues found that alcoholic clients who received RP along with naltrexone who returned to drinking were less likely to experience a relapse to heavy drinking compared to those who received supportive therapy plus naltrexone.[7]

2. *Opioid addiction*:[8] medications that benefit clients with ongoing recovery from opioid addiction include methadone (Methadose®, Dolophine®) or buprenorphine (Subutex®; buprenorphine and naloxone combined is Suboxone®). Methadone, a full mu opioid receptor agonist, is taken in liquid or pill form and is dispensed only in licensed opiate treatment programs that are highly regulated. This "replacement" medicine helps to prevent withdrawal symptoms and reduce drug craving. The client may have to attend the clinic daily at first and then several days per week later. Buprenorphine is a partial mu opioid receptor agonist that addresses the biological basis of opioid dependence. Both Subutex® and Suboxone® are administered as a single film or tablet dose sublingually. Buprenorphine prevents opioid withdrawal symptoms by providing mild agonist effects and occupies opioid receptors so illicit opioids will have no effect. Suboxone is the preferred method of buprenorphine treatment because it deters clients

from using the medication inappropriately or selling it illicitly. Buprenorphine is provided by specially trained physicians in private practice or as a part of a licensed addiction treatment program. This drug is used to help detoxify the client or as a maintenance drug once sobriety has been stabilized. The opiate antagonist naltrexone (Revia® and Vivitrol®) is used to block the euphoric effects of opiate drugs, which can lead to an extinction of drug craving. All of these drugs are used with therapy or counseling and/or participation in mutual support programs.

3. *Nicotine addiction:* medications used for withdrawal symptoms or ongoing abstinence from nicotine include varenicline (Chantix®), buproprion SR (Zyban®), nicotine gum, nicotine lozenges, nasal spray, puffer ("inhaler") or transdermal patch. These may be used singly or in combination to help the addicted client stop using nicotine and deal with strong cravings that often occur when a person stops using nicotine.[9]

4. *Stimulants addiction*: Many medications have been used for stimulants (cocaine and methamphetamine) addiction but at this time there are no FDA approved medications for this addiction. Several studies are currently being conducted so it is possible a helpful medication may be found in the near future. Also, a vaccine to treat cocaine addiction is also being studied to see if this helps cocaine addicts. According to a review of medication studies by O'Brien, a leading expert in medication-assisted treatment of cocaine addiction, the most promising medications to date to treat cocaine addiction include disulfiram, modafinil, topiramate, propranolol, buspirone, and baclofen. [10]

5. *Marijuana addiction* Medications for marijuana dependence have not received a lot of attention. To date no medications have FDA approval for addiction to this drug.

6. *Medications for co-occurring psychiatric illness*: As mentioned earlier two large community studies and many clinical studies show high rates of addiction combined with psychiatric illness (a condition called co-occurring disorders). Treatment of psychiatric illness with appropriate medications has important implications for recovery from mental illness and addiction, and in reducing relapse risk with both disorders. Several studies showed that anxious alcoholic clients receiving buspirone or atenolol (a beta-adrenergic blocker) showed greater retention in treatment at 12 weeks, reduced anxiety, a slower return to heavy alcohol use and fewer drinking days compared to those receiving placebo.[11] Cornelius found that fluoxetine was effective in decreasing both depressive symptoms and alcohol use among severely depressed alcoholics.[12] Salloum found that depressed alcoholics who only had a partial response to an SSRI benefited from adding naltrexone.[13]

Monitor Medication Use and Side Effects

Poor adherence to medications is a common problem and contributes to poor treatment outcome among individuals with chronic medical disorders such as asthma and diabetes, psychiatric disorders such as major depression, bipolar illness or schizophrenia, and addiction to any substance. Poor adherence shows in failure to take medications as prescribed (taking too much or too little or missing doses), failure to renew prescriptions, and mixing medications with alcohol or illicit drugs. Clients may be poorly adherent to medications for a number of reasons: they are disorganized and have difficulty following a schedule of taking medicine; their motivation to recover fluctuates; they have no access to care and they cannot afford to pay for medications; they experience uncomfortable side effects; or they want to continue using alcohol or other drugs and do not want to risk interactions between these substances and medications.

Monitoring medication use and side effects can help identify adherence problems early before these lead to adverse outcomes. This requires asking direct questions about medication use and side effects, and probing for specific details when there is some indication that medications are not being taken consistently as prescribed. For example, if a client attends an intensive outpatient program, part of the "check-in" procedure can include reporting on medication adherence (or non-adherence) in addition to reporting on substance use or close calls and attendance at support group meetings. Supervised administration of medications by either a family member or a concerned significant other could help enhance adherence to medications.

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3. Addiction Management Skills[14]

Teach Craving Recognition and Management

Cravings, urges or desires to use substances are common when a person stops using alcohol or other drugs. These are triggered by environmental cues associated with prior use such as the sight or smell of the substance or something associated with using it (e.g., a specific person, location, event, object, song, etc). Or, they are triggered by internal factors such as emotions or thoughts. For example, some clients report increased craving in response to feeling bored or anxious. Others report increased cravings when they start believing that they need some "action" to make life fun or want to escape from the monotony of life.

Dr. Nora Volkow, the Director of the National Institute on Drug Abuse, hypothesizes that the dopamine stimulation that occurs with long term drug use leads to disruption of the brain circuitry involved in regulating drives.[15] This in turn leads to a conditioned response such as craving when exposed to external stimuli, which may lead to relapse to compulsive drug taking. And, since there are so many external stimuli associated with addiction, cravings are common and can come out of the blue when not expected.

You can provide information about cues and how they trigger cravings for alcohol or other drugs. Teach clients how to monitor and record cravings (in early recovery), associated thoughts and behavioral outcomes in a daily log or journal. This can help them become more vigilant and prepared to cope with cravings. And, they may identify patterns to their cravings and how they respond to them.

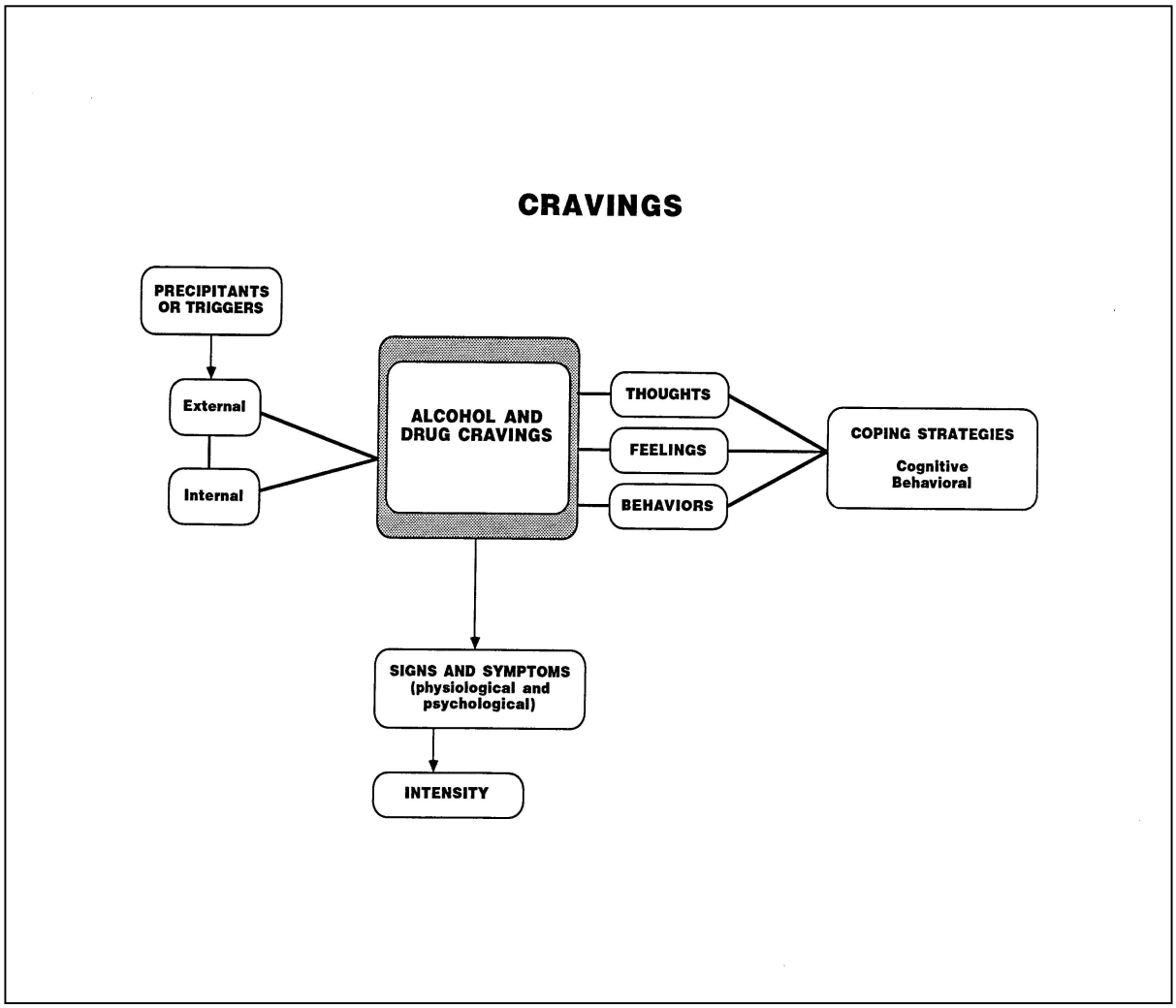
Cognitive interventions include changing thoughts about the craving, urge or desire to use, challenging euphoric recall (how good it felt being high), talking oneself through the craving, thinking beyond the high by identifying negative consequences of using again (immediate and delayed), positive benefits of not using, using recovery slogans and delaying the decision to use.

Behavioral interventions include avoiding, leaving a situation or event, changing situations that trigger or worsen a craving, redirecting activities, getting involved in pleasant activities, getting help or support from others by admitting and talking about cravings and hearing how others have survived them or attending self-help support group meetings.

Taking medications such as disulfiram, naltrexone or acomprosate may reduce cravings and increase confidence in the ability to cope with desires for alcohol, opioids or nicotine. Combining medications with counseling gives the maximum benefit in dealing with cravings.

Marlatt describes an interesting experiential strategy for managing cravings. The client is instructed to "detach" from his craving by externalizing and labeling it. Similar to a surfer who must learn to ride the waves so as not to get wiped out, the addicted client imagines riding "the crest of an urge or craving, maintaining balance until the crest has finally broke and the wave of feeling subsides." Another strategy is using "mastery imagery" to help the client view herself as successfully defeating the craving, for example, by driving a large tank and crushing the craving.

The figure that follows illustrates one way of thinking about cravings and how to manage these. It shows that many factors precipitate cravings, which can show in many different signs. Cravings or urges affect thinking, feelings and behaviors, which then leads to a decision on whether or not to use an active coping strategy. Since cravings are so common and can be quite intense, clients need a variety of coping strategies to call upon when they desire alcohol or other drugs.



Evaluate Environmental Triggers or Cues

While many triggers and cues are outside of the client's control, all are not. In early recovery, for example, clients can be advised to avoid high-risk people, places, things and events that are associated with substance use. The idea is to minimize exposure to people or situations that increase the risk of relapse. The more obvious ones are active substance abusers, bars, clubs, parties

and places or events where drugs are used. Avoidance is usually recommended because it takes away the direct threat often felt, especially during early recovery when the recovering person is less experienced using active coping strategies to manage cravings.

Clients can also take active steps to modify their immediate environment. The most obvious examples are to remove alcohol, drugs and drug paraphernalia such as needles, pipes or other items associated with preparing or using drugs or partying.

The chart that follows provides some examples of both internal and external triggers common among individuals in recovery.

Client Examples of Internal and External Triggers	
Internal	**External**
"I am so bored with recovery. I need some action."	"My girlfriend smoked dope in front of me."
"I'm pissed at my boss; it makes me want to drink."	"Everyone drinks at family gatherings. I want to fit in and feel normal!"
"I'm real upset with my husband"	"Hearing certain music makes me want to get high. It reminds me of partying."
"I can't get idea of drugs out of my head. I want to get high real bad."	"Seeing baby powder reminded me of cocaine."
"I wonder if I am capable of coping with problems and staying sober"	"Feeling a needle for flu shot reminded me of dope."
"Why would a few drinks hurt?"	"I found a joint in my sweater drawer. It looks so tempting."
"This pain is too much a joint would make me feel better."	"My boyfriend wants us to use cocaine for better sex."

Identify and Prepare to Resist Social Pressures to Use Substances

Direct and indirect social pressures often lead to increased thoughts and desires to use substances as well as anxiety regarding one's ability to refuse offers to drink alcohol or use other drugs.[16] In some instances, the client can be taken by surprise at the strength of such pressures, especially when it is unexpected. For example, a heroin addicted woman who had been drug free for several months received an unplanned visit from an old friend with whom she used to get high. After the client invited the friend into her house, the friend casually asked if she wanted to get high on crack. The client said she did not want to. The friend then asked the client if it was OK to smoke crack in her house. The client reluctantly gave in to this request and later in the evening ended up smoking crack. The next day she reflected on this experience and felt guilty for using drugs. However, she then told herself if she was going to relapse it might as well be on her drug of choice so she called her dealer and bought heroin. In reviewing this experience with her clinician, the client realized that she was not fully prepared to refuse social pressures to use drugs and, she had made two "apparently irrelevant decisions" that impacted on her relapse (i.e., first, by letting her drug using friend come

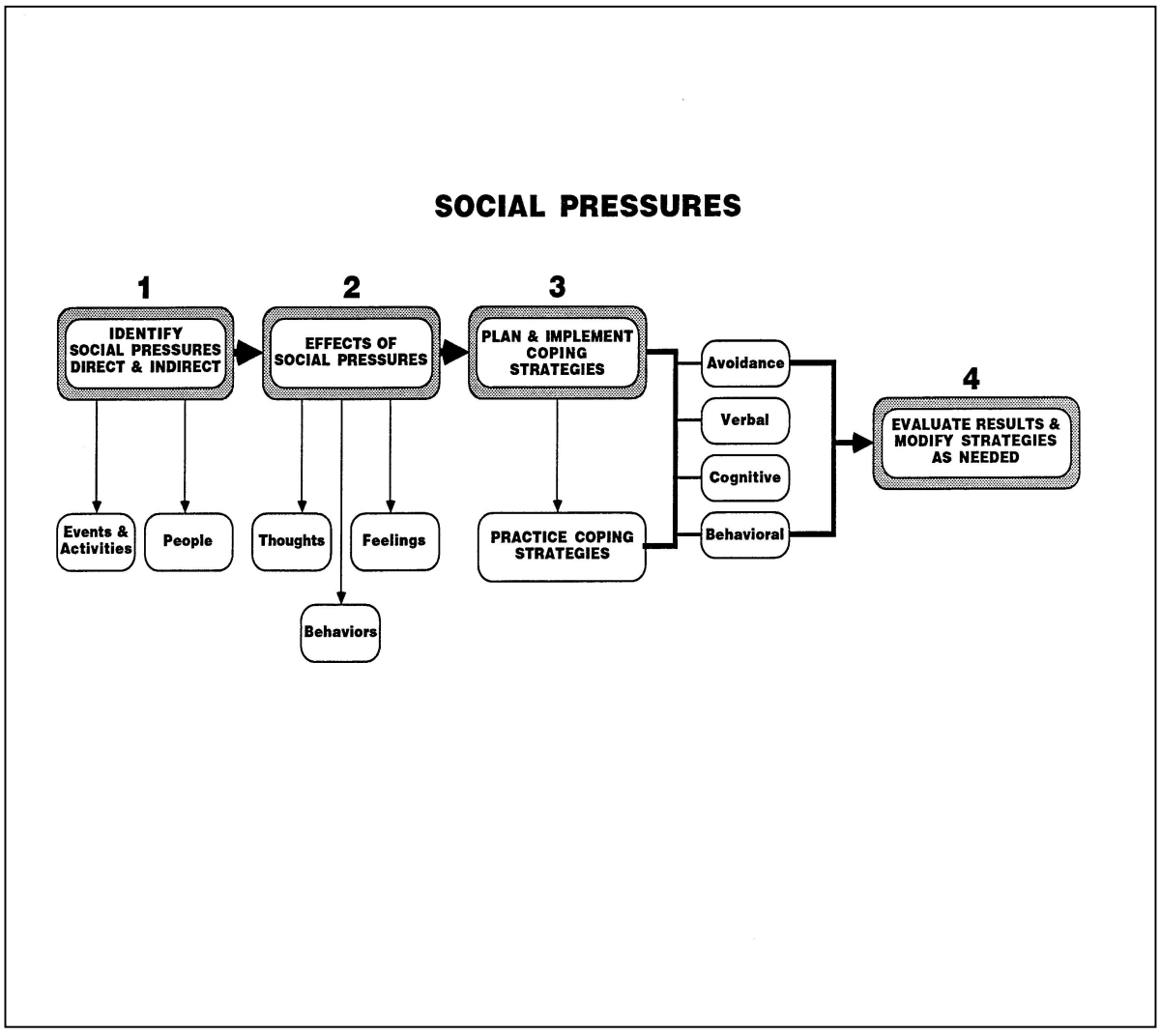
into her home, and second, by letting this friend smoke crack cocaine in front of her) that impacted on her relapse.

You can help your client identify high-risk relationships (e.g., living or socializing with, or dating an active substance abuser) and social situations or events in which the client may be exposed to, or offered, substances. The next step is to assess the effects of these social pressures on the thoughts, feelings and behaviors of the client. Planning, practicing, and implementing coping strategies is the next step. Coping strategies include avoidance of high-risk people, situations and events when appropriate, and the use of verbal, cognitive, or behavioral skills. Rehearsing ways to refuse offers of drugs or alcohol is one practical and easy-to-use intervention. The final step of this process involves teaching the client to evaluate the results of a given coping strategy and to modify it as needed. Ineffective strategies need to be replaced and effective ones continued.

While some social situations cannot be avoided, it is not unusual for a client to sabotage recovery by making what Marlatt refers to as "apparently-irrelevant-decisions," which are a "set-up" for relapse. For example, a recovering drug addicted client accepted a date with a man she knew was still using drugs and put herself in a very risky situation. An alcoholic sober for several months went on a weekend golfing trip with several friends with whom he used to drink. Since these weekend trips often involved excessive drinking just by accepting this invitation he put himself at higher risk for relapse to alcohol use. Although both of these individuals successfully resisted pressures to use substances, they reported feeling extremely awkward, anxious and "close" to using. It is likely that similar situations have occurred with others and contributed to their relapses.

In some cases, pressures to use alcohol or other drugs result from relationships with active substance abusers or being part of a high-risk social network in which substance use plays a significant role. Therefore, the client needs to assess his/her social network and if needed, learn ways to limit or end relationships that represent a high risk for relapse.

The chart that follows on the next page illustrates there are different types of social pressures (direct and indirect), which lead to different effects on the recovery person. As with other issues in recovery, multiple coping strategies are needed to successfully cope with social pressure to use alcohol or other drugs.



Identify and Manage Inaccurate Thinking ("stinking thinking")

Errors in thinking (also called cognitive distortions) are associated with both psychiatric and substance use disorders, and have been implicated in relapse to either type of disorder.[17] Marlatt believes that cognitive distortions may increase the probability that an initial slip or lapse will develop into a total relapse for the client. Twelve-Step programs refer to these patterns of thinking as "stinking thinking" and suggest that recovering people need to alter their thinking if they are to remain alcohol- and drug-free.

Teaching clients to identify their inaccurate or negative thinking patterns or cognitive errors (e.g., black-and-white thinking, awfulizing, overgeneralizing, catastrophizing, jumping to conclusions, etc.) and evaluate how these affect recovery and relapse is one strategy. Clients can then be taught to use counter thoughts to challenge their thinking errors or specific negative thoughts.

One way to achieve this is to have the client discuss or write down: (1) specific relapse-related thoughts (e.g., "relapse can't happen to me"; "I'll never use alcohol or drugs again"; "I can control my use of alcohol or other drugs"; "a few drinks, tokes, pills, lines won't hurt"; "recovery isn't happening fast enough"; "I need alcohol or other drugs to have fun"; and "my problem is cured"); (2) what is wrong with such thinking in terms of potential impact on relapse; and (3) new self-statements or thoughts that counteract negative thinking. Many of the AA and NA slogans were devised to help alcoholics and drug addicted individuals alter their thinking and survive desires to use substances. Slogans such as "this too will pass," "let go and let God," and "one day at a time" can help the client manage thoughts of using.

Teach the Client to Use a Daily Inventory

A daily inventory keeps the client vigilant about recovery and focus on recovering one day at a time. Such an inventory can be used at the beginning of the day to identify issues to work on during the day, and to identify recovery strategies to use. It can also be used at the end of the day to reflect on the day. Some questions for the day end inventory include:

1. What problems or goals did I work on today?
2. What progress did I make and how satisfied am I with my progress?
3. Were there any relapse warning signs present today that represent a potential threat to my ongoing recovery?
4. If yes, what steps can I take to manage my problems or relapse warning signs to reduce my risk of an actual relapse?

4. Psychiatric Illness Management Skills

Monitor Acute Symptoms of Psychiatric Illness

You can teach your client to regularly review or monitor the major symptoms of his specific psychiatric illness (es).[18] These may include mood, psychotic, somatic or behavioral symptoms. Symptom monitoring is important for both the client and clinician and helps them determine if improvements are being made. It also helps them know if symptoms are worsening and may require a new treatment strategy. For example, a client with moderate depression may elect to participate in psychotherapy and try to recover without medication. If mood symptoms do not improve or worsen with therapy alone, the clinician may then try to persuade the client to consider a trial of medications and arrange an evaluation with a psychiatrist or other physician.

