LEARNING MODULE I

Seminar # 18

The Relapse

Learning Objectives

1. What is the issue.

2. How can the issue impact the family.

3. What are the options.

Pathfinder: The 12 Key Issues a Family Faces

#1 **Enabling vs Consequences**

#2 **Addiction Behavior**

#3 **Family Intervention**

#4 **The Police**

#5 **Emergency Medical Services**

#11 **Bereavement** (Learning how to move forward)

#12 **Spirituality, Faith Practices**

#6 **Legal Court System**

#7 **Treatment Centers**

8 **Support Agencies Mapping**

 # 9 The Relapse

#10 **Successful Lifelong Recovery**

What is the issue?

Marlatt's (1985) cognitive behavioral model of relapse conceptualizes relapse as a "transitional process, a series of events that unfold over time" (Larimer et al., 1999). This contrasts with alternative models which view relapse as an *endpoint or 'treatment failure'*. Flexibility is a key advantage of such transitional models: they provide guidance and opportunities for intervening at multiple stages in the relapse process to prevent or reduce relapse episodes.

Marlatt's full model provides a detail of factors which can lead to relapse episodes. Larimer et al (1999) describe how these factors fall into two core categories:

Immediate determinants – such as high-risk situations, or an individual's coping skills, and
Covert antecedents – such as an imbalanced lifestyle which leads to urges and cravings

The cognitive behavioral model of relapse helps families to develop an understanding of the risk of relapse. Once the characteristics of everyone's high-risk situations have been assessed the clinician can:

- Work forwards by analyzing their client's response to these situations.

- Work backward to examine factors that increase the individual's exposure to high-risk situations.
- With these individual difficulties formulated and understood, the clinician can help their client to broaden their repertoire of cognitive and behavioral strategies to reduce risk of relapse.

This model was designed for working with those persons struggling with alcohol problems it has been applied to addictive and impulsive behaviors more broadly (Marlatt & Donovan, 2005) including all substance use disorders (Mines & Merrill, 1987).

References:

Larimer, M. E., & Palmer, R. S. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioral model. Alcohol Research and Health, 23(2), 151-160.

Marlatt, G. A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G. A. Marlatt & J. R. Gordon (Eds.), Relapse prevention (1st ed., pp. 280–250). New York: Guilford Press.

Marlatt, G. A., & Donovan, D. M. (Eds.). (2005). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. Guilford press.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviors (1st ed.). New York: Guilford Press.

Mines, R. A., & Merrill, C. A. (1987). Bulimia: Cognitive-behavioral treatment and relapse prevention. Journal of Counseling & Development, 65(10), 562-564.

How can the issue impact the family?

Relapse prevention is why most people seek treatment. By the time an individual seek help, they have already tried to quit on their own and they are looking for a better solution. This seminar offers a practical approach to relapse prevention that works well in both individual and group therapy.

There are four main ideas in relapse prevention. First, relapse is a gradual process with distinct stages. The goal of treatment is to help individuals recognize the early stages, in which the chances of success are greatest [1]. Second, recovery is a process of personal growth with developmental milestones. Each stage of recovery has its own risks of relapse [2]. Third, the main tools of relapse prevention are cognitive therapy and mind-body relaxation, which change negative thinking and develop healthy coping skills [3]. Fourth, most relapses can be explained in terms of a few basic rules [4]. Educating clients in these few rules can help them focus on what is important.

The Stages of Relapse

The key to relapse prevention is to understand that relapse happens gradually [6]. It begins weeks and sometime months before an individual has a drink or use their drug of choice. This means we can catch it early and change its trajectory. The goal of treatment is to help individuals recognize the early warning signs of relapse and to develop coping skills to prevent relapse early in the process when the chances of success are greatest. This has been shown to significantly reduce the risk of relapse [7]. Gorski has broken relapse into 11 phases [6]. This level of detail is helpful to clinicians but can sometimes be overwhelming to families. Many have found it helpful to think in terms of three stages of relapse: emotional, mental, and physical [4].

Emotional Relapse

During emotional relapse, individuals are not thinking about using. They remember their last relapse and they do not want to repeat it. But their emotions and behaviors are setting them up for relapse down the road. Because clients are not consciously thinking about using during this stage, denial is a big part of emotional relapse.

These are some of the signs of emotional relapse [1]: 1) bottling up emotions; 2) isolating; 3) not going to meetings; 4) going to meetings but not sharing; 5) focusing on others (focusing on other people's problems or focusing on how other people affect them); and 6) poor eating and sleeping habits. The common denominator of emotional relapse is poor self-care, in which self-care is broadly defined to include emotional, psychological, and physical care.

One of the main goals of therapy at this stage is to help them understand what self-care means and why it is important [4]. The need for self-care varies from person to person. A simple reminder of poor self-care is the acronym HALT: hungry, angry, lonely, and tired. For some individuals, self-care is as basic as physical self-care, such as sleep, hygiene, and a healthy diet. For most individuals, self-care is about emotional self-care. Both the family and the one abusing substance need to make time for themselves, to be kind to themselves, and to give themselves permission to have fun. These topics usually have to be revisited many times during therapy: "Are you starting to feel exhausted again? Do you feel that you are being good yourself? How are you having fun? Are you putting time aside for yourself or are you getting caught up in life?"

Another goal of therapy at this stage is to help clients identify their denial. I find it helpful to encourage clients to compare their current behavior to behavior during past relapses and see if their self-care is worsening or improving.