When symptoms of an acute episode of illness significantly improve or remit, regular monitoring enables the client and clinician to identify early signs of relapse. This may result in reducing the possibility of relapse to a full episode of illness.

Manage Persistent Symptoms of Chronic Psychiatric Disorders

Recurrent depression, bipolar illness, schizophrenia, and many of the anxiety and personality disorders are chronic conditions in which some symptoms may never totally remit. For example, individuals with schizophrenia may hallucinate or have delusions despite taking antipsychotic medications. Clients with depressive or anxiety disorders may still experience symptoms despite being treated with medications, therapy or combined treatments.

Dr. Alan Belleck and colleagues and Dr. Robert Liberman developed social skills training programs for clients with chronic mental disorders such as schizophrenia.[19] One of treatment modules in Dr. Liberman's program teaches clients four main skills to manage symptoms and reduce the risk of relapse:

1. Identify early signs of psychotic relapse.
2. Manage early signs of psychotic relapse so the client's condition does not worsen.
3. Manage persistent symptoms of illness.
4. Avoid alcohol and drugs since these substances interfere with the efficacy of medications or the client's motivation to recover.

One of the strategies to manage persistent symptoms is to have the client identify and label (or name) his persistent symptom(s). For example, a "hallucination" could be labeled or named by the client as a hallucination, hearing voices, or hearing voices telling the client that he is worthless. The client then rates the persistent symptom on a daily basis. Once an acceptable baseline is determined, the client and clinician can agree upon a symptom rating that indicates action is needed. Strategies to manage persistent symptoms are taught to the client so he has ideas on how to manage these should they occur.

Monitor Participation in Treatment and Recovery

Treatment participation can be monitored by discussing adherence to taking medications, attending therapy sessions, attending group sessions in a partial hospital program or intensive outpatient program, or completing therapeutic assignments aimed at helping the client reach goals. The clinician can also engage the client in a discussion of the treatment experience to identify and address impasses in therapy as well as client behaviors that could sabotage progress in treatment. For example, if a client fails to make agreed upon behavioral changes yet constantly demands changes in medications when symptoms change, the clinician can explore this in sessions. A joint session with the psychiatrist can also help in such a situation since clients can sometimes convince doctors to change medications without giving them all of the information that was provided to a clinician.

Monitoring participation in recovery support groups such as AA, NA, DRA (Dual Recovery Anonymous) or mental health related groups can help the client spot problems early, which in turn can have an impact on reducing relapse risk. It is not unusual, for example, for a client's relapse warning signs to show in reducing or stopping recovery activities without first discussing

such changes with his therapist. Such monitoring also gives the therapist an idea on whether the client is an "active" or "passive" participant in support programs. Those who actively participate in these programs usually do better than those who are passive and do not actively use the "tools" of the program.

5. Emotion Management Skills

Help Client Identify and Manage Emotions[20]

In my treatment programs we often implement quality improvement projects in which we ask clients about their experiences and ideas related to their addiction or recovery. One project involved asking 168 clients from 14 different treatment groups in residential and ambulatory programs to state what they thought were the challenges they faced in recovery from their addiction. The category with the most responses was "dealing with emotions." In order of concern for clients was dealing with painful feelings, boredom, anxiety and fear, depression, guilt and shame, anger, hopelessness, emptiness, and loneliness.

Another project had over 100 clients complete a questionnaire to identify how many had symptoms of "social anxiety" and how many "avoided" social situations because of this anxiety. About one-third of our clients identified significant social anxiety and most of these avoided situations causing this anxiety. This is something clients seldom talk about in treatment if clinicians do not ask about it. And, this issue has great implications for recovery since many of these clients will not attend, or will drop out early, from mutual support groups due to their excessive anxiety.

Most clinicians know that the emotions and feelings are factors in a substantial number of relapses. The acronym "HALT," cited by AA and NA members speaks to this important issue of negative emotions (i.e., "don't get too Hungry, Angry, Lonely, or Tired").

Interventions for helping clients develop coping skills for managing negative emotional states depend on the issues and needs of the individual. For example, strategies for dealing with depression that accompanies the realization that addiction caused havoc in one's life may vary from those for dealing with depression that is part of a bipolar or major depressive illness. Interventions to help the client who occasionally gets angry and seeks solace in substances may vary from those needed to help the client who is chronically angry. The former may need help in expressing anger appropriately rather than suppressing it. The chronically angry client may need to learn how to contain angry feelings, since these are often expressed impulsively and inappropriately. This type of client can benefit from cognitive techniques that help challenge and change angry thoughts. The chronically angry person may also benefit from seeing his or her angry disposition as a "character defect." Psychotherapy and/or use of the Twelve-Step program of AA and NA may help the client modify behaviors associated with this trait.

Interventions for clients who report feelings of chronic boredom, emptiness, or joylessness similarly depend on the specific nature of the emotional state. One client may need help in learning how to use free time or how to have fun without substances. Another may need help in developing new relationships or finding new activities that provide a sense of meaning in life and an emotional connection to other people. The client may also need to alter beliefs regarding fun, excitement, and

what is important in life. Many addicted individuals report that being drug-free is boring compared with the high provided by the drug or behaviors associated with getting the drug or "living on the edge." In such a case, the client needs not only to change behaviors but beliefs as well.

Facilitate Evaluation and Treatment of Mood or Anxiety Disorders

Some clients who have problems managing moods or feelings may have a psychiatric disorder than needs evaluated and treated. For example, there are high rates of depression, bipolar and anxiety disorders among clients with addiction. Many with anxiety disorders have significant depression, and many with depression have significant anxiety. Problems with their moods may be a result of a psychiatric illness rather than an effects of addiction or the problems caused by it. In addition, problems managing anger are common among clients with different types of personality disorders. For example, many women with borderline personality disorders internalize their anger and hurt themselves by cutting or burning themselves or overeating. Men with antisocial personality disorders often externalize their anger and use it to lash out at others either verbally or physically. These or other psychiatric disorders may require treatment for the client to be able to recover from the addiction.

6. 6. Relationships Skills and Support Systems

Improve Communication and Relationship Skills[21]

Many researchers and clinicians address RP from a broader perspective that includes focus on interpersonal relationships and support systems. The *Coping Skills* model of Monti and colleagues includes considerable focus on interpersonal skills such as giving and receiving criticism, refusing offers for alcohol, refusing requests, developing close and intimate relationships and enhancing social support networks.[22] McGrady has modified Marlatt's cognitive-behavioral model of RP and applied it to couples in recovery.[23] O'Farrell and colleagues developed a RP protocol for use in combination with behavioral marital therapy.[24] Maisto and colleagues found that alcoholics who were treated with their spouses with RP in addition to marital therapy had shorter and less severe relapses than clients not receiving RP.[24]

Positive family and social supports generally enhance recovery for the substance dependent member. Families are more likely to support the recovery of the addicted member if they are engaged in treatment and have an opportunity to ask questions, share their concems and experiences, learn practical coping strategies and learn behaviors to avoid. This is more likely to occur if the member with the substance use disorder understands the impact of substance abuse on the family and makes amends for some of the adverse effects on the family.

Facilitate Active Participation in Mutual Support Groups[26]

Clients can be oriented and prepared to get actively involved in support groups such as AA, NA and DRA. Active involvement refers to attending meetings, getting and use a sponsor, and using the "tools" of the program.

Help them develop a network of support to make their recovery a "we" process. Sponsors, other recovering peers in mutual support programs, supportive friends and family members may become part of an individual's support network.

Following are some suggested steps for helping clients develop a support network. First, the client needs to identify whom to involve in or exclude from this network. Others who abuse substances, harbor strong negative feelings toward the recovering person, or who are not supportive of recovery should be excluded. The client can then determine how and when to ask for support. Behavioral rehearsal can help the client practice ways to make specific requests for support. Rehearsal also helps increase confidence as well as clarifies thoughts and feelings regarding reaching out for help. Some clients feel guilty or shameful and question whether they deserve support from others. Others have such strong pride that the thought of asking others for support is difficult to accept. Rehearsal may clarify the client's ambivalence regarding asking for help or support from others. This process also helps the client better understand how the person being asked for support may respond, thus preparing the client for potentially negative responses from others.

Some clients find it helpful to put their action plan in writing. This plan can address the following issues: how to communicate about and deal with relapse warning signs and high-risk situations; how to interrupt a lapse; how to intervene if a relapse occurs; and the importance of exploring all the details of a lapse/relapse after the client is stable so that it can be used as a learning experience. A plan can make both the recovering person and family feel more in control when and if faced with the possibility of a relapse. This helps everyone take a proactive approach to recovery rather than sit back passively and wait for problems to worsen.

Involve the Family[27]

Family members are often adversely affected by a loved one's addiction. Families have many questions and concerns, and need information to help them better understand addiction and recovery. Involving them in treatment helps them learn what they can and cannot do to help support the family member with the addiction. Involvement can also help the family member become aware of relapse warning signs and how to point these out to their loved one.

Participation in treatment sessions or support groups such as Al-Anon or Nar-Anon can also help the family learn to deal with their own feelings and reactions to their addicted member. A family member can contribute to a loved one's relapse either purposely or inadvertently. Involvement in treatment or support groups can help families learn to work on their own issues, which in turn can have a positive impact on the addicted member's recovery.

7. Relapse Recognition and Interruption Skills

Identify and Manage High Risk Relapse Factors [28]

The need to recognize and manage high-risk (HR) factors is an essential component of RP. A framework I have used in groups and included in a written workbook adapts Marlatt's categories of high risk situations into the following (each category has specific examples):

1. *Upsetting feelings or difficulty managing emotions*: anger, anxiety, boredom, depression, guilt or shame, etc.
2. *Social situations and pressures to use alcohol or drugs:* difficulty saying no, having a partner, spouse or roommate who uses substances at home, etc.
3. *Sobriety plan or treatment-related problems*: change in motivation to stay sober, missing or dropping out of treatment or mutual support programs, etc.
4. *Relationship problems*: serious problems with spouse or partner, hard to enjoy sex without being high, etc.
5. *Urges, cravings, temptations or testing your control*: being around others using, having drugs or alcohol at home, seeing or smelling alcohol or drugs, etc.
6. *Other high-risk situations:* not taking medications as prescribed, other addictions, psychiatric problems, etc.

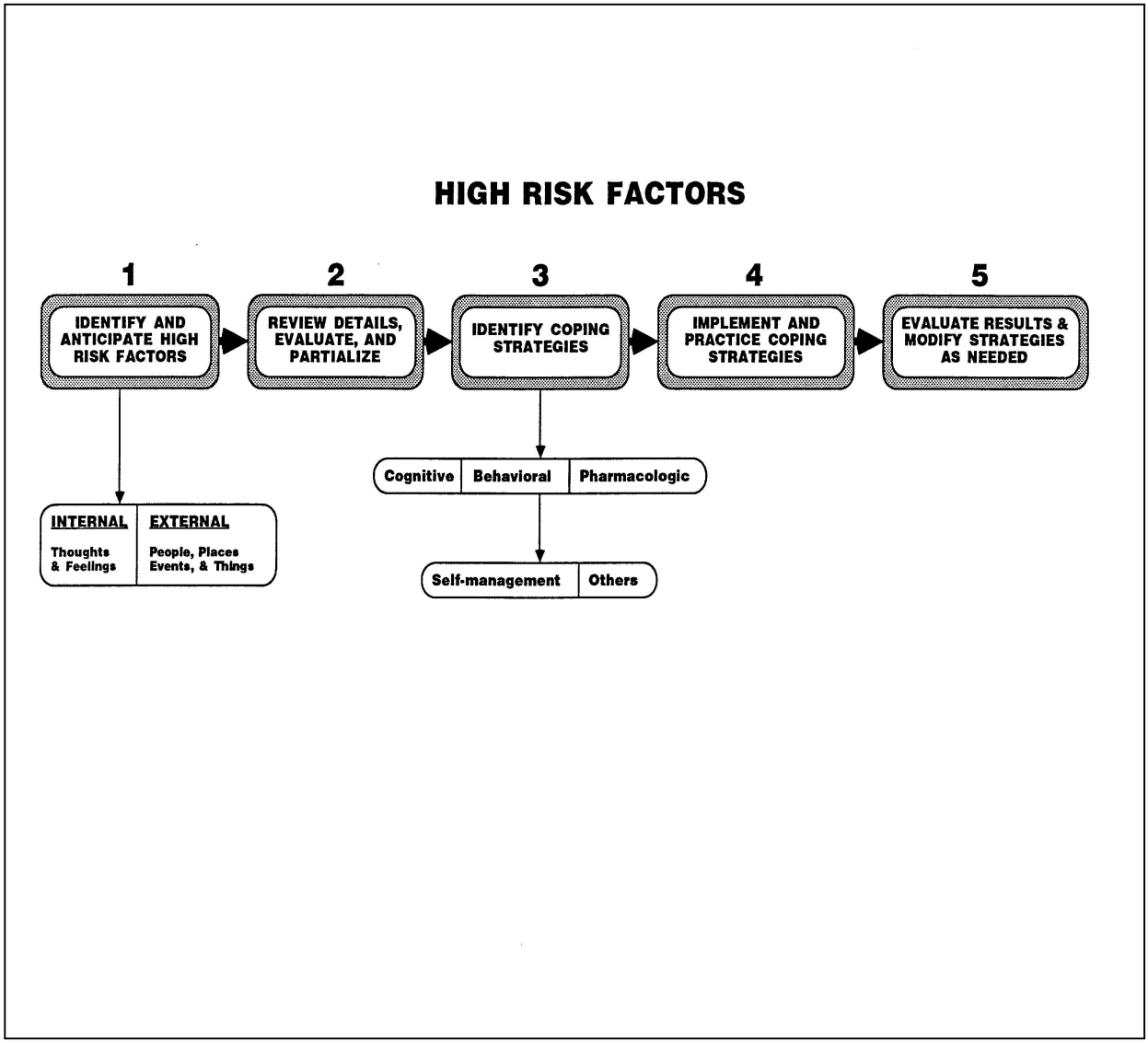
HR factors involve intrapersonal and interpersonal situations in which the client feels vulnerable to substance use. *Relapse is more likely to occur as a result of lack of coping skills than the high risk situation itself* so the clinician should assess the client's coping style to determine targets for clinical intervention. Findings from the Relapse Replication and Extension Project indicate that the availability of coping skills is a protective factor reducing relapse risk while ineffective coping skills are a consistent predictor of relapse.[29]

The meaning of specific HR factors also varies among clients. RP strategies and interventions will therefore need to take into account the nuances of each client's HR factors. For example, two clients identified depression as a serious relapse risk. In the first case, depression was described as the rather common and normal feeling experienced when the client realized that his drug addiction caused serious problems in his relationships with his wife and children. Getting his family involved in his treatment, facilitating their attendance at Nar-Anon meetings, making amends to them, and spending time with them led to improvement in his mood. In the second case, the client's depression worsened significantly the longer she was sober from alcohol. While she felt some of the behavioral and cognitive strategies explored in therapy were helpful in improving her mood, it wasn't until she took an antidepressant that she experienced the full benefits of treatment. Both of these clients reported that an improved mood was a significant factor in their ability to prevent a subsequent relapse to their addiction.

For some clients, identifying high-risk factors and developing new coping strategies for each are inadequate, since they may identify many risk factors. Such clients need help in taking a more global approach to recovery and may need to learn specific problem-solving skills. Marlatt, for

example, suggests that in addition to teaching clients "specific" RP skills to deal with high-risk factors, the clinician should also utilize "global" approaches such as problem solving or skill training strategies (e.g., behavioral rehearsal, covert modeling, assertiveness training), cognitive reframing (e.g., coping imagery, reframing reactions to lapse/relapse), and lifestyle interventions (e.g., meditation, exercise, relaxation).

The chart on the following page illustrates one way to think about high risk factors. Help the client identify these factors and the specific details, identify (and practice) then implement coping strategies, evaluate results, and change coping strategies as needed. These steps focus on "action."

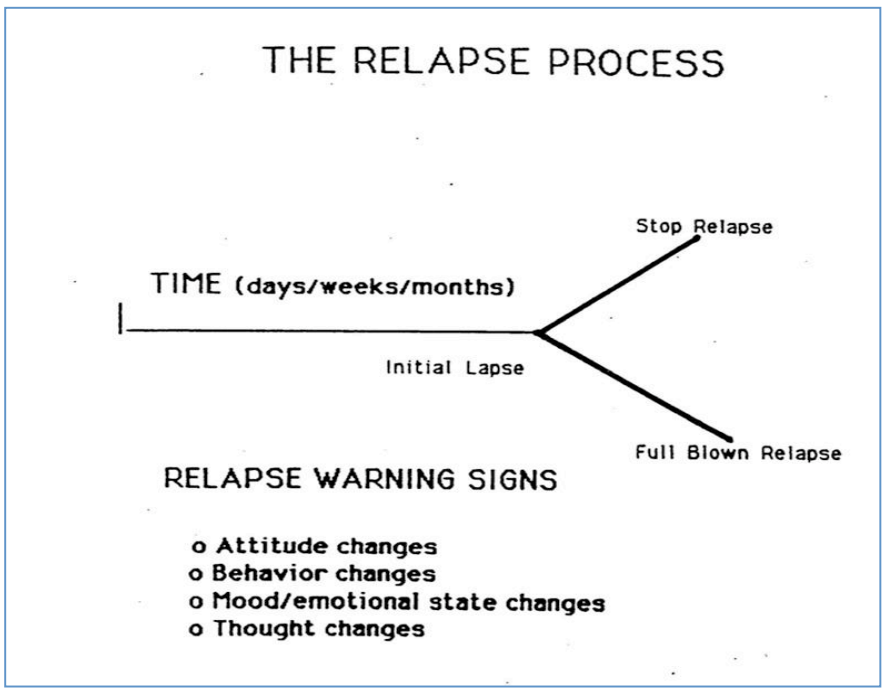


Identify and Manage Relapse Warning Signs[30]

Clients are better prepared for the challenges of recovery if they understand that clues or warning signs often precede an actual lapse or relapse. Although a relapse may result from an impulsive act, attitudinal, emotional, cognitive, and/or behavioral changes may show days, weeks or even longer prior to the actual ingestion of substances (see chart on next page). An individual's clues or warning signs can be conceptualized as links in a relapse chain.

Warning signs may be overt and obvious such as a significant increase in substance cravings, or stopping or reducing treatment sessions or self-help meetings without discussing this decision first with a therapist or sponsor. Warning signs can also be overt and more idiosyncratic or unique to the client. For example, a drug addicted client reported that one of his main warning signs was the return of dishonest behaviors. His review of several relapses helped him discover that even before obvious signs of relapse were present, he would start becoming dishonest by lying, scamming others and stealing money from his employer. Shortly thereafter, the more obvious relapse warning signs occurred such as thoughts of needing some action, contacting old friends who were still using drugs, dropping out of treatment, and reducing contact with his NA friends and sponsor.

Clients in treatment for the first time can benefit from reviewing common relapse warning signs identified by others in recovery. The clinician can ask the client to review the relapse experience in detail to learn the connections between thoughts, feelings, events or situations, and relapse to substance use. My (DD) survey of 511 clients found that "Understanding the Relapse Process" was the topic rated as most useful by clients participating in a residential treatment program.



Prepare to Manage Setbacks (Lapses and Relapses)

Clients should have an emergency plan to follow if they lapse so that a full-blown relapse can be avoided. However, if a full-blown relapse occurs, the client also needs to have strategies to interrupt it. The specific intervention strategies should be based on the severity of the client's lapse or relapse, coping mechanisms, and prior history of relapse. Helpful interventions include using self-talk or behavioral procedures to stop a lapse or relapse; asking family, AA or NA sponsors, friends, or professionals for help; carrying an *emergency card* with names and phone numbers of others who can be called upon for support; or carrying a *reminder card* that gives specific instructions on what to do if a lapse or relapse occurs. Marlatt recommends developing a relapse contract with clients that outlines specific steps to take in the event of a future relapse. The aim of this contract is to formalize or reinforce the client's commitment to change. He also recommends teaching clients strategies to manage a lapse such as:[31]

1. Stop, look and listen.
2. Keep calm.
3. Renew your commitment.
4. Review the situation leading up to the lapse.
5. Make an immediate plan for recovery.
6. Ask for help.

Once a relapsed client is stable, analyzing lapses or relapses is a valuable process that can aid recovery. The client can identify warning signs preceding actual substance use as well as the high risk factors that may have played a role in the relapse. This process can help the client reframe a "failure" as a "learning" experience and prepare for future high-risk situations. It can also help the client determine if any irrelevant decisions were made that impacted on relapse.

8. Lifestyle Changes

Facilitate Global Lifestyle Changes and Balance

In addition to identifying and managing intrapersonal and interpersonal high-risk relapse factors, clients benefit from global changes to restore or achieve a balance in their lives. Development of a healthy lifestyle is important in reducing stress that makes the client more vulnerable to relapse.[32] Lifestyle can be assessed by evaluating patterns of daily activities, sources of stress, stressful life events, daily hassles and uplifts, balance between wants (activities engaged in for pleasure or self-fulfillment) and shoulds (external demands), health, exercise and relaxation patterns, interpersonal activities, and religious beliefs.

Helping clients develop positive habits or substitute indulgences (e.g., jogging, meditation, relaxation, exercise, hobbies or creative tasks, etc.) for substance abuse can help to balance their lifestyle. Clients with a need for greater adventure or action may get involved in more active and challenging activities.

In recent years, mindfulness has been incorporated into treatment for psychiatric disorders (e.g., mood and anxiety disorders, borderline personality disorders) and RP practices for addiction (called mindfulness-based relapse prevention or MBRP).[33] MBRP integrates RP and mindfulness meditation practices as a way of helping clients learn skills to make behavior changes. This approach helps clients understand the changing nature of their minds, bodies and environments so they can better cope with cravings or urges for substances or the other challenges of recovery. In a recent study MBRP showed promised as an aftercare treatment for those completing a residential program. It involved eight weekly group sessions that focused on:

1. *Automatic pilot and relapse*: this helps the client become more aware of actions and unconscious thinking as these relate to alcohol or drug use.
2. *Awareness of triggers and cravings:* the client learns to accept cravings without automatically reacting so that there is an increase in choices in how to respond to a craving.
3. *Mindfulness in daily life*: the client learns meditation and how to accept physical sensations and emotions without reacting in harmful ways.
4. *Mindfulness in high-risk situations*: the client identifies personal high risk factors and ways to cope with feelings that these generate without using substances.
5. *Acceptance and skillful action*: the client learns to accept unwanted thoughts, feelings and sensations, and to take skillful actions to cope with high risk situations in daily life.
6. *Seeing thoughts as thoughts:* the client learns how thoughts affect the relapse cycle and how to work with problematic thoughts.
7. *Self-care and lifestyle balance*: the client learns to respond to personal warning signs and the importance of having nourishing activities as part of a healthy life.
8. *Social support and continuing practice*: skills learned in the program are reviewed and the importance of building a support system is emphasized. Plans to use mindfulness practices in daily life are shared among group members.

Address "Other" Addictions and Problems that Interfere with Recovery

Many clients have other addictions or co-existing medical, psychiatric, vocational, occupational, legal, housing, family, social or other problems, which can impact on recovery or relapse. Referrals may be needed for case management, social service agencies, medical or psychiatric services, other mutual support programs (e.g., GA, SA, SLA), or other addiction treatment programs to address these other problems or addictions.

CHAPTER FIVE

Counseling Aids for Relapse Prevention

Introduction and Overview of Chapter

This chapter reviews clinical aids that can be used with recovering clients or their families. These aids are listed alphabetically for ease of reference. Counseling techniques and tools include actual techniques for counseling sessions plus reading and writing tasks assigned to clients as part of the treatment plan. Many of the counseling aids such as the "Relapse Fantasy" or the *Relapse Prevention Workbook* can be easily adapted to individual or group counseling contexts. You can use some to assign clients "homework" tasks between counseling sessions.

Addict Aftercare: Recovery Training and Self-Help Manual

The *Addict Aftercare Model* briefly described in Chapter Two uses a manual consisting of 23 "recovery training" sessions along with handouts for clients.[1] Each session is organized according to objectives, background information about the session's topic, materials needed, key points, and format. Each session relates to an important recovery issue and falls within one of these four general topics:

1) *Being Clean*: cravings, dangerous situations, social pressures, pain, and slips.

2) *Highs and Lows:* having fun without drugs, dealing with stress, prescription medications.

3) *Social Relationships*: making new friends, love and intimate relationships, family issues, community service.

4) *Work and Growth*: presenting past employment history, job problems, planning ahead.

Challenging Relapse Thoughts

Both negative, inaccurate or "relapse-related" thoughts and "cognitive distortions" are associated with relapse.[2] AA and NA use the term "stinking thinking" to refer to these. "Challenging relapse thoughts" helps the client: (1) become aware of common relapse-related thoughts expressed by other alcoholics and drug addicts; (2) identify his own relapse thoughts, evaluate what is faulty about these particular thoughts, or thinking pattern; and (3) practice challenging the thought(s) in order to cope positively and stay sober.

Seven common relapse-related thoughts for making clients more aware of cognitive aspects of the relapse process and practicing counter statements are: (1) relapse can't happen to me; (2) I'll `never' use alcohol or drugs again; (3) I can `control' my use of alcohol or other drugs; (4) a few drinks, tokes, pills, lines, won't hurt; (5) recovery isn't happening fast enough; (6) I `need' alcohol or other drugs to have fun; and (7) my problem is `cured.' Clients can also add their own thoughts to this list to make it more applicable to there.

The process is simple. The client reviews the list of the seven thoughts above, then writes down what is wrong with each one followed by one or more counterstatements. The same process can be used with personalized thoughts identified by the client. The main skill taught is to identify and challenge thinking that can lead to relapse.

Cognitive Distortions and Relapse

Experts in the cognitive treatment of depression, such as Drs. Aaron Beck and David Burns, have written extensively about "depressogenic assumptions" and how these impact on depression in some people.[3] These assumptions or "cognitive distortions" are commonly found among addicted clients as well. Cognitive distortions may contribute to the relapse process by the client talking himself into using substances.[4]

Recovery can be aided by helping clients learn about these cognitive distortions, relating them to their individual life situations, and developing appropriate coping strategies for responding to them. The cognitive distortions, adapted to relate to the relapse process, are:

1. *Black and white or dichotomous thinking* is seeing things as either one extreme or the other, and not in terms of "degrees." The person either thinks he is doing well or poorly in recovery--nothing in between. For example, an alcoholic sober for fourteen months had cravings and thoughts about drinking. He told himself he was not motivated to recover, instead of simply accepting the truth that struggle and conflicts are sometimes experienced in recovery. He had to learn that even highly motivated people sometimes have periods when motivation wavers, and that harsh self-judgments are unwarranted.

2. *Making things worse than they really are, or 'awfulizing'* is exaggerating problems and turning minor difficulties into major problems. For example, a cocaine addict who stayed clean from all drugs for nine months "smoked a joint." Although she did not use again after this brief episode, she thought her recovery program had completely failed.

3. *Over-generalizing* is assuming that if something is true in one instance, it applies to any similar situation. For example, a heroin addict who has been clean for seven months "set herself up" by seeking out a male friend with whom she previously "shot dope." She ended up shooting dope again, once, with this man. She saw this as a sign of "total failure," and began to think she couldn't recover.

4. *Selective abstraction* is focusing only on errors, weaknesses, mistakes or failures and ignoring accomplishments or successes. The previous example also illustrates this concept. The addicted woman assumed that since she "gave in" one time and shot dope

she could not recover. She had a hard time understanding that her seven months of clean time was evidence of success and that perhaps she could do this again.

5. *Catastrophizing or magnification* exaggerates the meaning or importance of an event, expecting the worst outcome. It is thinking "I'll die if I don't get a drink," or pill, fix, or line. For example, an alcoholic went on a three-day binge following one year of sobriety. He told himself "I got drunk, I threw away my recovery." He expected his family and AA friends to sharply criticize him and was surprised when they were understanding and encouraged him to get back on the sober track.

6. *Jumping to conclusions* is reaching an end judgment without knowing all the facts. For example, a cocaine addicted alcoholic with a history of several relapses re-entered treatment following a fairly long relapse period. Because of her history of relapsing she thought, "I relapsed many times before, I'm hopeless and can't be helped. I don't know if I'm capable of recovering." Just because it happened before doesn't mean it will happen again. Although the clinician and client should always take the history of relapses seriously, they should be careful in assuming the person will relapse again. I have seen many individuals with a history of multiple relapse regain and maintain their sobriety.

7. *Emotional responses* involve assuming negative thoughts or feelings reflect the way things really are. But actually, if an alcoholic feels frustrated with his recovery and thinks he's not doing things right, it doesn't mean that he's "incompetent."

8. *Should statements* create rules that affect thoughts, feelings or behaviors. For example, a drug addict tells himself he "should" always like NA meetings, "should" always "want" to stay clean, or "shouldn't" get upset with his family. Such statements can lead the person to judging himself harshly during those times that he cannot comply with his "should" rule.

9. *Labeling and mislabeling* is creating a negative self-image from mistakes or errors. A "failure" experience leads to the conclusion that the person is a "failure." For example, an alcoholic relapsed after a long period of recovery and told himself he was a "failure" rather than simply admitting that a mistake was made. The danger with this type of cognitive error is that the person may tell himself there is no use trying to get back on the sober track even after a substantial period of recovery.

10. *Personalization* or *self-reference* is believing one is the center of attention, and if a lapse or relapse occurs, they will be "blamed" for what happened.

11. *Absolute willpower breakdown* means assuming that once willpower has failed, loss of control is inevitable. Although some addicted people lose total control over substance intake any time they use, many do not lose total control until the relapse progresses for a long time.

12. *Body over mind* means believing that once alcohol or drugs are in the body, physiological addiction takes over and makes the person powerless to control substance use. Again, while some people will lose control after they use, whether for physiological and psychological reasons, others will not lose control at first. The client must know that

while he cannot *consistently* control substance use, if he lapses, he should be careful not to talk himself into continued use.

Consequence of Using Substances Again: Decision Chart

This is an adaptation of Marlatt's "Decision Matrix" in which the client who is thinking about relapsing considers the possible consequences.[5] The aim is to encourage rational decisions by helping the client clarify all the possible effects of substance use before an actual decision is made. Since some clients develop "positive outcome expectancies" regarding substance use, this may help them clearly see the total picture, including possible adverse affects. For example, a client who is thinking of how good it feels to get high may see that a return to use will cause a loved one considerable distress. This, in turn, may serve as a motivator to stay sober. While some clients impulsively use substances immediately after thinking about it, many do not and first struggle with the question "should I or should I not use?"

This exercise gives the client permission to talk about both perceptions of "positive effects" of substance use and negative ones. What often emerges from discussions is the client's ambivalence and internal struggles over substance use.

Control-O-Log

The *Control-O-Log* is similar to the *drunk-(drug-)-o-logs* often expressed by alcoholics and drug addicted clients, except the focus is on positive coping mechanisms as opposed to substance use. This technique helps the client focus on when and how he successfully coped with a desire to use substances, or a high-risk situation. It identifies the coping mechanisms used to sustain recovery. The purpose is to help the client increase personal control over substance use decisions and to help him draw upon past successful experiences.

This technique is especially suited for group discussions. A client presents an issue or situation involving a struggle with the desire to use. You can ask the group, "have any of you experienced a similar situation where you've been able to successfully resist using alcohol or drugs?" The group not only provides support, but also gives practical ideas on how others have coped with a particularly difficult situation.

Daily Relapse Prevention Inventory

The daily inventory has long been used in mutual support programs and has aided many people's recovery. One approach involves answering two questions at the end of the day to detect relapse warning signs, or high-risk situations that could trigger a relapse. The questions are:

1. Were there any clues (warning signs) present today suggesting that the client is moving away from recovery and building up to substance use?

2. Did the client experience any "high-risk" situations today that could trigger a relapse if not managed?

If the client responds positively to any of these questions, she should devise a plan to follow to reduce the chances of relapse.

Relapse Autobiography

Many clinicians use autobiographies to get the client to reflect on the history and context of her substance use, and the effects on her and others. The relapse autobiography is a similar tool except that it focuses on the relapse experience(s) of the client.

In her own words, the client writes a detailed relapse history. This autobiography should contain information about: what substances were used, for how long, with whom, when, why they were used, and in what context. It should also include the period preceding the actual relapse to help the client determine what relapse warning signs occurred before the actual relapse. This time frame may vary among clients, but attention should be paid to changes in thinking, attitudes, emotions or behaviors preceding the relapse. Often, a client is less defensive when privately reflecting on his or her relapse experience.

The relapse autobiography should portray the client's reaction to the relapse, including feelings and thoughts about herself as a recovering person. It should also touch on the effects of the relapse, both on the client and her family or significant others. Last, it should describe what happened following the initial period of substance use, that is, how she acted following the lapse. This task is easy to adapt for those who have difficulty expressing themselves in writing. For example you can ask the client to tape record her relapse autobiography.

Relapse Debriefing

Debriefing is similar to the process used in the *Relapse Autobiography* in that the client explores the details of lapses or relapses. Marlatt uses this process to deal with "serious temptation situations" in addition to "actual slips." The clinician can explore the details surrounding the high-risk situation, alternative coping responses, and the client's reactions--affective, cognitive, and behavioral. Such an intervention provides an opportunity for the client to learn from past mistakes.

I (DD) find it helpful to help the client deal with the guilt and shame that often accompany a relapse. Some clients try to avoid discussing a relapse. One practical way to counteract this is to build into the therapeutic contract the expectation that all close calls, lapses and relapses must be reported and discussed. With few exceptions, my experience has been that if relapse is openly discussed at the onset of treatment, and made part of the therapeutic contract; most clients will report lapses and relapses. In group therapy and multiple family sessions, such discussions provide a valuable source of learning for all participants.

Relapse Fantasy

This technique involves exploring the client's dreams involving substance use, or asking the client to "imagine what it would take for you to return to the old habit pattern--alcohol or drug use." Such exploration helps the clinician assess the client's potential "high-risk" situations, how she perceives the possibility of relapse, and how she would think, feel or behave in a relapse situation. This information can then be used to help the client develop positive coping skills.

Relapse Prevention Workbook (RPW)

The RPW was developed by the author (DD) from an extensive review of the research, clinical and self-help literature on relapse and discussions with hundreds of relapsed clients and many addiction professionals.[6] The RPW is an educational aid for clients in treatment. It provides information on several relapse prevention and management topics and engages the reader in reading and writing tasks to relate the material to his own situation. The workbook can be used with clients in recovery for the first time as well as with those who have relapsed. Each section covers a unique recovery topic. It operationalizes many of the concepts from Marlatt's model of RP. The RPW is available in Spanish. A version for adolescents is also available. Following is a summary of the topics reviewed in this workbook.

1. *Understanding the relapse process* is an introduction to relapse as a process, discussing common clues or warning signs that may suggest the relapse process is in motion. This section also gives a case example, and asks clients who have relapsed to learn from their past experience by answering several questions.

2. *Identifying "high-risk" factors* introduces the person to the idea of anticipating "high-risk" situations that could trigger a relapse. An inventory of 66 items, based on an adaptation and expansion of Marlatt's categories of high-risk categories, is reviewed by the client. The high-risk categories include: (1) negative feelings, attitudes or thoughts; (2) social pressures to use alcohol or drugs; (3) sobriety plan or treatment related problems: (4.) problems in relationships with other people; (5) urges, cravings, or testing my control; and (6) other high-risk situations.

3. *Strategies for handling high-risk factors* engages the person in prioritizing these high-risk factors and developing relapse prevention plans based on them. This section also provides two case examples that illustrate coping strategies for high-risk situations.

4. *Handling cravings for alcohol or other drugs* helps the person identify signs and causes of cravings, and reviews practical coping strategies.

5. *Handling social pressures to use substances* focuses on preparing for direct and indirect social pressures that may confront the person during recovery.

6. *Anger management in sobriety* helps the client understand the connection between unresolved problems and a possible relapse. Anger is viewed as a problem from "within." The section provides a five-step problem solving process aimed at helping the client recognize and handle angry feelings.

7. *Use of leisure time in sobriety* helps the client begin to look at how to manage boredom and maintain active involvement in leisure pursuits that do not evolve around alcohol or drugs, or people who get high.

8. *What to do if a lapse or relapse occurs:* focus on developing plans to stop a lapse or relapse should one occur. Clients need concrete and easy-to-use strategies to take action should they use substances, regardless of how long the episode of use lasts.

9. *Building a long-term sobriety plan* focuses on mapping out a long-term recovery program to continue to change and reduce relapse risk. Recovery is not an easy or quick process for anyone, so accepting the need for long-term involvement helps reduce relapse risk if the client follows through with the plan.

10. E*mergency sobriety card* focuses on the importance of having specific people and organizations to call upon for help and support.

11. *Lifestyle balancing and sobriety* helps clients begin to examine the need to make global changes in lifestyle. An outcome of good recovery is improvement in the quality of life. Being more balanced can contribute to this quality.

12. *A daily relapse prevention inventory* asks the client to monitor relapse warning signs or high risk factors on a daily basis. This helps him remain vigilant about relapse warning signs and high-risk factors.

Relapse Prevention Readings (Bibliotherapy)

Readings increase a client's knowledge of recovery and RP and stimulate interest in using this information in recovery. *Bibliotherapy*, as this technique is called, has been used for years in treatment. Topics that are potentially threatening or difficult for some clients to talk about can often be presented in non-threatening ways through reading. Each clinician should develop a list of suggested readings relevant to various types of addiction and co-occurring psychiatric disorders (readings from mutual support programs like AA, NA or DRA, as well as those from professionals or others in recovery who share their knowledge or experiences).

Role Plays (Behavioral Rehearsals)

Many of the issues reviewed in the RPW can be adapted to role plays so that clients increase their awareness of these issues and begin to learn coping strategies to reduce their risk of relapse. Virtually any problem that involves other people can be practiced in role-plays.

The clinician first discusses the problematic interpersonal situation, or the one the client wants to change, in order to get as much information as possible. The client then practices new responses in a role-play. The clinician can play the role of the "other" person, or the role of the client to "model" responses that seem too difficult for the client to produce. For example, a client may not be used to rationally or calmly expressing a feeling such as anger to a family member. If so, it may be advisable to first see the clinician "role play" this situation.

Interpersonal role-plays are effective in groups because more clients can get directly involved in the role-play, supporting the person who is practicing new coping behaviors. Other clients, for example, can often be more realistic than the clinician when enacting offering drugs or alcohol to a recovering person. Group role-plays also provide the other members situations with which to identify. Often, these role-plays lead to productive therapeutic discussions and behavioral rehearsal of positive coping strategies.

There are many variations of role-plays that the clinician can use. Some of these include:

1. *Use another group member to verbally serve as the client's "alter ego" in the role-play*. The clinician first gets the client's permission to do this. The person functioning as the alter ego speaks out loud during the role-play, saying what he thinks the client would like to say but is unable to. For example, in an actual role-play situation, a cocaine addict may be offered drugs by a friend. While he may say something such as "no thanks, I'm staying clean," he may be thinking, "I really want to get high. I really crave the drug." The alter ego expresses these inner thoughts or feelings, thus allowing conflicts to surface, be discussed, and hopefully be resolved. This process also helps the client understand the role of ambivalence in recovery, when mixed feelings surface.

2. *Use another group member to serve us the role playing client's "alter ego" by recording thoughts and feelings*. This is similar to the method above except that instead of the alter ego speaking out loud, thoughts or feelings are written down.

3. *Use dyads or triads to role-play problems identified by one or more clients*. This makes all group members active participants in the role-play, and is less threatening than when done in front of large groups.

Role-plays usually work best when the clients choose the situations to practice. However, the clinician can have available several common scenarios--expressing anger, refusing substance use offers--which many clients identify with. Suggest these to the group if necessary.

Another effective technique in role-plays with groups is to ask those not directly participating in the role-play to imagine that they are in the actual situation being enacted. They are told to pay close attention to their thoughts and feelings.

At the end of role-plays I have found it useful to give the client a chance to talk about what the experience was like. What did he think? How did he feel? How effective did he think his responses were? What did he dislike about his responses? What did he like? The other members of the audience can also respond with feedback. This often provides an excellent opportunity for the group to mutually explore issues and problems that are commonly faced in recovery.

If there is sufficient time and the situation permits, videotaping role-plays can be an effective tool for helping clients learn about themselves. They can dissect role-plays to learn what works best.

The Road to Relapse

This is a very powerful way to illustrate the process of moving from recovery towards a relapse. While this exercise can be conducted in an individual session, it is better suited for use in a group. The group leader asks the group who has relapsed following a period of sobriety in order to identify a specific person to illustrate the relapse process. It is best to use a client who was "in recovery" (i.e., had accepted the addiction, accepted the need to change, and worked a program of recovery) prior to the relapse as opposed to someone who was abstinent for just a few weeks or months, primarily for external reasons. The leader asks for a specific volunteer, which preferably should be a client with an extended period of recovery prior to the relapse (reality sometimes dictates that the volunteer may have had less than a year in recovery before relapses, but many times there will be clients with one or more years of sobriety who relapsed).

The group leader tells this client to recreate the relapse by remembering as much as possible about warning signs that preceded this relapse. The experience is recreated by having this client physically walk down an imaginary road from recovery towards relapse. Have the client imagine that this road has a fork in it, which has two paths—the lower path leads to substance use lapse and possible relapse; the upper road leads back to recovery. The client is then instructed to take one step down the road to relapse and state out loud a specific warning sign.

It is best to instruct the client ahead of time to use examples of both obvious warning signs (e.g., I cut down or stopped AA meetings; I skipped group counseling sessions, then never returned) and those idiosyncratic to her relapse (e.g., I became interested in a man who was still getting high; I started to become dishonest in my daily life). Have the client take 4-6 steps, stopping after each one to state out loud the warning sign.

Then, ask the client to stand at the fork in the road, which represents the point in time a decision was made to use alcohol or drugs. Have the client discuss out loud what she was thinking and feeling prior to going down the bottom path in the road to a lapse or relapse. Ask the client to talk about what she used, when and where, how she feels, and what she thinks about the experience in retrospect. It isn't unusual for the initial description of substance use to be presented in a positive way (e.g., it felt good to drink or catch a buzz, what a relief it was to smoke pot, etc.). This is usually followed by a description of the negative consequences of the lapse or relapse (e.g., I realized that I was messing up again, this will lead me to big trouble, I'll disappoint or hurt my children).

Once this process is finished, ask this client to discuss her reactions to this exercise in terms of what she learned about the relapse process and what she could do in the future to manage warning signs without going down the path to lapse or relapse. Then, ask the other group members to share what they observed and what they learned. Ask them what they could do in a similar situation. Focus both on early warning signs and being at the fork in the road, stressing that the earlier clients catch their warning signs, the greater the likelihood of a positive response. Often, clients who watch a peer conduct a walk down the road to relapse will relate to the experience of moving from recovery to relapse.

After the group has discussed this experience, have the same client repeat this exercise as close to possible as the way it unfolded the first time. This time, have a support person (another client) walk next to her as she travels the road from recovery to relapse. Instruct this "helper" to make a

supportive statement each time the client states out a loud a specific warning sign. For example, if the client says "I'm tired of going to AA meetings" as a warning sign, the helper might say "talk to an AA friend about what you think is going on to cause you to be tired of AA." Or, if the client says "I started thinking privately about how to get some cocaine," the helper might say "don't keep secrets; share your struggles with a sponsor, counselor or friend." The client is not to respond to the helper's comment but only listen to them.

Once the client and helper walk to the fork in the road, and the client shares the relapse experience, ask her if it felt different to have a support person with her during this trip down the road to relapse. Then, talk with the group about the difference between "going down the road to relapse alone" or "using support" from another person. You can then ask the group members "what is the first word in Step One of AA/NA/DRA?" This often leads to a discussion of recovery as a "we" vs. an "I" process. Clients have choices—they can struggle alone or reach out for help and support from others. Although there are no guarantees, those who reach out for help and support do better than those who keep their struggles privately.

Sobriety Journal (Written)

The *Sobriety Journal* can help clients regularly monitor and review their recovery and progress, and write their thoughts, feelings and behaviors in a journal.[7] Although a specific *Sobriety Journal* exists with a specific format, the clinician can also use a generic journal that is broad in focus. A client can record anything related to his unique recovery experience. However, the clinician can ask the client to record specified recovery issues, problems, or concerns such as temptations to use substances, cravings, or feelings about socializing with others who are using substances.

The journal is intended to provide a means for the client to ventilate feelings, and to reflect on experiences and reactions in recovery, particularly positive or successful ones. The client is instructed to make sure that successful experiences are recorded. These positive coping mechanisms are identified and built upon. The *Sobriety Journal* may help the client keep recovery in perspective, especially during those times when recovery is perceived as going too slow or few positive gains have been made.

I usually ask clients to regularly share with me whatever part of their journal they wish so that we can discuss their experiences. I give them the freedom to not share any parts of the journal, which they prefer to keep private. However, seldom has a client not wanted to share the journal.

Sobriety Journal (Electronic) (www.stayingsober.lifejournal.com)[8]

This user-friendly journal has many features to stimulate the client and aid work in recovery. Following is an outline of this unique recovery tool that can be used by individuals in various stages of recovery.

1. *Write about your addiction and recovery.* Write about your history of addiction, treatment and recovery, or any other aspect of your life. Write as much as you want, as often as you

want. You can organize your writing into categories such as family, emotions, relationships, spirituality, leisure interests, etc.

2. *Regularly review your progress.* Reflecting upon progress has always been encouraged by AA or NA through the use of a "daily inventory." You can review your recovery as often as you wish. In the early phases of recovery, more frequent reviews are recommended.

3. *Reflect on your recovery and strategies to prevent relapse.* Thinking about your recovery and actions to take to manage the challenges of recovery will reduce your relapse risk.

4. *Daily tips*. These provide food for thought for your recovery.

5. *Quotes.* These come from recovery writings (e.g., "Big Book" of AA or "Basic Text" of NA), professionals in the field of addiction, and well known individuals (writers, politicians, philosophers).

6. *Daily Pulse.* This allows you to track cravings, moods and many other aspects of your life and recovery. You can rate each item and write narrative comments as well.

7. *Timeline*. This can help you review your history of addiction and recovery

Conclusions

There are many counseling aids or tools that can help the counselor in conducting RP groups. Some of these can be given as homework assignments between sessions. Others can be used in a group session. These aids can be incorporated with addiction treatment or recovery groups in all types of settings.

Clients respond favorably to "experiential" strategies as it enables them to learn more about their internal processes (i.e., what they think and how they feel). This also keeps and/or stimulates their interest in RP topics reviewed in groups, especially in programs in which clients are exposed to a large number of group sessions per week.

CHAPTER SIX

Relapse Prevention Groups

Creating Relapse Prevention Groups

Group treatments are used throughout the continuum of care in inpatient, residential and ambulatory treatment programs.[1] Groups help clients acquire information, increase self awareness, gain support from peers, and learn coping skills to manage the challenges of recovery and reduce relapse risk. RP groups can easily be integrated into existing services or programs. Many structured residential or ambulatory programs incorporate a "relapse track" in which RP issues are covered.

You can provide a "stand alone" RP group as part of an ambulatory (outpatient) treatment program. A RP group can focus on topics relevant to recovery or relapse. Other groups such as therapy, process or problem solving groups can focus on relapse issues as clients' present their experiences with the relapse process during treatment.

For ambulatory programs that provide one group per week, a group session can be divided in two segments. One segment covers the RP topic. The other segment allows for an open discussion of the problems or concerns that clients currently face that affect their recovery or relapse potential.

Many of the RP models and other evidenced-based group models use a structured curriculum to cover issues important to recovery and relevant to relapse prevention. Therapy and other recovery groups spend considerable time on relapse since it is a problem facing individuals in recovery, especially those in the early phases.

Group leaders can use a variety of interventions in conducting RP group sessions. These include:

1. Providing educational information (about addiction, treatment, recovery and relapse)
2. Facilitating group discussion and interaction among clients.
3. Helping members relate to the RP concepts discussed in a personal way.
4. Monitoring "close calls," strong urges or cravings, and lapse or relapse experiences.
5. Validating issues or struggles contributing to lapse or relapse presented by group members.
6. Emphasizing positive coping strategies used by members to aid recovery and prevent relapse, or intervene early in the process.
7. Encouraging continuing participation in treatment, and attendance at mutual support programs such as AA, NA, other 12-Step or other non 12-step programs.

8. Having members to talk directly to each other when sharing their opinions, discussing experiences or providing feedback related to topics of RP groups or problems discussed within the group.

9. Asking group members to identify and practice new coping skills or RP skills (e.g., catching early signs of relapse, managing emotions, refusing substance offers, reaching out for help, etc.). Skills can be practiced within the group or outside the group.

Group Format for Outpatient Settings

The following format is adapted from one of our large scale studies as well as our partial hospital and intensive outpatient programs. Changes can be made to this format based on the clinical characteristics of your clients (e.g., if your population is a Criminal Justice one, an item about adherence to their plan to meet with the probation or parole agent could be included; or, they could relate the topic of the session to behaviors that led to getting in trouble with the law).

1. *Welcoming clients:* the group leader welcomes members to the RP group session, states the topic and goals or objectives of the session. Any pertinent announcements are made to members.

2. *Member introductions and check-in:* members state their name, drug and alcohol problem, date of last use, any strong cravings or "close calls" since the previous group meeting, any lapse or relapse to use, and meeting attendance since last session. Many programs have a chart on the wall listing these "check-in" items to help group members stay focused during this process. Other check-in items can be added based on type of group and time of sessions. The check in should take 10-20 minutes so that the majority of the session is spent on the topic of the session.

3. *Substance use lapse or relapse:* if a group member has used since the last session the group will briefly process the event and discuss a plan to reduce relapse risk. The goal of total abstinence is emphasized. The group leader has to resist the tendency to spend extensive time on members' relapses in structured recovery groups as this could easily consume most or all of the group time, which would lead to failure to cover the content of the RP group topic. However, group members' lapses or relapses can be used to illustrate points covered during the educational component of the session.

4. *Handouts or assignments:* recovery and relapse prevention handouts from a workbook, journal or other source or behavioral assignments are briefly reviewed if assigned at the previous session. Since interactive recovery tasks take time, it is most efficient to assign these tasks prior to the RP group session so members can reflect upon the topic, and complete interactive tasks aimed at getting them to relate to the RP material. If members fail to complete an assignment this should be discussed in terms of the implications for recovery or relapse.

5. *RP group topic introduction:* the group leader introduces the RP topic and reviews the major points noted on the outline for the specific topic. Questions and interactive discussions are used throughout the session. Members are asked to share their reactions to the material presented. They are encouraged to discuss how the RP topic relates to their personal situations. Group members are encouraged to interact and offer feedback to one another when appropriate. Most of the session is spent on an interactive discussion of the material related to the group topic. This part of the group should last 45-60 minutes in 90 minute sessions. If groups are 60 minutes, this section should last 40-45 minutes. Make sure sufficient time is spent on "coping strategies" so that all or most of session is not spent only on the problems or struggles presented by clients relevant to the topic.

6. *Review of homework (optional):* in small groups (less than 10 members) members can briefly share answers to questions on the handouts provided if homework was assigned. This is optional as some groups can discuss the questions without using written handouts. The group leader has to control the flow of discussion so that members do not get into lengthy discussions when they share their answers to a specific question. Some members, for example, want to give extensive details about any issue they discuss whether it is a personal craving, a relapse warning sign, or any issue related to recovery or relapse.

7. *Group ending:* in the final 10-15 minutes of the group session, members state one thing they learned (information, idea, coping strategy) from the RP group and state their plans for recovery until the next session. Clients are encouraged to attend mutual support meetings, get and use a sponsor, get phone numbers from other AA/NA members, and actually call these members.

8. *RP assignment (optional):* assignments related to the next session topic can be given to group members with a brief explanation as to what is required. These can be from a written guide (e.g., a workbook or recovery journal), a written handout (e.g., a sheet of paper with a few questions related to the next group session's topic) or a behavioral task (e.g., members are asked to talk to at least 1 or 2 other people in a mutual support program to find out how they managed substance cravings, resisted social pressures to use, or managed upsetting emotions that previously contributed to relapse).

9. *Serenity Prayer (optional):* the group joins hands and recites the Serenity Prayer aloud to end the session.

Group Format for Residential or Inpatient Settings

The group format depends on group size. Large goups conducted in rehab programs or hospitals in an auditorium or large room are more likely use a lecture format. However, ever large groups can incorporate interactive tasks with clients such as brief interviews with a client related to group topic, or sharing of experiences relevant to the group topic by someone with a sustained period of recovery. For example, a recovering person with several years of ongoing sobriety could be a guest in group and share their initial struggles with relapse warning signs or risk factors, then share what helped them deal with the issues in their ongoing recovery that led to preventing relapses.

Since some clients are in a supervised residential or inpatient environment, actual episodes of substance use are not likely (although possible) so focus can be more on what clients should learn about RP. They will have plenty of time to complete recovery assignments (reading, writing, behavioral) so these do not have to be completed during the RP group session. Group endings can focus mainly on sharing something they gained from the RP group sessions or one goal they will work on during the rest of the day or over the next few days.

Orienting Clients to RP Groups

Orienting clients to RP groups can help them prepare to get the most from the sessions. Orientation can include a review of any of the following in addition to questions or concerns of the client. The process can include the client signing an agreement to abide by the rules of the RP group.

1. Purpose and goals of the RP Group.

2. Types of RP group sessions and how these are conducted (structured RP topic, open ended therapy or discussion group, etc.).

3. Logistics of group (location and time), length of time or number of sessions client will attend.

4. How to get the most out of RP group sessions (e.g., come prepared with completed assignments or with problems to discuss, be honest during check-in periods, etc.).

5. The importance of self disclosure or talking about one's experiences, thoughts, feelings, behaviors and ideas relevant to RP topics, issues or problems discussed in group.

6. Specific rules of the RP group such as coming on time, not leaving early, turning off cell phones during the session, not coming to group sessions under the influence of alcohol or other drugs, honestly reporting lapses or relapses and completing therapeutic assignments from journals, workbooks, readings, etc.

7. Other issues (when a referral may be needed to a higher level of care based on poor compliance with treatment, lack of progress, a relapse etc.).

Strategies for RP Group Leaders in Covering Group Content

Group leaders who use a broad repertoire of interventions can keep groups engaged, especially sessions that use a curriculum on a specific RP group topic. This may also help reduce burnout for clinicians who conduct multiple group sessions each week by enabling them to cover the material for clients in different ways.

These strategies include but are not limited to:

1. *Brief lectures* in which interactive discussions are initiated to get members to relate to the material presented. For example, when presenting information on "Relapse Warning Signs" elicit examples from group members on obvious and subtle warning signs preceding their past relapses. Get a variety of answers to show examples of signs.

2. *Use of brief stories* to illustrate points discussed during the session. These stories can focus on failure and success experiences. For example, if a group leader is discussing the importance of clients reaching out for help and support when experiencing strong cravings for drugs or alcohol, examples can be shared of a client who kept cravings to self and eventually relapsed, and of a client who called an NA friend to talk about the strong craving and managed to stay sober as a result. Or, when discussing the issue of using social support in recovery, the group leader can share a story about a previous group member who did not reach out for help and support, then follow this with a story in which a previous member did reach out for help and support.

3. *Guest speakers.* These may include professionals with different perspectives on relapse or recovery (e.g., a medical professional who discussed medication-assisted treatment for addiction). Or, they can include others in recovery, especially treatment program graduates, who share their story of recovery and relapse prevention strategies they used. When using others in recovery, make sure the person spends more time on the "story" of recovery and relapse prevention, and less time on the "story" of addiction.

4. *Educational videos or audiotapes.* These can be used to provide information, stimulate discussion or provide "role models" of others in recovery who share their stories of using positive coping strategies. Or, they can illustrate how others stopped a lapse or relapse. A brief video or audio material with interactive discussion is the most appropriate manner to use these to supplement other interventions. Group leaders should avoid using the majority of group time to show a video or play an audio. Most of the time in group should be spent discussing specific segments of these materials. For video or audiotapes longer than 15+ minutes, one strategy is to show or play a specific segment then follow this with a brief discussion before showing or playing another segment.

5. *Use of written recovery handouts, workbooks or journals***.** Many programs use interactive materials to educate clients and engage them in relating written materials to their own situation. These provide information, raise self awareness and help clients learn coping strategies to manage problems and the challenges of recovery. It is best to have clients complete written handouts prior to the RP group session so the group time can be used to discuss what they learned from this written material and how they relate it to their recovery. Since group size varies, it is not necessary to ask every member to share answers to every question on a written assignment. The idea is to use the experience of group members to review specific materials assigned by having some members share their personal learning from completing a written assignment.

6. *Use of recovery readings***.** Readings related to any topic covered in group sessions can be assigned or recommended between sessions or shared during a session, provided they are brief. Readings can come from many sources such as books, pamphlets, recovery guides,

the internet or even novels. Readings may come from the "Big Book" of AA, the "Basic Text" of NA, other 12-Step related readings, or other readings on specific addictions (alcoholism, cocaine) or other topics (anger, relapse, depression, cravings, family issues).

7. *Role plays or behavioral rehearsals***.** Many interpersonal problems contributing to relapse can be adapted for practice in role-plays. These can relate directly to recovery such as refusing an offer for alcohol or drugs, asking for a sponsor or talking with a family member about one's addiction and recovery. For example, a role play can be set up in which a friend offers alcohol (or drugs) to the person in recovery. The person being offered can be instructed to respond in any way that he wants. The person offering the substance can be instructed to exert strong pressure on this other person.

   Role plays can also relate to other problems that impact on recovery such as addressing an interpersonal conflict, reaching out to a friend for support when feeling depressed, or learning to express anger in healthy ways that do not push others away or harm relationships.

   Interpersonal role-plays enable group leaders to engage members not involved in the actual role play by asking them to imagine they are in the situation that is the focus of the role play. Group members can be asked to pay attention to what they think and feel, and how they might handle the situation illustrated in the role play. Often, these role-plays lead to productive therapeutic discussions and additional behavioral rehearsal of positive coping strategies relevant to the specific problem or issue that the role play focuses on.

   Here are some variations of role-plays that the group leader can use.

   - *Use another group member to verbally serve as the client's "alter ego" in the role-play*. The clinician first gets the client's permission to do this. The person functioning as the alter ego speaks out loud during the role-play, saying what he thinks the client would like to say but is unable to. For example, in an actual role-play situation, a cocaine addict may be offered drugs by a friend. While he may say something such as "no thanks, I'm staying clean," he may be thinking, "I really want to get high. I really crave the drug." The alter ego expresses these inner thoughts or feelings, thus allowing conflicts to surface, be discussed, and hopefully be resolved. This process also helps the client understand the role of ambivalence in recovery, when mixed feelings surface.

   - *Use another group member to serve us the role playing client's "alter ego" by recording thoughts and feelings*. This is similar to the method above except that instead of the alter ego speaking out loud, thoughts or feelings are written down.

   - *Use dyads or triads to role-play problems identified by one or more clients*. This makes all group members active participants in the role-play, and is less threatening than when done in front of large groups.

     Role-plays work best when the clients choose the situations to practice. However, the clinician can have available common relapse scenarios--expressing anger, refusing

substance use offers--which clients identify with. Suggest these to the group if necessary.

At the end of role-plays ask the client to talk about what the experience was like. What did he think? How did he feel? How effective were his responses? What did he dislike about his responses? What did he like about his responses? The other members of the audience can also respond with feedback. This often provides an excellent opportunity for the group to mutually explore issues and problems that are commonly faced in recovery that are highlighted by the role play.

If there is sufficient time and the situation permits, videotaping role-plays can be effective for helping clients learn about themselves. They can dissect role-plays to learn what works best.

8. *Monodramas.* This refers to a technique in which a problem or issue is "externalized" and the thinking and behaviors of a client are explored. For example, when discussing craving to use alcohol or drugs, the group leader can ask for a client to volunteer to participate in an "empty chair" experience. The client is asked to "imagine your craving is sitting in this chair in front of you. Describe what it looks like, what it would say and how it would act."

   A variation of this would be to ask the client to have a discussion with the "substance craving sitting in the empty chair." The client can go back and forth between being the "craving" and being the client affected by it.

9. *Creative media (arts, crafts, music).* Many media can be adapted to express oneself related to the RP topics. Specific "themes" can be the focus of a session using creative media. For example, one of our creative and expressive arts therapist asks clients to create drawings or collages to illustrate their experience traveling down the "road to relapse."

10. *Use of PowerPoint Slides.* The use of slides can provide visual support for educational presentations on any topic conducted in a RP group session. This can take the focus off the group leader as well as group members can shift from looking at the presenter to looking at the slides**.**

    Slides can integrate information as well as visual materials that support the information provided. The possibilities for visuals on a PowerPoint slide are endless. Pictures of people, quotes related to the topic of the group, props (alcohol, drugs, places), cartoons, graphs and charts are just a few examples. This is especially helpful in large groups (e.g., in an auditorium or large meeting room where a lecture is provided to a large group of clients in a residential treatment program). However, slides can also be used in small groups (8-12 clients).

Curriculum for 12 Structured RP Groups

In the sections that follow, we provide curriculum for 12 RP group sessions that can be a "core" program or track within a residential or IOP program to address key issues of relapse and recovery. Each session can stand alone, but taken together, they provide a broad overview of important issues relevant to recovery and relapse. The *Relapse Prevention Workbook* can be used to supplement group sessions by having clients complete sections on the topic of the group sessions.

Most RP group topics can easily be conducted in multiple sessions to cover the material in greater detail if time permits. More group sessions on a specific topic also gives the leader time to have group members practice the skills being discussed. For example, for the topic "Establishing a Recovery Support System," additional sessions could be used to have members practice asking other for help and support with any type of problem or issue such as craving drugs, feeling depressed, wanting to act out on anger, etc.

Following is a brief review of these 12 group sessions.

1. *Group #1: The process and domains of recovery.* This provides an excellent overview of recovery and the areas clients should consider in developing their recovery plans as a way to reduce relapse risk.

2. *Group #2: Managing cravings to use substances.* All RP models stress the importance of clients' learning to identify and manage substance cravings.

3. *Group #3: Managing anger.* Inability to manage emotional states is the number one relapse factor (especially anger, anxiety, boredom, depression). Since anger is such a common problem among clients, this is addressed in this group session.

4. *Group #4: Managing boredom and using leisure time.* This group helps members understand ways to identify boredom and engage in substance free activities.

5. *Group #5: Managing social pressures to use substances.* Inability to refuse substance use offers is one of the highest relapse risk factors in recovery. This group helps prepare members to identify and manage the direct and indirect pressures they may face.

6. *Group #6: Establishing a recovery support system.* This session focuses on the need for a support system, and how to ask for help and support from people and organizations.

7. *Group #7: How mutual support programs help reduce relapse risk.* These programs are the mainstay of long-term recovery for many addicted individuals. This session focuses on how to take advantage of community support programs like AA, NA, other 12-Step, and non 12-Step programs.

8. *Group #8: Identifying and managing relapse warning signs.* This helps members understand relapse as a process, signs that precede relapse and focuses on the importance of taking action to manage warning signs.

9. *Group #9: Identifying and managing high-risk relapse factors*. This covers the major categories of relapse risk factors and gets members to begin to identify their own, and begin to develop strategies to manage these.

10. *Group #10: Managing setbacks.* Since lapses and relapses occur, this group session helps members understand the importance in preparing to intervene early should a lapse or relapse occur.

11. *Group #11: Building a long-term recovery plan.* This promotes recovery as a long-term process and helps members look at specific components of their plans. The importance of active participation in mutual support programs is emphasized.

12. *Group #12: Lifestyle balancing.* This session helps members review the major domains of life to look at which ones are out of balance and could impact on relapse. Members then begin to plan ways to change one area out of balance.

Twelve Structured RP Group Sessions with Curriculum

Topic #1: The Process and Domains of Recovery

Objectives of Group Session

1. Define recovery as a long-term process of "abstinence + change."
2. Review the domains of recovery: physical, psychological, family, social and spiritual.
3. Review internal and external aspects of change.
4. Discuss how good recovery reduces relapse risk.

Points or Issues for Discussion

1. Ask group members their view of the difference between "treatment" and "recovery."
2. Treatment involves: attending a program (e.g., detoxification, rehab or IOP), participating in counseling, taking medication for an addiction, or a combination of these.
   - It is provided by professionals and helps you get and stay sober and deal with problems caused or worsened by your addiction.
   - Treatment helps you understand and engage in recovery.
   - Treatment helps you learn recovery skills to sustain your sobriety over time.
   - Multiple episodes of treatment may be needed to help you sustain long-term recovery.

3. Recovery is a long-term process of *abstinence* + *change*. Ask group members what this means.

4. Ask members their view of the importance of abstinence from all substances.
   - Discuss why abstinence from all substances (alcohol, street drugs and non-prescribed drugs) is recommended not just the "primary" drug of choice (if there is one).
   - Any substance use can affect relapse to the primary drug of addiction or lead to developing an addiction to another substance.

5. Ask group members to share their views of recovery as a "*long-term*" process.
   - Treatment may be short-term (e.g., 5 days of detoxification, 21 days of residential rehab), but recovery continues to prevent relapse AND improve the quality of life.
   - For addiction, it is best to view recovery as occurring for years. Many engage in recovery programs such as AA, NA for their entire life.

6. Ask members to identify and discuss coping strategies to deal with periods of low motivation. You can also have members discuss barriers to "using" positive coping strategies.
   - Reminding oneself of the negative effects of addiction on self, family and others.
   - Reviewing the benefits of sobriety, both short and long term.
   - Repeating one's goals and how important sobriety is in reaching these goals.
   - Accepting motivational struggles as normal and remaining patient.
   - Admitting motivational struggles and sharing them with others who understand.
   - Talking every day to AA, NA, CMA, CA friends or sponsor (or peers in other programs).
   - Reading inspirational literature or recovery literature.
   - Maintaining recovery disciplines even in the face of declining motivation.

7. Review the *physical domain of recovery.*
    - Good nutrition
    - Regular exercise.
    - Getting adequate sleep and relaxation.
    - Taking care of medical problems (including pain), or dental problems.
    - Learning to cope with cravings to drink alcohol or ingest drugs.
    - Using medication-assisted treatment for addiction to alcohol, nicotine or opioids.

8. Review the *psychological domain of recovery.*
    - Accepting the addiction and need for help and support from others.
    - Learning to cope with problems and stresses without relying on substances.
    - Changing distorted, negative or "stinking" thinking.
    - Managing emotions without relying on substances.
    - Getting help for psychological problems or psychiatric disorders.

9. Review the *family domain of recovery.*
    - Reviewing the effects of addiction on the family and individual members.
    - Involving the family in treatment and recovery.
    - Improving relationships with family members.
    - Making amends when appropriate (with the input of a sponsor or therapist).

10. Review the *social domain of recovery.*
    - Developing relationships with sober people.
    - Learning to resist pressures from others to use substances.
    - Developing healthy social and leisure interests to occupy time.
    - Reaching out to others for help and support (peers in recovery, family, confidante).

11. Review the *spiritual domain of recovery.*
    - Relying on a Higher Power for help and strength.
    - Developing a sense of purpose and meaning in life.
    - Taking other steps to improve one's faith or "inner life."
    - Engaging in religious or faith based practices.
    - Praying, meditating, reading spiritual literature.

12. Discuss how recovery is best viewed as a *"we" process* in which you use the support of others, especially sober individuals who are actively working a program of recovery.

13. Ask for examples of change that may occur in any of these domains of recovery.
    - Internal change refers to changes within one self (how you think or manage emotions).
    - External change refers to changes in relationship and lifestyle.
    - Positive changes lead to "good" recovery, which can reduce relapse risk.

Topic #2: Managing Cravings to Use Substances

Objectives of Group Session

1. Define cues, triggers, or precipitants of cravings or urges to use alcohol or drugs.
2. Identify external and internal precipitants of cravings.
3. Review strategies to manage cravings to reduce relapse risk.

Points and Issues for Discussion

1. Cravings, urges or desires to use substances are common during periods of recovery. "*Overt*" cravings are those that members easily identify. "*Covert*" cravings are those that may show in others ways (irritability, low motivation, wanting to leave a program against professional advice).

2. A key component of RP is learning to manage these without using substances.

3. Ask group members to define and describe cravings for alcohol or drugs.
   - How do cravings show in physical symptoms?
   - How do cravings show in their thoughts?
   - How do cravings show in their behaviors?

4. Ask group members to identify external factors that trigger their cravings and ask for specific examples for each category.
   - *People:* people they used with, dealers spouse or partner who uses or gets high.
   - *Places:* parties, clubs, bars, any location associated with using substances.
   - *Events:* family or work functions, concerts, events where substances are used.
   - *Things or objects*: alcohol, drugs or things associated with drinking, using drugs or preparing drugs (papers, pipes, needles, any drug paraphernalia).

5. Ask group members to identify internal factors that trigger their cravings and ask for specific examples for each category.
   - Thoughts: "I need a drink or drug; I'm dying to get high; I have to use to get through the day. I can't cope without something."
   - Feelings: boredom, anxiety, loneliness, depression, anger.
   - Physical pain or discomfort.

6. Discuss levels of intensity of cravings (from mild to severe). The level of craving will determine coping strategies to use.
7. Review how drugs "hijack" the reward system of the brain, which results in substances bringing more pleasure than food, sex, or other activities.
8. One result of this hijacking is the susceptibility to "cravings" when experiencing memories of substance use or exposed to external triggers.

9. This hijacking helps to partially explain the "compulsion" to use substances despite the damage they cause.
   - Ask members to describe experiences with a compulsion to use alcohol or other drugs.
   - Ask members to discuss at what level of intensity they believe it is difficult to manage their cravings to use substances and they are at risk for relapse.

10. Discuss the importance of using multiple strategies to manage cravings since one strategy may not work in every instance of a craving.

11. Review coping strategies to manage cravings by asking group members to share examples of times in which they successfully managed a craving such as:
   - Recognize and label your craving for alcohol or drugs and accept these are normal.
   - Keep a daily craving log in early recovery in order to remain vigilant and track your triggers, cravings and intensity of them.
   - Talk about your craving and thinking with a sponsor or confidante so you do not keep it a secret and let it overwhelm you.
   - Go to a mutual support program meeting such as AA or NA (or non 12-Step program).
   - Talk to others in recovery to find out what they do to manage their cravings.
   - Talk yourself through the craving ("this will pass," "I can resist using," "I control my craving, it does not control me" or "one craving at a time").
   - Remember how far you have come in your recovery and how good you will feel if you stick with it and don't give in to your craving for drugs or alcohol.
   - Accept that your craving will pass in time, and most last just a few minutes.
   - Redirect your activity to distract yourself temporarily from your craving.
   - Write your thoughts about your craving and your related feelings in a journal.
   - Get rid of booze, drugs, and drug paraphernalia (external triggers).
   - Avoid high-risk people, places, events and things when having strong cravings.
   - Pray or use your Higher Power and ask for help and strength.
   - Read recovery literature to stay focused on your sobriety.

12. Ask group members to discuss why they sometimes have given in to cravings in the past and other times resisted them.
   - What can they learn from these experiences?
   - What determines "not giving in" to "giving in" to a craving?
   - How do they feel when they "give in?"
   - How do they feel when they "resist" their cravings?

13. *Optional:* have group members shut their eyes and imagine their craving as some solid object. Then, ask them to imagine driving a truck or tank and crushing the craving. Discuss reactions to this exercise once it is finished and stress the importance of not letting their cravings (or addiction) dictate their behaviors.

14. *Optional:* have members share some of their responses to Section 5 "Managing Cravings for Substances" in the Relapse Prevention Workbook, pages 9-10. Remind them to use some of the craving management strategies listed on page 10.

Topic #3: Managing Anger

Objectives of Group Session

1. Define the three components of anger: feelings, thoughts and behaviors.
2. Identify connections between anger and relapse.
3. Review causes and effects of anger and the ways in which it is managed.
4. Review strategies to manage or cope with anger from other people.

Points for Discussion

1. Ask group members to define anger and discuss the degree to which it is a problem for them.
   - Some will report chronic problems with anger and state they have a "short fuse."
   - Others will state they have difficulty allowing themselves to feel angry or express it.

2. Ask members how mismanaged anger can impact on relapse or create other problems in their lives.

3. Relate their answers to anger having three components.
   - Emotional (feelings like hurt, resentment).
   - Cognitive (thoughts and beliefs).
   - Behavioral (actions).

4. Discuss what group members learned from parents and others about anger and how to express it or deal with it in their relationships with others.

5. Review unhealthy and healthy ways of expressing anger:
   - *Unhealthy*: acting out and hurting others physically or verbally; hurting oneself; being passive and letting anger build up; drinking or using drugs; and acting in passive-aggressive ways.
   - *Healthy*: expressing it to others in a controlled manner when it is appropriate to do so; talking about feelings with a confidante; talking oneself out of being angry; engaging in activity that helps release or control anger; praying; or using anger as a motivator.

6. Ask group members to give examples of the effects of unhealthy anger management strategies on themselves and others.
   - *On self*: using substances, becoming enraged, depressed, or out of control.
   - *On others*: causing fear or worry, pushing others away, causing emotional damage in a relationship or causing it to end.

7. Discuss the connection between anger and methods of expression, and substance use.
   - Anger can lead to substance use and be an excuse for relapse.
   - Anger that controls a person can lead to acting out in ways that hurt others emotionally or physically.
   - Anger that is not dealt with and suppressed can contribute to depression, self-harm, anxiety, low self-esteem, or internal turmoil.

8. Review strategies for managing anger and elicit examples from group members on both positive and negative ways they have deal with their anger.
   - *Verbal strategies*: talking about it directly with the person one is angry at; talking with a confidante to release feelings in a safe context; or getting support and another person's perspective.
   - *Cognitive or self-talk strategies*: changing thoughts, internal dialogue or core beliefs; or, using the slogans of AA, NA or DRA ("this too shall pass").
   - *Behavioral strategies*: going for a walk or exercising, redirecting one's activity, working around the house, praying or meditating, or going to an AA, NA, or DRA meeting to "drop off" anger.
   - *Medications*: when anger is intense, persistent, and acted upon impulsively or aggressively, a mood stabilizer may be useful. An evaluation by a psychiatrist can determine if medications are needed for a psychiatric illness that contributes to these emotional problems.

9. Review a process to deal with angry feelings:
   - Step 1: recognize anger in thoughts, feelings and behaviors.
   - Step 2: examine causes of anger.
   - Step 3: evaluate the effects of anger and coping strategies used.
   - Step 4: identify coping strategies to manage anger in each situation.
   - Step 5: rehearse or practice new coping strategies.
   - Step 6: put these into action, evaluate their effects, and change as needed.

10. *Optional:* Create role plays in which a client has to deal with anger towards a stranger (e.g., a server in a restaurant who is rude), friend or family member (e.g., something they said or did to the client was hurtful and led to feelings of anger). Focus on using healthy verbal strategies to talk with another person about the situation contributing to the anger or the feeling itself (e.g., usually it is best to focus on the situation with people who are not intimate in the client's life).

11. *Optional:* Identify concerns of group members related to dealing with anger expressed by others.

12. *Optional:* Discuss strategies to cope with anger from other people.

13. *Optional:* have members share some of their responses to Section 6 "Managing Anger" in the Relapse Prevention Workbook, pages 11-13. Remind them to use some of the anger management strategies listed on page 13.

Topic #4: Managing Boredom and Using Leisure Time

Objectives of Group Session

1. Identify ways that boredom affects recovery and can impact on relapse.
2. Identify sources of boredom and "high-risk" times.
3. Review the importance of structure and routine in daily life.
4. Review strategies to manage boredom and engage in substance-free social activities.

Points for Discussion

1. Ask group members to identify and discuss how boredom affects recovery from a substance use disorder. Problems associated with boredom include:
   - Relapse to alcohol or drug use.
   - Feeling depressed.
   - Getting involved in activities that may temporarily reduce boredom but create other problems.
   - Getting involved with people you used substances within the past who may pose a threat to your recovery.
   - Making major decisions not well thought out that are based on feeling bored (e.g., ending important relationships or quitting a job without having another job).

2. Discuss how group members feel about living without alcohol or drugs, or partying.
   - They may miss the company of people they used or got high with.
   - They may miss the action of bars or parties.
   - They may feel nothing can replace the high feeling produced by alcohol or drug use.
   - They may even feel "empty" at first, like life has little meaning or direction.

3. Identify and list leisure activities given up due to the substance use disorder.
   - Why did they give up certain activities?
   - Which of these do they miss the most?
   - Which of these could be regained?

4. Identify drug-free or non-substance activities or situations that bring pleasure or enjoyment, or are fun. Discuss how or why these activities bring pleasure, enjoyment or meaning.
   - Social events.
   - Interpersonal relationships.
   - Athletic.
   - Creative.
   - Artistic.
   - Musical.
   - Spiritual.
   - Collecting things.
   - Fixing or repairing things (cars, furniture).
   - Other.

5. Identify and discuss the benefits of having structure in daily life.
   - Reduces the chances of engaging in high risk situations causing relapse.
   - Gives a sense of direction and purpose.
   - Forces you to focus on goals and methods to achieve these goals.
   - Facilitates accountability with your time.

6. Review practical coping strategies to reduce boredom.
   - Recognize boredom, high-risk times for it and reasons for boredom.
   - Regain "lost" activities that are not substance-related.
   - Develop new leisure interests or hobbies.
   - Learn to appreciate the simple pleasures in life.
   - Build fun or pleasant activities into day-to-day life.
   - Change thoughts and beliefs about boredom.
   - Change thoughts and beliefs about involvement in drug-free activities.
   - Evaluate relationship or job boredom before making major life changes.
   - Deal with persistent feelings of boredom.
   - Participate in recovery support groups or recovery clubs.

7. Discuss the issue of "emptiness" and "joylessness" associated with giving up substances, and how this contributes to both boredom and an inability to experience pleasure in normal activities.

8. *Optional:* have group members complete a daily or weekly activities schedule to get them to practice building structure and activities into their daily lives.

9. *Optional:* create role plays in which a client asks another person (family member or friend) to participate in a non-substance leisure activity. A variation of this is to have a client role play a situation in which he is invited to participate in a leisure activity that could threaten his sobriety (e.g., event where alcohol flows freely or others will be using drugs).

10. *Optional:* have members share some of their responses to Section 7 "Managing Boredom and Using Leisure Time" in the Relapse Prevention Workbook, pages 14-15. Remind them to use some of the strategies to manage boredom listed on page 15.

Topic #5: Managing Social Pressures to Use Substance

Objectives of Group Sessions

1. Teach group members to anticipate direct and indirect social pressures to use substances.
2. Identify the effects of social pressures on thoughts, feelings, and behaviors.
3. Teach group members about "relapse set-ups" or how they put themselves in high risk social pressure situations either consciously or unconsciously.
4. Review strategies to refuse social pressures to use alcohol or other drugs.

Points for Discussion

1. Social pressure to use substances is one of the most common relapse risk factors with substance use disorders.
   - Social pressure can be direct in which drugs or alcohol are offered to you.
   - Social pressure can be indirect when others are using and you feel some pressure to use.
   - However, it is not the social pressure itself, but your ability to manage it that determines if you will relapse and use alcohol or drugs.

2. Ask group members to provide examples of direct and indirect social pressures they have faced or expect to face in the future. These will fall in one of these categories:
   - *People:* family members or friends who use; people with whom group members drank or got high, and drug dealers.
   - *Places:* bars, parties or other places where substances were used.
   - *Events or situations:* weddings, graduations, holiday celebrations, sporting events, concerts, or family events.

3. Set up role-plays where a member is offered alcohol or drugs by another person.
   - Ask other group members observing the role-play to identify with the client being offered substances, and to pay attention to their thoughts and feelings.
   - Have the group members being offered drugs or alcohol to respond based on how they feel at the moment.

4. After the role-play, process it with the group. Focus on the following:
   - What do you feel when confronted by social pressures to use?
   - What thoughts come into their minds when offered alcohol or drugs.
   - How do social pressures impact on your motivation to stay sober?
   - What can you do to refuse offers of substances?

5. Option: have group members pair up in dyads. Each offers the other alcohol or drugs. After this experience, discuss the same questions listed above.

6. Option: use a male-female in the role play and instruct the individual offering alcohol or drugs to add an offer of a "good time" or sex.
   - A male client might feel more vulnerable to an offer by a female to get high because of the association between sex and getting high with a woman (or vice versa).

- A variation is to use male-male or female-female scenarios in order to address social pressures experienced by gay men and lesbian women.

7. Discuss what could happen if the group member gives in to social pressure.
   - Could continue use and have relapse.
   - Could experience negative effects: medical, family, psychological, spiritual, legal, and financial.
   - Could lose desire to get back on track.

8. After the group processes the role-play, review positive coping strategies:
   - Avoidance of high-risk social pressure situations when appropriate.
   - Verbal (ways to say no).
   - Behavioral (ways to reduce or deal with unavoidable social pressures).
   - Stress the importance of preparing by anticipating social pressures AND having coping strategies to use to manage these pressures.

9. Also, discuss the issue of "ambivalence" ((i.e., this role play often helps group members realize that part of them that still wants to get high and they "miss the action").

10. Ask group members why social support is so important during the holidays.

11. Discuss strategies to manage holidays such as:
    - Spending them with supportive family and friends who do not threaten your sobriety.
    - Remaining active in recovery program activities such as meetings or events.
    - Participating in special events sponsored my mutual support programs like AA or NA.
    - Being more vigilant about your sobriety and recovery.
    - Planning ahead to feel prepared for holidays perceived as the most risky for group members.

12. *Optional:* have members share some of their responses to Section 8 "Managing Social Pressures to Use Substances" in the Relapse Prevention Workbook, pages 16-17. Remind them to use some of the strategies to resist social pressures listed on page 17.

Topic #6: Establishing a Recovery Support System

Objectives of Group Session

1. Identify the benefits of having a recovery support system.
2. Identify supportive people and organizations to include in a recovery support system.
3. Identify reasons why it may be difficult to ask others for help or support.
4. Identify ways to approach others and ask for help or support.

Points or Issues for Discussion

1. Many mutual support programs exist to aid recovery and reduce relapse risk. All of these programs have "tools" to help the person recover.

2. Many people find the 12 Step fellowship of AA, NA, and CA helps their ongoing recovery.
   - Meetings, sponsors, friendships with peers in recovery, the 12 Steps, slogans and recovery literature are all "tools" of 12-Step recovery that can help you stay sober and make positive changes over time.
   - Others find non 12-Step programs helpful in their recovery (Women for Sobriety, SMART Recovery, Rational Recovery, etc).

3. In addition, other people and organizations can also provide you with help and support. These people do not have to be associated with a recovery program.

4. Then ask group members to give examples of people they might ask for help and support.
   - Specific family members
   - Specific friends
   - A boss or coworker
   - A neighbor
   - A priest, minister or rabbi
   - Other people?

5. Ask members of the group to give examples of organizations or groups that can play an important role in their efforts to stay sober and change their lifestyle.
   - Church or synagogue
   - Sports team
   - Club that evolves a specific interest
   - Volunteer organizations

6. Ask group members to give examples of how other people and organizations can play a role in their recovery.
   - Other people can listen to their problems or concerns.
   - Other people can be asked for specific help with a problem or situation.
   - Other people can participate in mutually-satisfying activities or events that do not evolve around alcohol or drug use (e.g., share a hobby, go to a movie together, etc.).
   - Organizations can give a sense of belonging.

- Organizations can offer opportunities for social interaction, a chance to develop new friendships or interests, or a chance to learn new skills.
- Church related organizations can provide an opportunity for spiritual growth.
- Other?

7. Ask group members to give examples of people they <u>should not ask for help</u> or support.
   - Others who still get drunk or high and have no interest in supporting them in recovery.
   - People who are angry at the recovering person and may still be holding a grudge.
   - People who don't want the recovering person to succeed at getting or staying sober.
   - Other?

8. Ask the group to give reasons why it is difficult to reach out and seek help or support from others.
   - Fear of rejection.
   - Feeling unworthy to be helped by others.
   - Don't know how to be assertive and make requests from other people.
   - Feeling shy and awkward.
   - Embarrassed to have to ask another for something.
   - Fear of sounding inadequate.
   - Hard to trust others and open up.

9. Ask members to share ideas on how to "reach out" to others for help and support.
   - Make a list of people that they trust and feel they can rely on.
   - Choose one or two to start with in terms of asking for help or support.
   - Talk with them about recovery and the need for their support.
   - Communicate regularly, not just in time of trouble.
   - Talk face-to-face, by phone, email or text messaging.
   - Take a risk and open up to others.
   - Also, show an interest in their lives.

10. *Optional*: create role plays in which a member: a) asks for help and support from a friend, family member or confidante; or b) asks a member of AA or NA to be a Sponsor.
    - Then, discuss what the experience was like.
    - What were the barriers to reaching out for help and support?
    - Who are the people to reach out for to get help and support in recovery?
    - What are ways to reach out (i.e., what can the members say?).

11. *Optional:* see Section 5 "Sober Friends and Social Support in Recovery" in the workbook <u>Sober Relationships and Support Systems in Recovery</u>, pages 11-12.

Topic #7: How Mutual Programs Aid Recovery and Reduce Relapse Risk

Objectives of Group Session

1. Provide an overview of the 12-Step and non 12-Step mutual support programs.
2. Discuss experiences and beliefs about 12-Step programs
3. Emphasize the importance of "we" in the "Fellowship" of these programs.

Points and Issues for Discussion

1. Ask members what types of mutual support programs they can use to aid recovery and reduce their risk of relapse.
   - 12-Step programs (AA, NA, etc).
   - Mention some areas have "specialty" mutual support programs for Native Americans, Christians, Gays and Lesbians, and other groups of people. These programs take into account some of the differences of people that can affect recovery.
   - Other programs (Rational Recovery, SMART Recovery, Women for Sobriety, etc.).

2. Ask group members to share their experiences and beliefs about mutual support programs.
   - What types of mutual support programs and meetings did they attend?
   - What did they dislike about these programs?
   - What did they like about these programs?
   - What did they find helpful?
   - Which of these programs can aid their long-term recovery?

3. Discuss how 12-Step programs are a major source of support in ongoing recovery from addiction. These programs involve many components such as:
   - Meetings (open, closed, leader, discussion)
   - Sponsorship
   - 12-Steps
   - Recovery events
   - Readings on addiction and recovery such as "Big Book of AA" "Basic Text" of NA.
   - Slogans such as "One day at a time," "This too will pass," or "Easy does it."
   - Service

4. Get group members to discuss experiences and beliefs about 12-Step meetings.
   - How often they attended or think they should attend.
   - Types of meetings they liked the most (or least) and why.
   - Why having a "Home Group" is important.
   - Why regular meeting attendance is important.

5. Ask group members to discuss experiences and beliefs about Sponsors.
   - Why get a sponsor and how a sponsor can help.
   - How to get a sponsor.

- Reservations about getting and trusting a sponsor.
- How to actively "use" a sponsor to mentor them in recovery.
- The difference between a sponsor and a therapist or counselor.

6. Get group members to discuss experiences and beliefs about the 12-Steps.
   - Purpose of the 12-Steps.
   - Focus on the "we" that is in all steps vs. the "I" to stress the "Fellowship."
   - Which of the 12-Steps have members "worked" before and what was the outcome?
   - Focus on the importance of "Step 1" during early recovery.

7. Ask members to share experiences attending events sponsored by the 12-Step Fellowship.
   - Types of events attended (social, recovery oriented)
   - What they gained from these events.
   - How these events aided their recovery.
   - How holiday related events can help them through difficult time periods.

8. Get group members to discuss experiences and beliefs about reading recovery literature.
   - What have they read?
   - How has recovery literature helped them?
   - Mention the "Big Book of AA" and the "Basic Text of NA" for drug addiction.
   - State there are many books, pamphlets and workbooks available related to the 12-Step program of recovery through AA, NA and other publishers.
   - Inform group members where they can get 12-Step recovery literature.

9. Ask group members to discuss some of the "Slogans" used in the 12-Step program.
   - What are slogans and how can they help in daily recovery?
   - Review a few of the common ones that help in early recovery.
   - "Easy Does It; One Day at A Time; Let Go and Let God."
   - "Think Through the Drink/Drug; This Too Shall Pass" and other slogans.

10. Get group members to discuss experiences and beliefs about "Service"
    - How do members "serve" each other?
    - Service can be formal (chair meetings)
    - Service can be informal (help set up and clean up after meetings).
    - Service gets recovering person to focus on others rather than self.

11. Emphasize the "Fellowship" is a "we" program and discuss what this means to group members to work "with" others in recovery rather than try to recover alone.

12. *Optional:* there are many excellent readings from AA, NA or other mutual support programs that can be used. Also, see the workbook "Using 12-Step Programs in Recovery", which provides an overview of addiction, treatment, recovery and 12-Step programs (meetings, sponsorship, 12-steps, slogans, service, recovery resources).

Topic #8: Identifying and Managing Relapse Warning Signs

Objectives

1. Teach group members that warning signs precede substance use relapse.
2. Introduce the idea that relapse is a process as well as an event.
3. Review *common warning signs* associated with relapse.
4. Review *subtle warning signs* that may be unique to each individual.
5. Identify strategies to manage relapse warning signs.
6. For those who have had one or more episodes of relapse, teach them to use this as a *learning experience* to help their future recovery.

Points for Discussion

1. Ask group members to define lapse or relapse as it relates to their substance use disorder. Give the following definitions:
   - A lapse refers to the initial period of use and may or may not progress to a full-blown relapse.
   - Addiction relapse refers to the process of returning to regular alcohol or drug use after a period of sobriety. A relapse can be brief or last very long.

2. Ask group members who have relapsed for examples of relapse warning signs from past experiences. Add additional examples as needed and state that warning signs will fall in the following categories:
   - *Changes in thinking*: "I don't need recovery, it's not worth the effort, I don't need medications anymore;" increase in severity of obsessions to drink or use drugs.
   - *Changes in mood*: significant increase in anger, anxiety, boredom, or depression.
   - *Changes in health habits or daily routines*: not taking care of personal hygiene or changes in daily habits or rituals.
   - *Changes in behavior*: stopping or cutting down on treatment sessions, medications, or support group meetings without prior discussion with a professional or sponsor; reducing social interactions or activities; or reduced use of the "tools of recovery."

3. For relapse to substance use, emphasize it seldom "comes out of the blue."
   - Discuss the context of relapses (who, where, when).
   - Help group members see that it may be days or longer between an emergence of warning signs and substance use.

4. Emphasize the importance of catching relapse warning signs early.
   - The earlier that group members intervene, the less likely that relapse will occur.
   - Ignoring warning signs is not a good strategy as they must be dealt with.

5. Discuss the importance of not keeping warning signs a secret as things can build up and end in a relapse. Failure to identify or deal with relapse warning signs invites problems.

6. Discuss the difference between "common" and "individual or personal" warning signs. Elicit examples from each category.
   - Common warning signs include cutting down or stopping mutual support meetings, counseling or medication-assisted treatment for addiction.
   - Individual or personal warning signs may include an increase in dishonestly, or depression during the holidays.

7. Ask group members to identify strategies to manage relapse warning signs. Their specific examples should fall in the following broad categories:
   - *Cognitive*: changing thoughts and beliefs (e.g., challenging the thought "I can't have fun without alcohol or drugs" or "just because I didn't get the job I wanted doesn't mean I have to get depressed and give up").
   - *Behavioral*: changing a behavior (e.g., resuming regular meeting attendance when one identifies cutting back as a warning sign; taking medications as prescribed after one identifies cutting down or stopping without first discussing this with a doctor or therapist).
   - *Interpersonal*: seeking help and support from others in AA or NA (e.g., talking with others about ways to manage warning signs).

8. Use this information to emphasize the importance of *being aware of warning signs* and having a plan to manage them.

9. Discuss the importance of *seeking support from others* to manage warning signs (e.g., AA or NA friends and sponsors, counselor, friends, family, etc.).

10. Discuss the importance of *learning from past experiences* with lapse or relapse. If a group member has had multiple relapses following periods of recovery, the group leader can suggest that she review the most recent ones to see if there are any patterns to her behavior that indicate a relapse was likely to happen. Focus should also be on coming up with strategies to manage past warning signs that may occur in the future.

11. *Optional:* have members share some of their responses to Section 2 "Understanding the Relapse Process in the Relapse Prevention Workbook, pages 2-4. Remind individuals with a history of multiple relapses to use this information to examine several relapses to help them determine if there is any pattern to their relapses.

Topic #9: Identifying and Managing High Risk Factors

Objectives

1. Review factors that increase the risk of relapse to addiction and label these as "high risk."
2. Teach group members that relapse risk factors fall into different categories, but it is usually a combination of factors, rather than just one, that leads to relapse.
3. Emphasize the importance of learning and using active coping skills to manage relapse risk factors.

Points for Discussion

1. Relapse is common with substance use disorders.
   - Relapse does not mean failure.
   - It is common with chronic or recurrent disorders (medical, psychiatric or addiction).

2. There are a number of external and internal factors that increase group members' vulnerability to relapse. These are referred to as "high-risk" factors.

3. Ask group members to identify high-risk relapse factors in relation to their addiction
   - These are situations in which they used alcohol or drugs in the past.
   - These can occur regardless of how engaged you are in a recovery program.
   - These are situations that increase their desire to use or lower their interest in recovery.

4. Review the major categories of causes of relapse, eliciting and giving some examples from each category:
   - Negative emotional states (anger, anxiety, boredom, depression, etc).
   - Social pressures to use alcohol or drugs.
   - Strong urges, cravings or desires to use alcohol or drugs.
   - Relationship conflicts (family, friends, others).
   - Physical pain or discomfort.
   - Positive emotional states.
   - Lifestyle factors (health habits, structure, etc.).

5. Group members need more than awareness of their high-risk relapse factors. They also need to *actively use coping skills to* manage these factors effectively. Ask them why they think coping skills are necessary to reduce relapse risk?

6. The specific coping skills needed by group members will vary and depend on their relapse risk factors.

7. Stress the importance of having a plan to deal with potential high-risk factors. They are usually situations in which alcohol or drugs were used in the past. The idea is to:
   - Identify (anticipate) high-risk factors.
   - Examine the details of these high-risk factors.
   - Develop strategies to manage relapse-risk factors.

- Implement coping strategies into daily recovery.
- Change strategies that do not work and try new ones.
- Learn from peers steps they took to reduce exposure to certain potential high-risk relapse factors (e.g., what people, places, events, things did they need to avoid and why?).
- Learn from peers what they did to cope and prevent relapse when they were faced with high-risk factors.

8. Reinforce the importance of making a commitment to long-term recovery using both professional counseling and mutual support programs.
   - This provides an ongoing mechanism to identify and manage high-risk factors.
   - It provides social support so that you can get help from others in recovery.

9. Some group members are more vulnerable to relapse than others, based on their history and severity of their illnesses and coping skills. For example:
   - A group member with a long history of addiction and multiple attempts at recovery is more vulnerable to relapse than a first-timer.
   - A group member with an untreated psychiatric disorder is at increased relapse risk.
   - A group member who lacks social support on a recovery network is more likely to keep problems to oneself and return to substance use.

10. Medication-assisted treatment can be very helpful to group members who:
    - Have an opioid addiction and have not been able to sustain recovery from addiction to these drugs with professional treatment and/or participation in mutual support programs. Methadone (Methadose®), buprenorphine (Subutex® and Suboxone®) and naltrexone(Revia®, Vivitrol®) are medications for opioid addiction.
    - Have an alcohol dependence and have not be able to sustain sobriety with professional treatment or participation in mutual support programs like AA. Disulfiram (Antabuse®), naltrexone (and acamprosate (Campral®) are examples of medications for alcoholism.
    - Have nicotine dependence and want to quit. Medications used for withdrawal symptoms or ongoing abstinence from nicotine include varenicline (Chantix®), buproprion SR (Zyban®), nicotine gum, nicotine lozenges, nasal spray, puffer ("inhaler") or transdermal patch. These may be used singly or in combination to help the addicted client stop using nicotine and deal with strong cravings that often occur when a person stops using nicotine.
    - While the FDA has not approved any drug for cocaine or methamphetamine addiction, research continues to try to find a drug that helps. Group members can always ask their doctor or therapist about medications for stimulant addiction.

11. *Optional:* have members share some of their responses to Section 3 "Identifying High Risk Situations" and Section 4 "Managing High-Risk Situations" in the Relapse Prevention Workbook, pages 5-8. Remind them that it is not the high risk situation but the use of coping strategies that determines if a relapse is prevented.

Topic #10: Setbacks: Stopping a Lapse or Relapse

Objectives

1. Review the importance of being prepared to handle a setback, emergency, lapse or relapse.
2. Identify benefits of continued involvement in treatment and recovery.
3. Raise awareness that failure to comply with ongoing treatment increases the chance of relapse.

Points for Discussion

1. Ask members how they define a lapse, relapse, setback or emergency as it relates to recovery from addiction.

2. Group members who comply with treatment do better than those who do not. Failure to comply with treatment often contributes to relapse.

3. Stress the importance of keeping therapy appointments even after sobriety has been achieved and maintained for a while.

4. Ask group members who have failed to comply with treatment in the past, why they were non-compliant, and how this affected their recovery.

5. Ask group members who complied with treatment in the past to state why they complied with treatment, and how this affected their recovery.

6. Ask group members to identify the potential benefits of complying with treatment and recovery plans.
   - Improves their chances of recovery and making positive changes.
   - Decreases the risk of relapse.
   - Keeps them connected with others willing to support them in recovery.
   - Provides reminders of what addiction has done to them and how recovery benefits them.

7. Many group members relapse so it helps to be prepared should this occur.
   - Relapse can occur even if group members comply with treatment.
   - However, it is less likely if treatment is complied with.

8. Discuss the benefits of preparing ahead of time for a setback, lapse or relapse.
   - Group members are better prepared to take action quickly and early in the relapse process.
   - Group members feel more hopeful about recovery if they know how to handle setbacks and potential problems.
   - Damage that occurs following a lapse or relapse is limited. For example, catching a lapse may prevent a full-blown relapse.

9. Ask group members what they could do if they felt their treatment plan was not working or not helpful instead of dropping out of treatment.

- Talk to their treatment team about changing the plan.
- Figure out why the plan is not working.
- Talk to a sponsor.
- Talk to a peer in recovery.
- Talk to a confidante, someone who they trust.

10. Ask group members to identify steps to take if they relapse to substance use.
    - Stop using and get rid of booze, drugs and drug paraphernalia.
    - Ask for help from a sponsor or other AA or NA friends.
    - Ask for help from the treatment team.
    - Seek detoxification if physical addiction has reoccurred.
    - Get back in treatment if they had dropped out before their relapse.

11. Review the following ideas about setbacks and emergencies:
    - Preparing ahead of time allows group members to catch setbacks early, which may help prevent a full-blown relapse.
    - Group members can ask for help with setbacks or emergencies from counselors, other professionals, sponsors, and friends in recovery.
    - When possible, your family should be involved.
    - Group members who get re-addicted physically and cannot stop alcohol or drug use will need detoxified under medical supervision.

12. Ask group members what they learned from previous lapses, relapses or setbacks.
    - Causes.
    - Effects.
    - What they learned about relapse and recovery.
    - What they learned about themselves.
    - What they can do differently in the future.

13. Have group members complete an *Emergency Sobriety Card*. This can be written on a 3 x 5 index card and should include the following information.
    - Names, phone numbers and emails of 5 supportive people.
    - Names and phone numbers of organizations than can help (e.g., AA, NA, hotline).
    - Reasons they would hesitate to ask for help or support.
    - Benefits of asking for help or support from others.

14. *Optional:* have members share some of their responses to Section 11 "Emergency Sobriety Card" and Section 12 "What to Do if You Relapse" in the Relapse Prevention Workbook, pages 22 and 23.

Topic #11: Building a Long-Term Recovery Plan

Objectives of Group Session

1. Stress the importance of a daily plan for recovery.
2. Reinforce the helpfulness of participation in mutual support programs after completion of professional treatment (AA, NA and other 12-Step and non 12-Step recovery programs).
3. Review the "tools" of recovery that can be used in daily life to help one maintain sobriety and continue to make positive changes.

Points or Issues for Discussion

1. Ask group members why is important to comply with treatment and keep their appointments.
   - Those who stay in treatment do better than those who drop out early.
   - Treatment can help even during times of difficulty when a person is struggling or relapses.

2. Ask group members why they think it is important to follow a daily plan in recovery. Add examples as needed to cover these benefits:
   - Helps keep group members focused and vigilant about recovery.
   - Keeps them busy and focused on using positive coping strategies.
   - Helps group members achieve their goals.
   - Helps them spot problems or relapse warning signs early.

3. Discuss the possible negative consequences of dropping out of treatment early, or not following a recovery plan on a daily basis. Add examples as needed to cover the following potential problems:
   - Problems are not identified or addressed promptly.
   - Priorities change, and recovery can take a back seat to other priorities in life.
   - Group members lose a major source of support and feedback.
   - Boredom and hopelessness are more likely.
   - Members can lose focus on recovery.
   - Members can become too passive about recovery and actions needed to sustain recovery.
   - The risk of relapse may increase.

4. Ask the group members to identify the benefits of ongoing participation in a recovery program following completion of treatment. Some examples include:
   - Can receive continued help and support from others in recovery.
   - Actively working a program of recovery reduces relapse risk.
   - Involvement in recovery, especially support groups, is a constant reminder of the seriousness of addiction and the importance of following the "disciplines" of recovery.
   - Staying sober puts the recovering person in the position to continue to make positive changes in self and lifestyle, which can improve the quality of life.
   - Many problems and issues emerge over time, even if one is sober from alcohol or drugs. Participation in a recovery program can make you feel better prepared to handle these issues or problems.

5. Discuss the length of time group members should stay involved in a mutual support recovery program such as AA or NA. This varies considerably among recovering individuals with many staying involved for years or even lifelong.

6. Ask members what happened to them in the past if they dropped out of treatment and/or mutual support programs early.
   - How were they affected?
   - Why did they drop-out?
   - Did they talk about their impulse to stop treatment or recovery BEFORE making the decision to do so? If not, why not?
   - What does this type of poor decision to drop out say about addiction?

7. Ask the group what "tools" of recovery they can use on a regular basis. They can also state how these various recovery tools can help their ongoing recovery.
   - Attending AA, NA or other mutual support meetings.
   - Spending time at a recovery club or clubhouse.
   - Talking with a sponsor or peers in a mutual support programs every day.
   - Sharing social or recreational activities with sober friends.
   - Avoiding high risk people, places, events or situations when possible.
   - Using techniques to fight off thoughts of using substances, or to fight off strong cravings.
   - Using positive affirmations by reminding oneself of the benefits of recovery.
   - Getting physical exercise.
   - Attending religious services; praying or using one's Higher Power.
   - Focusing on one of the 12 Steps.
   - Repeating and thinking about a recovery slogan.
   - Reading recovery or inspirational literature; writing in a recovery journal or workbook.
   - Participating in pleasant activities that don't involve alcohol or drugs.
   - Doing something nice for someone else as a way of "giving back."
   - Reviewing the plan for recovery at the beginning of each day.
   - Evaluating how the day went at the end of it to review positive growth and identify problems needing attention.
   - Regularly reviewing relapse warning signs to catch them early.

8. Ask group members why recovery should be approached "one day at a time." How can a daily inventory help?

9. Ask members how medications can aid recovery from alcoholism or opioid addiction?

10. *Optional:* have members share some of their responses to Section 9 Building a Long-Term Recovery Plan" in the Relapse Prevention Workbook, pages 18-19.

Topic #12: Lifestyle Balancing

Objectives of Group Session

1. Review the importance of a balance lifestyle in preventing relapse and becoming more satisfied with life.
2. Identify areas of life to check for "balance."
3. Identify one area to rebalance and identify steps to take to achieve this balance.

Points or Issues for Discussion

1. Ask group members for their view of "lifestyle balance" as it relates to recovery and relapse prevention.
   - How do they define this?
   - What is lifestyle balance important in recovery?
   - What areas of life should be considered?

2. *Addiction Recovery* areas to consider:
   - Following a daily recovery program and "working" at recovery.
   - Keeping appointments with addiction counselors or doctors providing medications.
   - Participating actively in mutual support programs.
   - Keeping recovery a high priority in life.

3. *Physical Health* areas to consider:
   - Getting regular dental and physical examinations.
   - Complying with treatment for dental or medical problems.
   - Getting sufficient sleep and relaxation.
   - Following a reasonable diet.
   - Stopping the use of tobacco products (especially if addicted).
   - Taking medications for addiction, psychiatric or medical problems only as prescribed.

4. *Psychological Health* areas to consider:
   - Using active coping strategies to manage emotions or feelings.
   - Challenging addictive thinking or negative thoughts.
   - Coping with stresses and problems.
   - Dealing with conflicts rather than avoid them.

5. *Relationship or Interpersonal Health* areas to consider:
   - Having and using a support network.
   - Staying connected to family and loved ones; involving family in recovery.
   - Relating to sober people.
   - Knowing who to ask for help and support.
   - Knowing how to ask for help and support (learning how to reach out to others).

6. *Spiritual Health* areas to consider:
   - Relying on God or a Higher Power for strength.
   - Praying and meditating.
   - Participating in religious activities.
   - Participating in spiritual activities.
   - Having a sense of meaning or purpose in life.

7. *Recreational or Leisure* areas to consider:
   - Having enough substance-free leisure activities.
   - Getting enjoyment from these activities.
   - Feeling connected to others with whom to enjoy activities.

8. *Work or School* areas to consider:
   - Pursuing educational or occupational (career) goals.
   - Not being a workaholic at the expense of other areas of life.
   - Functioning at work (being on time, doing your job).

9. *Financial Health* areas to consider:
   - Taking care of financial obligations (self and family).
   - Living within your means.
   - Following a budget and managing money responsibly.
   - Saving or investing in your future (and your family).

10. Ask group members to identify one area of their lives that is out of balance. Get several to share the details.
    - What area is out of balance?
    - Why? For how long?
    - What steps can be taken to re-balance and change this area?

11. *Optional:* ask members to rate the degree to which each area is in our out of balance (1=way out of balanced; 5=mid range; 10=well balanced).
    - Addiction Recovery _____
    - Physical Health _____
    - Psychological Health _____
    - Relationships and Interpersonal Health _____
    - Spiritual Health _____
    - Recreation/Leisure _____
    - Work or School _____
    - Financial Health _____

12. *Optional:* have members share some of their answers to Section 10 "Lifestyle Balancing" of the Relapse Prevention Workbook, pages 20-21.

CHAPTER SEVEN

Problem Solving or Therapy Groups

Purpose of Groups

Therapy or problem solving groups provide clients an opportunity to discuss specific issues, concerns or problems that impact on their recovery and their lives.[1] Specific issues discussed may relate to any domain of life: physical, psychological, social, family, interpersonal, spiritual, or other. Therapy groups allow members to discuss issues in greater detail than structured recovery groups, which can lead to gaining personal insight and making decisions to change something specific. Any issue affecting recovery or relapse can be addressed in these groups.

Objectives of Groups

These groups are used in many structured residential and ambulatory treatment programs. Programs that offer substantial numbers of groups per week can incorporate therapy groups on a daily basis or several times per week. This provides ample opportunity for clients to explore issues affecting recovery and relapse.

The overall objectives of problem solving or therapy groups in addiction treatment are to:

1. Help clients learn to prioritize their problems, and to work together on these as a group.
2. Support clients dealing with difficulties faced in their recovery.
3. Encourage personal responsibility for ongoing recovery and relapse prevention.
4. Facilitate clients' self-disclosure of feelings and thoughts.
5. Help members learn to give and receive support from peers.
6. Help members identify and use positive coping strategies to address problems.
7. Help members learn relapse prevention coping strategies (behavioral and cognitive).
8. Assist clients in learning how to give and receive constructive feedback.

Group Format

Following is one way in which to structure and conduct these types of groups. This format can be changed depending on whether the group is held weekly or is one of many types of groups clients are participating in as part of a rehabilitation or intensive outpatient program.

1. When the group meeting starts, members introduce themselves, admit to their addiction and state their dates of last use (this includes use of any type of drug or alcohol). Members are encouraged to briefly discuss how they are doing, any cravings, temptations, or "close calls" they have experienced since the previous group meeting. If this is a daily therapy group in a rehab or intensive outpatient program, discussions can focus on current problems of clients.

2. If someone has used since the last session, the member can briefly process the event and develop a plan to prevent further relapse.

3. Members are encouraged to identify current problems in life or concerns about recovery that could impact on relapse. Since not all members will have a chance to discuss their individual problems, the group leader should help the members prioritize problems for discussion. Problems can be listed on a chalkboard or flip chart before deciding which ones to discuss in the group session.

4. In the final 10-15 minutes of a weekly therapy group, members are asked to state their plans for the next week in an effort to help them structure their time. In addition, they are encouraged to state their plans to attend mutual support meetings.

Problems Discussed in Problem Solving or Therapy Groups

Any of the recovery issues and problems discussed in structured recovery or RP groups may be explored in therapy or problem solving groups. The most common issues discussed are those related to staying free from alcohol or other drug use, relapses, relationships, managing emotions and making positive changes in self or lifestyle. Specific problems and issues discussed in groups include, but are not limited to the following:

1. *Motivational struggles* such as loss of, or lowered desire to stay substance free or make personal and lifestyle changes. Motivational problems often lead to poor adherence with attending treatment sessions, mutual support programs, or following the recovery plan. Poor adherence in turn often contributes to relapse.

2. *Strong desires, obsessions or craving to use substances.* These are common in the early months of recovery from addiction. Failure to pay attention to these can lead to a client becoming overwhelmed and giving in to the strong craving or obsession to use. Clients are taught to share their desires rather than keep them private as this gives them greater control over what they can do to manage these cravings or desires for substances.

3. *Lapses or relapses to alcohol or other drug use*. Group members vary widely in their experiences with lapses or relapses. Some have none, others have one, and others have multiple relapses during the course of treatment. The focus is on trying to get the group member to develop a desire to initiate and maintain abstinence by following a recovery plan. If a group member is unable to stabilize from a lapse or relapse, the group leader should consider other types of treatment at a higher level of care (e.g., move from an IOP to a residential; move from outpatient to IOP; go to a detoxification program if physical addiction occurs and the client cannot safely stop using substances or has a history of complications such as seizures related to withdrawing from drugs like alcohol.

4. *Giving up the main substance of use but continuing to use other substances.* Although total abstinence is the main goal of treatment, some group members will not accept this and may continue to use substances other than their primary drug of choice. The use of these substances increases the risk of relapse to the primary drug of choice. Opioid and cocaine addicted clients often use alcohol or marijuana. Some opioid- addicted clients use and misuse prescription medications, especially pain and anti-anxiety medicines.

5. *Problems in mutual support program participation.* Members vary in their use of programs such as AA, NA, CA, CMA, other 12-Step programs or other mutual support programs. While attendance is highly encouraged, some clients refuse to attend, attend only occasionally, or participate minimally. They do not get a sponsor, work the steps or attend social functions sponsored by NA, CA or AA. Some members discuss concrete problems such as conflicts with a sponsor or other members or being offered substances by a member of a mutual support program.

6. *Boredom with recovery and the feeling that life is not much better despite being off of alcohol or drugs.* Many individuals with an addiction like excitement, action and "living on the edge." Recovery can be a major adjustment for them. Recovery often is much less exciting the feelings produced by certain drugs, wheeling and dealing on the streets, getting over on other people and partying. Some members also experience boredom with relationships, their job or other aspects of life, which is a different type of boredom requiring careful consideration before major decisions are made.

7. *Managing emotions such as anger, anxiety, depression or guilt and shame***.** Inability to use active coping strategies to manage emotions is a major factor in many relapses to alcohol or drug use following a period of recovery. Group members often benefit from learning emotional management skills such as being able to identify and recognize feelings, accept them, and learn to live with them without using substances. In some instances, an emotional state (e.g., anxiety or depression) can be part of a psychiatric disorder that may require treatment.

8. *Relationships problems or conflicts with family members, friends or colleagues at work.* Interpersonal problems run the gamut from mildly problematic to severe ones that pose a major threat to recovery or well being. Specific problems or issues often discussed include conflicts or disputes with others, anger or disappointment at others, emotional or

physical violence, or inappropriate sexual interactions (e.g., unprotected sex, sex with a stranger, sexual promiscuity). Involvement in relationships that are non-supportive or characterized by lack of reciprocity, difficulty saying no or setting limits with others, and difficulty asking others for help or support are other problems that may be explored in group sessions.

9. *Relationships within the group.* Group members may have strong feelings towards each other that impact on their participation in a therapy group and their recovery. It is not unusual for group members to exhibit problems in interpersonal style in a therapy group, especially one that occurs over a long period of time and members get to know each other. These dynamics show in numerous ways. A few example include a group member: criticizing another group member, not responding to a member's emotional pain, showing anger towards a member, avoiding eye contact or direct conversation with a group member,

10. *Psychiatric disorders or other types of addictions.* In some instances, group members will have co-morbid psychiatric disorders or other compulsive disorders that contribute to difficulty with emotional states, interfere with recovery, cause personal distress, or contribute to suicidal feelings. Some members may also have other addictions or excessive behaviors such as compulsive gambling, sex, spending or work. While the group is not intended as a therapy group for mental health disorders unless part of a co-occurring disorders program, these problems may be discussed in the context of recovery from addiction. The group leader should encourage members with psychiatric disorders to get an appropriate evaluation to determine if psychiatric treatment is needed in addition to addiction treatment. The leader can also offer to help facilitate this evaluation if needed.

11. *Other psychosocial problems discussed include those related to:* school, work, housing, finances, the legal system, or how to structure leisure time. Engaging in substance-free activities is an issue frequently discussed in these groups.

Problems Encountered in the Group Process

In addition to specific problems related to recovery or the lives of the group members, problems are also commonly encountered in the group process. These problems require the Group Counselor to intervene to make sure the group addresses them. Following is a discussion of some of the more common group process problems and some suggested strategies for the Group Counselor:

1. *A group member dominates the discussion or always brings the discussion back to his own problems or issues.* The Group Counselor can thank the member for the contributions and then elicit opinions and experiences from other group members. If the group member persistently tries to dominate group discussions or turns the discussion back to his own problems or issues, this behavior pattern can be pointed out by the Group Counselor to make this member and other group members aware of the behavior. The

other members can be asked how they feel about the member's dominating the discussion, and how they want to deal with this in a way that is satisfying to everyone in the group. Even though this creates a problem on one level, on another level some group members find that it creates a safety net for them because they may believe they do not have to self-disclose personal problems or feelings as long as another member is taking up the group time.

2. *A group member does not disclose any problem or open up in the group session.* The Group Counselor can share his observations about the member's behavior, generalize the issues by group members to talk about any difficulties that contribute to problems in self-disclosing (e.g., shame, shyness, social anxiety). Discussion can then focus on ways this member (or other group members who have trouble self-disclosing) can gradually learn to trust the group and self-disclose personal thoughts, feelings, problems or concerns.

3. *A member rejects the input, advice or feedback of other group members.* The Group Counselor can point out this pattern and engage the group in a discussion of why this pattern is occurring. Members' who offer help and support only to have their attempts rejected can be asked to talk about what this feels like so that the member rejecting their help is aware of the impact of this behavior pattern on others.

4. *A member only pays attention when the discussion focuses on his problems or who interrupts others when they talk.* The Group Counselor can point out his observations of the group member and discuss the reasons for this behavior. The group can then engage in a discussion of the effects of this behavior (e.g., upsets other members, turns them off, makes them feel like their problems aren't important) and the importance of "giving and receiving" mutual support by listening to each other's concerns and problems.

5. *A member who wants easy answers to problems or is quick to provide easy solutions to others when they discuss personal problems.* The Group Counselor can share his observations of this behavior and ask the group to discuss the importance of taking responsibility to find solutions to their problems, and to identify more than one strategy to address a particular problem. The leader can emphasize that while there are different alternative ways to resolve specific problems, seldom are their easy or simple solutions, and that time, patience and persistence are needed for group members to resolve problems. When a group member provides an easy solution, the Group Counselor can acknowledge this is one strategy that may help some people, but it is also helpful to have other strategies. The Counselor can then engage the group in a discussion of other strategies to address the problem under discussion. Finally, the Group Counselor can emphasize to the group that learning how to think about problem solving is just as important as dealing with specific problems since everyone in the group will continue to face multiple problems in their ongoing recovery.

6. *A member tries to use the Group Counselor for individual therapy during the group session.* The Group Counselor can ask other group members to comment on the problems or issues presented by this member to engage the group in the discussion. Group members can also be asked how they relate to the problem or issue presented on a

personal level. If the group member asks the Counselor how to handle a specific problem, he can encourage the member to directly ask peers in the group their ideas on dealing with this problem. This helps members learn to use group support.

7. *Members who arrive late for the group session or want to leave during discussions.* The leader and group should decide on a rule regarding lateness to group. Sometimes, there are legitimate reasons for being late (e.g., the bus a member takes was running 15 minutes late, the member got a flat tire, etc.). Members may be given a break once or twice for being late. Or, the group may establish a rule in which the member cannot join the group after a certain amount of time (e.g., more than 5-10 minutes after the start of the group). If time limits are not set, the Group Counselor can predict that some members will often be late as long as this behavior is tolerated. Members who are persistently late can be asked to discuss this pattern of behavior, how it shows in other areas of life, and what they think needs to be done to change this pattern. Group members should never leave the session unless some emergency occurs (e.g., they have a minor illness and need to use the restroom). Routinely allowing people to walk in and out disrupts the flow of the conversation and gives the message that what members say is not important because people can leave at any time. Members may want to leave group due to boredom, feeling like the discussions do not relate to them, or as a way to avoid personally discussing problems or feelings

8. *The group talks in generalities and avoids exploring specific problems in depth.* The Group Counselor can point out this dynamic to the group and ask them to discuss why they aren't talking about specific problems or concerns in recovery. Members can then be asked to set the agenda in a concrete way so that specific problems or concerns are identified for discussion in group. It isn't uncommon for group members to view Counseling Groups no different as free floating discussions held in some NA or AA meetings. However, group therapy sessions are designed to explore and solve problems and not simply be a repetition of 12 Step recovery meetings.

9. *The group avoids confronting a member who behaves inappropriately***.** The Group Counselor can point out this dynamic and ask the group what they think about the inappropriate behavior, and what led to their avoiding it.

Other problems may occur during the group time, but these are some of the ones that we've seen over the past several years reviewing hundreds of group sessions. We wish to stress again that while the "content" (i.e., problems and issues discussed) of the group is important, if the "process" bogs down, not much will get accomplished. In addition, some group members may miss sessions or drop out as a result of process problems that aren't addressed. Unfortunately, group members may avoid these issues directly so the Group Counselor won't always know the reasons for a member's poor attendance or early drop out from group. In our experience, it is not uncommon for members to be upset over process issues. A "preventive" strategy is to periodically engage the group in a discussion of the group process. The Group Counselor can ask what they think about the group sessions, what they like and dislike about how the group has been going, and what they would like to see different in the group.

Appendices

1. Endnotes
2. References and Suggested Readings
3. Recovery Workbooks and Journals
4. Web Sites

Appendix 1:
Endnotes

Chapter 1: Addiction, Treatment and Recovery

1. Regier.
2. Daley & Marlatt (2006a); Kleber & Galanter; Lowinson et al; Ries et al.
3. Diagnostic criteria for all substance use disorders can be found in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.
4. See also Ries et al for the American Society on Addiction Medicine's dimensions of functioning used to assess substance problems.
5. Cloninger; Kleber & Galanter; Lowinson et al; Ries et al; Volkow & Fowler.
6. Condon et al; Dennis & Scott; McLellan, Lewis & O'Brien;
7. Daley & Moss; Daley & Thase; Kessler et al; Mueser et al; Regier.
8. CSAT (2000a); Daley & Miller.
9. Adverse effects of alcohol and drug problems are documented in many publications. For example, see:
    a. Major textbooks on addiction (e.g., Galanter & Kleber; Lowinson et al; and Ries et al).
    b. Clinical books for professionals (e.g., Daley & Marlatt 2006a: Mueser et al).
    c. Publications by the U.S. Government (e.g., CSAT, NIAAA, NIDA and SAMHSA references).
10. Daley & Moss; Kessler et al; Mueser et al; Regier.
11. Daley & Douaihy (2010a); Daley & Miller; Kelly & Falls-Stewart; Moss et al; Nunes et al; Tartar et al.
12. Behavioral treatments and interventions for substance use disorders are described in the major textbooks of addiction, clinical manuals, and publications of NIAAA, NIDA & SAMHSA. See the following for more information:
    a. Galanter & Kleber, Parts 4 & 5, pp. 333-489
    b. Lowinson et al, Part VI, pp. 579-803.
    c. Ries et al, Section 8, pp. 743-908.
    d. Beck, Wright & Liese; Daley & Marlatt (2006a); Scott & Dennis; Scott et al; Fals-Stewart et al; Miller & Rollnick; Monti et al; Nowiski & Baker; O'Farrell & Fals-Stewart; Project MATCH; Rawson et al.

e. NIAAA, NIDA and SAMHSA manuals, NREPP webpage, and NIDA (2008) "Science of Addiction" Dissemination kit.

f. The SAMHSA National Registry on Evidenced-Based Programs and Practices (NREPP) describes a large number of interventions and includes numerous references based on clinical trials.

13. Medication-assisted treatments for substance use disorders are described in the major textbooks of addiction, clinical manuals, and publications of NIAAA, NIDA & SAMHSA. See the following for more information:

    a. Galanter & Kleber, Part 3, pp. 111-329.

    b. Lowinson et al, Section III, pp. 121-467 & Section VI, pp. 615-652.

    c. Ries et al, Section 7, pp. 629-642.

    d. Bouza et al; Carroll et al; Cornelius et al; Mann, Lehert & Morgan; NIAAA (2000); Rychtarik et al; Salloum et al; and Vocci, Acri & Elkashet.

    e. CSAT (Treatment Improvement Protocol, TIP manuals #40, 42 & 45); NIDA, 2008 and 2010.

14. When medications are used to treat addiction they are usually combined with behavioral treatments such as Motivational Incentives or addiction counseling or therapy (e.g., Cognitive Behavioral Therapy, Individual Drug Counseling, Group Drug Counseling, Relapse Prevention Therapy, etc).

15. For a review of outcome measures for treatment of alcohol and drug problems, see APPI (2008). See also McLellan, Kleber & O'Brien for a comparison of outcomes among drug abusers compared to outcomes of patients with three major medical disorders.

16. Many books and papers describe recovery from alcohol and drug problems and recovery management. See the following:

    a. CSAT (2006).

    b. Daley & Douaihy (2010b).

    c. Daley & Marlatt (2006a,b).

    d. Dennis & Scott.

    e. Dennis, Scott & Funk.

    f. Hser.

    g. Laudet.

    h. McLellan et al.

    i. Morgen & White.

    j. Nowiski & Baker.

    k. Scott, Foss & Dennis.

    l. White, Kurtz & Sanders.

17. Marlatt & Donovan; Marlatt & Gordon.
18. The various psychosocial treatment models aim to help clients learn cognitive and behavioral recovery skills to manage their addiction over time. See the following:
    a. Baer et al.
    b. Daley & Marlatt (2006a & b).
    c. Litt et al.
    d. Moser & Annis.
    e. NIAAA and NIDA treatment manuals.
19. Daley & Marlatt (2006a).

Chapter 2: Relapse in Addiction

1. McLellan, Kleber & O'Brien; Marlatt & Gordon; Daley (1988).
2. Marlatt & Donovan.
3. Daley (1989 & 2009); Gorski & Miller; CSAT (2006); Zywia et al.
4. There are many excellent reviews of relapse factors or precipitants. See the following:
    a. Catalano et al.
    b. Daley (1989, 1989 & 2009); Daley, Marlatt & Spotts; Daley, Douaihy & Marlatt.
    c. Gorski & Miller.
    d. Dobkin et al.
    e. Gossop et al.
    f. Ito, Donovan & Hall.
    g. Lancaster et al.
    h. Lowman, Allen & Stout.
    i. Maisto, McKay & O'Farrell.
    j. Marlatt (1985, 1985a&b; 1986).
    k. McCrady, Epstein & Kahler.
    l. McKay; Miller et al.
    m. NIDA (1993 &1994).
    n. Noone, Dua & Markham.
    o. SAMHSA (2005).
    p. Sandahl.
    q. Scott, Foss & Dennis.
    r. Zackon.

Chapter 3: Relapse Prevention

1. Daley & Ross; Daley & Douaihy (2010b); Maisto, McKay & O'Farrell; Marlatt & Donovan; and O'Farrell & Fals-Stewart.
2. See endnotes 11, 12, 13 from Chapter 1 for listing of authors of books and treatment manuals on evidenced-based treatments or practices for addiction.
3. NIAAA (1995b).
4. NIAAA (1995c); Nowinski & Baker.
5. NIDA (1999).
6. NIDA (2000).
7. Maisto, McKay & O'Farrell; O'Farrell & Fals-Stewart.
8. Rawson et al.
9. Annis; Bowen, Chawla & Marlatt; Daley (1988 & 1989); Gorski & Miller; Marlatt & Donovan; Marlatt & Gordon; NIDA (1994).
10. NIDA (1994).
11. Marlatt's model of RP is described in many books, chapters and papers. See Daley (1988 & 1989); Marlatt & Donovan; Marlatt & Gordon; Witkiewitz & Marlatt. Also, his model was integrated with mindfulness techniques in a Mindfulness-based Relapse Prevention (MBRP) program used in aftercare. See Bowen, Chawla and Marlatt for a description of this aftercare group treatment MBRP model.
12. Daley (1989); Daley (2011).
13. Carroll; Carroll, Rounsaville & Ball; Carroll, Rounsaville & Gawin; Carroll et al (1994a)
14. Irvin et al.
15. McKay et al; NIDA (1994); Schmidtz et al.
16. Maisto, McKay & O'Farrell; O'Farrell; O'Farrell & Fals-Stewart (2006a & b); O'Farrell, Choquette & Cutter; Winters et al.
17. Carroll et al (1994b); Goldstein et al; Rawson et al.
18. Annis; Saunders & Allsop; Chaney & O'Leary; Koski-James.
19. See endnotes 12 and 13 from Chapter 1. See also Kranzler et al; and O'Malley et al.
20. SAMHSA (2008).

Chapter 4: Counseling Strategies to Reduce Relapse Risk

1. Annis; Bowen, Chawla & Marlatt; Daley (1988 & 1989); Gorski & Miller; Marlatt & Donovan; Marlatt & Gordon; NIDA (1994).
2. Daley & Zuckoff (1998 & 1999); Kemp et al; NIDA (1997 & 2009).

3. Many studies show incentives improve treatment adherence as well as reduce substance use. See JSAT (2010); NIDA (2008 & 2009); Stitzer et al.
4. Daley & Zuckoff (1998); Swanson, Pantalon & Cohen; Zuckoff & Daley.
5. Mann, Lehert & Morgan; NIAAA (2004); O'Malley et al. See also the major textbooks on addiction for chapters on medications used with alcoholic clients (Galanter & Kleber; Lowinson et al; and Ries et al).
6. Garbutt et al.
7. O'Malley et al.
8. A review of medications used for opioid addiction and other substance addictions can be found in Galanter & Kleber, Part 3, pp. 111-329; Lowinson et al, Section III, pp. 121-467 & Section VI, pp. 615-652; and Ries et al, Section 7, pp. 629-642.
9. Galanter & Kleber (see chapter 11); Lowinson et al (see Chapter 13); and Ries et al (see Chapter 5).
10. Galanter & Kleber (see chapter 15); Lowinson et al (see Chapter 23); and Ries et al (see Chapter 52).
11. Kranzler et al; Gottleib et al.
12. Cornelius et al
13. Salloum et al.
14. Many books on recovery published by mutual support programs such as AA or NA (e.g., "Big Book" of AA; "Basic Text" of NA), or written by professionals review specific recovery skills that help the addicted client stay sober, change and address relapse risk issues (e.g., cravings, addictive thinking, motivation, upsetting emotions, social pressures to use, relapse warning signs). See Daley & Marlatt (1996a&b). See also appendix C for interactive materials that promote recovery from the various addictions and co-occurring disorders.
15. Volkow & Fowler.
16. Marlatt (1985b); Daley (2009); Daley & Douaihy (2011).
17. Marlatt (1985a); Daley (2009); Beck; Burns.
18. Daley & Douaihy (2010b); Daley (2011).
19. Liberman; Belleck et al.
20. Daley & Douaihy (2005); Daley (2004 & 2006); Zackon.
21. Daley (1996); Daley & Douaihy (2010c).
22. Monti et al.
23. McCrady, Epstein & Kahler.
24. O'Farrell, Choquette & Cutter; O'Farrell & Fals-Stewart.
25. Maisto, McKay & O'Farrell.
26. Daley, Donovan & Douaihy (2010).

27. Daley & Douaihy (2010a); Daley & Miller.
28. All of the RP models of treatment stress the importance of helping clients learn to identify and manage high-risk factors. Most fall into one of several major categories: negative emotional states; social pressures; cravings; and interpersonal conflicts. See Annis; Daley (1988, 1989, 2009); Gorski & Miller; Marlatt & Donovan; Marlatt & Gordon; and NIDA (1994).
29. SAMHSA (2008).
30. The RP models promote relapse as a process in which warning signs, red flags or clues occur BEFORE the client uses substances. The concepts of "apparently-irrelevant decisions" or "seemingly irrelevant decisions" describe how the process of relapse may unfold for some individuals.
31. Marlatt & Donovan; Marlatt & Gordon; Daley (2009).
32. Marlatt & Donovan; Marlatt & Gordon.
33. Bowen, Chawla & Marlatt; Linehan; DiMeff & Koerner; Orsillu & Roemer; Roemer &Orsillu; Segal, Williams, & Teasdane.

Chapter 5: Counseling Aids for Relapse Prevention

1. NIDA (1994).
2. Daley (2011[b]).
3. Beck; Burns.
4. Beck, Wright & Leise.
5. Marlatt & Gordon.
6. Daley (2011[b]).
7. See Appendix C for interactive recovery materials for clients aimed at facilitating recovery and reducing relapse risk.
8. Daley (2005).
9. Daley (2006).

Chapter 6: Relapse Prevention Groups

1. Daley (1988, 1989, 2011[b]); NIDA (2002); SAMHSA (2005 & 2007)

Chapter 7: Problem Solving or Therapy Groups

1. Daley (201[b]); NIDA (2002).

Appendix 2:
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Appendix 3:
Recovery Materials for Clients and Families

The authors have written many books and interactive recovery materials for clients with substance use, psychiatric and co-occurring disorders. These materials address relapse issues and provide strategies to help the reader reduce relapse risk. Materials are informative, practical, hopeful, user-friendly and affordable. Surveys from over 300 clients show high rates of satisfaction with information and coping strategies learned to aid recovery from using these materials.

Dr. Daley was the first in the country to develop interactive recovery materials for co-occurring disorders, and one of the first to develop similar materials for recovery from addiction. His "Relapse Prevention Workbook" has been used in numerous treatment programs throughout the U.S., Canada and Europe for many years.

For more information about these materials for clients or families, or books and treatment manuals for professionals go to: www.drdenniscdaley.com.

1. **A Family Guide to Addiction and Recovery: Coping Strategies for Family Members.** This provides the family with an overview of addiction, treatment, recovery and relapse. It provides coping strategies for families to help them deal with an addicted member and their reactions to this person.

2. **Addiction and Mood Disorders: A Guide for Clients and Families**. This book provides a thorough overview of depression and bipolar illness combined with substance use disorders. Extensive information is provided on treatment, recovery and relapse prevention.

3. **Adolescent Recovery: For Alcohol and Drug Abuse or Addiction.** This workbook provides an overview of substance use disorders and recovery for adolescent. It is geared towards early recovery.

4. **Adolescent Relapse Prevention: A Guide to Staying Off Alcohol and Drugs.** This workbook reviews the relapse process and high risk situations contributing to relapse. It helps the adolescent address common relapse issues and develop a relapse prevention plan.

5. **Anxiety Disorders Recovery: Strategies to Manage Symptoms and Change.** This recovery workbook provides an overview of anxiety disorders, treatment, recovery and relapse prevention, and dealing with setbacks.

6. **Coping with Feelings Workbook: For Adults in Recovery from Addiction.** Inability to manage emotions is the most common factor contributing to relapse. This focuses mainly on the emotional aspect of recovery by helping the reader understand and cope with feelings.

7. **Depression Recovery: Strategies for Mood Management and Personal Change.** This recovery workbook provides an overview of depression, treatment, recovery and relapse prevention.
8. **Detox Recovery: Getting Sober and Developing a Sobriety Plan.** This workbook provides an overview of medical detoxification for the addicted person. It focuses on the need to engage in a long-term recovery process to manage the addiction over time to reduce relapse risk.

9. **Dual Diagnosis Workbook: Recovery Strategies for Substance Use and Mental Health Disorders, 4th ed.** This comprehensive recovery provides an overview of co-occurring disorder, treatment, recovery and relapse prevention, and dealing with emergencies or setbacks. A companion manual for clinicians is available that provides a structured curriculum for conducting recovery groups ("Dual Disorders Recovery Counseling").

10. **Improving Communication and Relationships: An Adults-in-Recovery Workbook.** This workbook focuses entirely on the interpersonal and social domains of recovery from addiction. It reviews strategies to improve communications and relationships, and develop a relapse prevention network.

11. **Managing Anger: For Recovery from Mental Health or Substance Use Disorders.** Inability to manage anger is a potential relapse risk factor for many individuals in recovery. This workbook reviews causes and effects of anger, and 25 cognitive, verbal and behavioral anger management strategies.

12. **Managing Emotions: Recovery from Mental Health or Substance Use Disorders.** Inability to manage emotions is the most common relapse precipitant according to many studies. This recovery workbook provides a framework for understanding and managing emotions, regardless of Axis 1 or Axis 2 diagnoses. By learning strategies to manage emotions, the reader can reduce the risk of relapse to addiction.

13. **Opioid Addiction Recovery.** This workbook reviews opioid addiction, treatment and the many challenges of recovery. It includes a section on relapse prevention to help the reader understand the relapse process, high risk factors and strategies to reduce relapse risk or catch a lapse or relapse early and take steps to get back on track.

14. **Recovery from Alcohol Problems: Strategies for Sober Living.** This workbook reviews alcohol dependence, treatment and the many challenges of recovery. It includes a section on relapse prevention to help the reader understand the relapse process, high risk factors and strategies to reduce relapse risk or intervene if a lapse or relapse occurs.

15. **Recovery from Cocaine or Meth Addiction: Strategies for Drug-Free Living.** This workbook reviews addiction to cocaine or meth (or other stimulants), treatment and the many challenges of recovery. It includes a section on relapse prevention to help the reader understand the relapse process, high risk factors and strategies to reduce relapse risk to manage episodes of substance use.

16. **Recovery from Psychiatric Illness.** This workbook provides an overview of psychiatric disorders, treatment and recovery. It can be used with any type of psychiatric illness, and includes a section on relapse prevention.
17. **Recovery and Relapse Prevention for Co-Occurring Disorders.** This workbook addresses strategies to manage recovery from any combination of co-occurring disorders. Significant focus is on learning to identify and manage warning signs of relapse and high risk factors. It also addresses the need to intervene early should their be a recurrence of psychiatric illness or a return to substance use.

18. **Relapse Prevention: for Recovering Alcoholics & Drug Dependent Person.** This highly popular workbook provides an overview of the relapse process, high risk factors, lifestyle balancing, and taking action quickly to stop a lapse or relapse. This can be used with any type of substance addiction in all types of treatment programs. It is also available in Spanish. Adapted versions are available for adolescents with substance problems, individuals with compulsive sexual behaviors or those addicted to tobacco.

19. **Relapse Prevention Workbook: For Sexually Compulsive Behaviors.** This is an adaptation of the RPW for alcohol and drug addiction to sexual compulsivity. It helps the reader understand the relapse process, high risk factors and how to manage the many challenges of recovery that impact on relapse.

20. **Sober Relationships and Support Systems in Recovery: For Substance Use or Co-occurring Disorders.** This workbook reviews the impact of disorders on family and social relationships. It addresses the need for ongoing support to reduce the risk of relapse.

21. **Sobriety Journal: Your Plan for Recovery in Year 01.** This journal helps the reader regularly review recovery in order to assess problems, difficulties or progress on a regular basis. It provides strategies to cope with the common challenges of recovery that can impact on relapse. It is compatible with the strategy used in mutual support programs to take a daily inventory as part of ongoing recovery.

22. **Using 12-Step Programs in Recovery.** Research shows that active involvement in mutual support programs improves recovery. This workbook provides an overview of the main elements of 12-Step programs of AA, NA and others. Active involvement in these programs enhances recovery and reduces relapse risk.

23. **When Symptoms Return: A Guide to Relapse Prevention in Psychiatric Illness.** This guide focuses on recovery and relapse as they relate to any type of psychiatric illness. It helps the reader understand how to identify and manage warning signs, high risk factors and setbacks.

Appendix 4:
Web Sites

Al-Anon Family Groups	www.alanon.alateen.org
Alcoholics Anonymous	www.alcoholics-anonymous.org
American Psychological Association	www.apa.org
American Psychiatric Association	www.psych.org
Dennis C. Daley	www.drdenniscdaley.com
Dual Recovery Anonymous (DRA)	www.draonline.org
Guilford Publications, Inc.	www.guilford.com
Hazelden Educational Materials	www.hazelden.org
Herald House, Independence Press	www.heraldhouse.org/
Nar-Anon Family Groups	www.naranon.org
Narcotics Anonymous	www.na.org
National Alliance for the Mentally Ill	www.nami.org
National Clearinghouse for Alcohol & Drug Information	www.higherdcenter.org/resources/national-clearinghouse-alcohol-and-drug-information-ncadi
National Institute of Mental Health	www.nimh.nih.gov
National Institute on Alcohol Abuse and Alcoholism	www.niaaa.nih.gov
National Institute on Drug Abuse	www.nida.nih.gov
National Mental Health Association	www.nmha.org
Substance Abuse and Mental Health Services	www.samhsa.gov
U.S. Journal & Health Communications	www.hci-online.com

American Psychological Association: www.apa.org

The APA publishes many clinical and empirically-based books for clinicians, which cover a range of psychological disorders. Books are also available on topics such as spirituality, forgiveness and healing as well as treatment of a range of substance use, psychiatric and co-occurring disorders. APA, 750 First Street S.E., Washington, D.C., 20002.

American Psychiatric Association: www.psych.org

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR)*, practice guidelines, a book on outcome measures, and many books with the most recent evidenced-based practices for psychiatric and substance use disorders. APA, 1400 K. Street N.W., Washington, D.C., 20005.

Dennis C. Daley: www.drdenniscdaley.com

This webpage of the author of this book includes descriptions of materials written for clinicians, clients and families on many topics related to substance use disorders, psychiatric illness, and co-occurring disorders. Dr. Daley was one of the first in the U.S. to write brief,

interactive workbooks for recovery from addiction, and the first to write workbooks for recovery from co-occurring disorders. He and his colleagues wrote the first book for counselors on working with clients with substance use disorders and psychiatric illness. Several of his writings have been translated to foreign languages. Daley Publications, PO Box 161, Murrysville, PA 15668, (724) 727-3640.

Hazelden Educational Materials: www.hazelden.org

Hazelden is one of the largest publisher of recovery oriented literature for SUDs in the U.S. It also has books and treatment manuals for clinicians. Hazelden, Pleasant Valley Road, PO Box 176, Center City, MN: 55012, (800) 328-9000.

National Institute on Alcohol Abuse and Alcoholism (NIAAA): www.nih.niaaa.gov.

NIAAA has many excellent resources for medical and health professionals, researchers, clients, families and anyone interested in alcohol problems. Some examples of publications for professionals include: Alcohol Alert; Alcohol Research and Health; The 10th Annual Report to Congress on Alcohol and Health; Helping Patients Who Drink Too Much: A Clinician's Guide; many treatment manuals (e.g., manuals for clinicians from project MATCH and COMBINE); a "Graphics Gallery" with pictures used in NIAAA presentations (e.g., pictures of different systems of the body; and pictures related to Fetal Alcohol Syndrome).

Some examples of publications for people with alcohol problems, families or others interested in alcohol problems include: "Drinking and Your Pregnancy; Tips For Cutting Down on Your Dirnking; A Family History of Alcoholism: Are You At Risk? and Frequently Asked Questions" (alcohol problems).

National Institute on Drug Abuse (NIDA): www.nih.nida.gov.

NIDA has many resources, including an extensive portfolio of publications, for medical and health professionals, researchers, clients, families, students and young adults, parents and teachers, and anyone interested in alcohol problems. Some examples include facts and information handouts for all drugs of abuse, treatment manuals for clinicians, brief updates on research, clinical resources on evidenced-based treatments (see "Science of Addiction"), an extensive list of publications (including some materials en Espanol) and news articles.

NIDA offers free subscriptions by mail or e-copy to "Addiction Science & Clinical Practice", a peer-reviewed journal for drug abuse researchers and treatment providers, and "NIDA Notes," a brief, 16-page summary of current research sponsored by NIDA.

This webpage has a link to resources on treatment and prevention for medical and health professionals "NIDAMED." This provides extensive information to caregivers and information that can be used with patients who have drug abuse. NIDAMED also includes a drug use screening tool (NM ASSIST), information for referrals for treatment and a link to NIDA's Clinical Trials Network (CTN). The CTN is a national network of medical centers and community treatment programs where research is conducted across a variety of settings with diverse clinical populations. The CTN link provides information on all participants in the CTN and a list of all the specific studies funded. Finally, NIDAMED provides links to

other websites of interest to professionals. For example, the "MEDLINEplus Health Information on Substance Abuse" from the National Library of Medicine at NIH provides access to information to professionals and patients on a range of topics related to substance use, substance use disorders and co-occurring disorders.

Substance Abuse & Mental Health Services Administration (SAMHSA): www.samhsa.gov

SAMHSA has many publications on prevention and treatment of substance use, psychiatric and co-occurring disorders. Similar to the NIAAA and NIDA webpages, this website provides extensive information for medical and health care professionals, researchers, clients, families and anyone interested in substance use and mental health issues. Examples include sections for "Military Families," "Recovery Supports" that promote health and resilience, and a "Data, Outcomes & Quality" section that provides information about the "National Survey on Drug Abuse and Health."

A "**Find Help**" section on the right side of the SAMHSA home page provides information for help on suicide prevention (1-800-273-8255) and a link for "Treatment Locators" so you can find locations for services for substance abuse or mental health problems. A 24-hour helpline is available to aid in locating help with any of these problems (1-800-662-4357).

This webpage provides access to numerous resources for clinicians including the NREPP (National Registry of Evidenced Based Programs and Practices. In addition, 1) CSAT's Treatment Improvement Protocol (TIP) Series of manuals on numerous specific topics related to addiction or co-occurring disorders (e.g., adolescent treatment, older adult treatment, detoxification, group therapy, family treatment, medication treatments, etc); these are consensus-based guidelines developed by clinical, research and administrative experts in the field. 2) CSAT's Knowledge Application Program (KAP) gives knowledge about best treatment practices wings by putting it in the hands of providers who help individuals seeking substance abuse treatment. 3) Quick Guides for Clinicians based on the TIP Series. 4) Quick Guides for Administrators based on the TIP Series.

Materials for Clients, Families and Professionals on Substance Use, Psychiatric or Co-occurring Disorders

Client and Family Materials

A Family Guide to Coping with Dual Disorders

Addiction and Mood Disorders

Addiction in Your Family

Adolescent Recovery

Adolescent Relapse Prevention

Anxiety Disorders Recovery

A Family Guide to Addiction and Recovery

Athlete's Guide to Substance Use and Abuse

Co-occurring Disorders Recovery

Coping with Feelings

Depression Recovery

Detox Recovery

Family Recovery

Gratitude Workbook

Grief Journal

Group Counseling Participant Workbook

Improving Communications and Relationships

Managing Anger

Managing Emotions

Managing Your Alcohol and Drug Problem

Money & Recovery

Overcoming Negative Thinking

Recovery from Alcohol Problems

Recovery from Cocaine or Meth Addiction

Recovery from Opioid Addiction

Recovery from Co-Occurring Disorders

Recovery from Psychiatric Illness

Recovery & Relapse Prevention for Co-occurring Disorders

Relapse Prevention (Drug & Alcohol)

Relapse Prevention (Compulsive Sex)

Sober Relationships and Support Systems

Sobriety Journal

Surviving Addiction

Using 12-Step Programs in Recovery

Working Through Denial

Books for Professionals

A Counselor's Manual for Chronic Mental Illness and Substance Abuse

Dual Disorders Recovery Counseling: Integrated Treatment for Substance Use and Mental Health Disorders

Dual Disorders: Counseling Clients with Chemical Dependency & Mental Illness

Group Treatment of Addiction: Counseling Strategies for Recovery and Therapy Groups

Improving Treatment Compliance

Overcoming Your Alcohol or Drug Problem

Relapse Prevention Counseling: Strategies to Aid Recovery from Addiction and Reduce Relapse Risk

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Appendix A: Relapse Prevention Counseling

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE QUESTIONS AND/OR ANSWERS MAY BE IN A DIFFERENT ORDER ON THE ONLINE EXAM.

Answer the following questions by selecting the most appropriate response.

1. Addiction is a multifaceted illness involving all of the following except _____ factors.
a) psychological
b) social
c) financial
d) physiological
e) cultural

2. The co-existence of serious medical or psychiatric disorders also helps to determine the effects of addiction.
a) True
b) False

3. Recovery is a rapid process of change through which an individual achieves abstinence and improves health, wellness and quality of life.
a) True
b) False

4. The client in relapse usually shows signs of changes in _____.
a) thoughts
b) emotions
c) attitudes
d) behaviors
e) all of the above

5. A(n) _____ relapse can actually help a person's recovery.
a) fatal
b) partial
c) emotional
d) therapeutic
e) physical

6. Most relapse prevention (RP) models incorporate principles or clinical strategies from _____ original conceptualization of relapse.
a) Mercer's
b) Marlatt's
c) Carpenter's
d) Daley's
e) Woody's

7. With regard to the Addict Aftercare Model, all of the group sessions fall into one of four categories, with the exception of _____.
a) being clean
b) work and growth
c) cognitive behavior
d) highs and lows
e) social relations

8. The three cognitive factors that interact in the relapse process are _____.
a) outcome expectancies
b) self-efficacy
c) attribution of causality
d) all of the above
e) none of the above

9. Clients with _____ levels of psychiatric and addiction severity appear to benefit most from relapse prevention.
a) lower
b) constant
c) fluctuating
d) undetectable
e) higher

10. Instead of lengthy follow-up periods to study relapse following a period of treatment, clinicians would prefer short-term studies to determine the efficacy of relapse prevention.
a) True
b) False

11. Studies show that _____ treatment results in better outcome and lower relapse rates.
a) one-on-one
b) group
c) electronic
d) team
e) client adherence to

12. Disulfiram is a medication used in the treatment of _____ addiction.
a) opioid
b) marijuana
c) alcohol
d) stimulant
e) nicotine

13. _____ includes changing thoughts about cravings.
a) Cognitive intervention
b) Taking medication
c) Behavioral intervention
d) Recovery
e) Relapse

14. A client may be kept more vigilant about recovery by _____.
a) having cognitive distortions
b) making irrelevant decisions
c) socializing with an active abuser
d) keeping a daily inventory
e) ignoring environmental cues

15. Interventions for helping clients develop coping skills for managing negative emotional states depend on the issues and needs of the _____.
a) group
b) individual
c) therapist
d) family members
e) peer groups

16. Active participation by family members is more likely to occur if the abuser understands the impact of substance abuse on the family.
a) True
b) False

17. Relapse is less likely to occur as a result of lack of coping skills than the high risk situation itself.
a) True
b) False

18. Marlatt recommends all of the following to manage a lapse except _____.
a) commitment renewal
b) asking for help
c) keeping calm
d) reviewing the situation
e) changing clinicians

19. _____ is seeing things as either one extreme or the other, and not in terms of "degrees".
a) Over-generalizing
b) Selective abstraction
c) Dichotomous thinking
d) Magnification
e) Personalization

20. _____ is focusing only on errors, weaknesses, mistakes or failures and ignoring accomplishments or successes.
a) Labeling and mislabeling
b) Willpower breakdown
c) Magnification
d) Selective abstraction
e) Over-generalizing

21. The process of the client exploring the details of lapses or relapses is referred to as _____.
a) analyzation
b) debriefing
c) coordination
d) referring
e) joint discussion

22. Group leaders can use a variety of interventions in conducting relapse prevention group sessions such as _____.
a) monitoring
b) providing educational information
c) encouraging continuing participation in treatment
d) facilitating group discussion
e) all of the above

23. With regard to the authors's programs, he recommends spending the final 20-30 minutes of the session allowing members to state what they have learned and plans for recovery.
a) True
b) False

24. The psychological domain of recovery involves all of the following except:
a) changing distorted thinking
b) accepting the addiction
c) adequate sleep and relaxation
d) managing emotions without relying on substances
e) learning to cope with problems without substances

25. People, places, events, and objects are _____ factors that can trigger cravings.
a) internal
b) rare
c) usually not
d) external
e) always

26. Healthy ways of expressing anger include:
a) talking oneself out of being angry
b) using anger as a motivator
c) acting passive-aggressively
d) all of the above
e) (a) and (b) but not (c)

27. Having structure in daily life can reduce the chances of engaging in high risk behavior and give a sense of direction and purpose.
a) True
b) False

28. Relapse to substance abuse most often "comes out of the blue".
a) True
b) False

29. A(n) _____ should contain such information as supportive people, helpful organizations, reasons for hesitating to ask for help, and benefits of asking for help.
a) clinicians logbook
b) court-ordered document
c) relapse justification
d) emergency sobriety card
e) treatment plan

30. Problem solving groups are designed to:
a) support clients dealing with difficulties
b) help members receive support
c) help members learn relapse prevention
d) encourage personal responsibility
e) all of the above