The transition between emotional and mental relapse is not arbitrary, but the natural consequence of prolonged, poor self-care. When individuals exhibit poor self-care and live-in emotional relapse long enough, eventually they start to feel uncomfortable in their own skin. They begin to feel restless, irritable, and discontent. As their tension builds, they start to think about using just to escape.

Mental Relapse

In mental relapse, there is a war going on inside people's minds. Part of them wants to use, but part of them does not. As individuals go deeper into mental relapse, their cognitive resistance to relapse diminishes and their need for escape increases.

These are some of the signs of mental relapse [1]: 1) craving for drugs or alcohol; 2) thinking about people, places, and things associated with past use; 3) minimizing consequences of past use or glamorizing past use; 4) bargaining; 5) lying; 6) thinking of schemes to better control using; 7) looking for relapse opportunities; and 8) planning a relapse.

Helping clients avoid high-risk situations is an important goal of therapy. Clinical experience has shown that individuals have a hard time identifying their high-risk situations and believing that they are high-risk. Sometimes they think that avoiding high-risk situations is a sign of weakness.

<u>In bargaining, individuals start to think of scenarios in which it would be acceptable to use</u>. A common example is when people give themselves permission to use on holidays or on a trip. It is a common experience that airports and all-inclusive resorts are high-risk environments in early recovery. Another form of bargaining is when people start to think that they can relapse periodically, perhaps in a controlled way, for example, once or twice a year. Bargaining also can take the form of switching one addictive substance for another.

Occasional, brief thoughts of using are normal in early recovery and are different from mental relapse. When people enter a substance abuse program, I often hear them say, "I want to never have to think about using again." It can be frightening when they discover that they still have occasional cravings. They feel they are doing something wrong and that they have let themselves and their families down. They are sometimes reluctant to even mention thoughts of using because they are so embarrassed by them.

Clinical experience has shown that occasional thoughts of using need to be normalized in therapy. They do not mean the individual will relapse or that they are doing a poor job of recovery. Once a person has experienced addiction, it is impossible to erase the memory. But with good coping skills, a person can learn to let go of thoughts of using quickly.

Clinicians can distinguish mental relapse from occasional thoughts of using by monitoring a client's behavior longitudinally. Warning signs are when thoughts of using change in character and become more insistent or increase in frequency.

Physical Relapse

Finally, physical relapse is when an individual starts using again. Some researchers divide physical relapse into a "lapse" (the initial drink or drug use) and a "relapse" (a return to uncontrolled using) [8]. Clinical experience has shown that when clients focus too strongly on how much they used during a lapse; they do not fully appreciate the consequences of one drink. Once an individual has had one drink or one drug use, it may quickly lead to a relapse of uncontrolled using. But more importantly, it usually will lead to a mental relapse of obsessive or uncontrolled thinking about using, which eventually can lead to physical relapse.

Most physical relapses are relapses of opportunity. They occur when the person has a window in which they feel they will not get caught. Part of relapse prevention involves rehearsing these situations and developing healthy exit strategies.

When people do not understand relapse prevention, they think it involves saying no just before they are about to use. But that is the final and most difficult stage to stop, which is why people relapse. If an individual remains in mental relapse long enough without the necessary coping skills, clinical experience has shown they are more likely to turn to drugs or alcohol just to escape their turmoil.

References

Gorski T, Miller M. Staying Sober: A Guide for Relapse Prevention. Independence, MO: Independence Press; 1986. [Google Scholar]

Brown S. Treating the Alcoholic: A Developmental Model of Recovery. New York: Wiley; 1985. [Google Scholar]

Marlatt GA, George WH. Relapse prevention: introduction and overview of the model. Br J Addict. 1984;79(3):261–273. [PubMed] [Google Scholar]

Melemis SM. I Want to Change My Life: How to Overcome Anxiety, Depression and Addiction. Toronto: Modern Therapies; 2010. [Google Scholar]

Melemis SM. A Relapse Prevention Video: Early warning signs and important coping skills. AddictionsandRecovery.org [Internet] 2015. Available from: http://www.addictionsandrecovery.org/relapse-prevention.htm .

Gorski TT, Miller M. Counseling for Relapse Prevention. Independence, MO: Herald House/Independence Press; 1982. [Google Scholar]

Bennett GA, Withers J, Thomas PW, Higgins DS, Bailey J, Parry L. et al. A randomised trial of early warning signs relapse prevention training in the treatment of alcohol dependence. Addict Behav. 2005;30(6):1111–1124. [PubMed] [Google Scholar]

Larimer ME, Palmer RS, Marlatt GA. Relapse prevention: an overview of Marlatt's cognitive-behavioral model. Alcohol Res Health. 1999;23(2):151–160. [PMC free article] [PubMed] [Google Scholar]

What are the options?

Trigger Management

Best time to record these answers is after the trigger is presented:

- What was their trigger?
- How were they feeling just before they felt like drinking or drugging?
- What were they telling themselves just before they started to drink or drug? (Look for additional, hidden thoughts.)
- What did they do?
- Which thoughts led to which addictive feelings and behaviors?
- What was the chain of thoughts, feelings, and actions?
- What could they have told themselves?
- What could they have done?
- What emotions could they have pushed themselves to feel, in its place?
- How do they feel now about what happened?

Sit with a drug counselor or peer to peer coach and write a Family ***Plan for Prevention of Relapse,*** using their input and guidance. This will prove to be invaluable.

REF: American Addiction Centers
Follow
Feb 20, 2018

How the Family Responds to a Relapse

There are many things that can trigger the urge to drink or use drugs during active recovery, and some of the most common are stressors and difficulties with loved ones at home. For almost everyone working on staying sober who returns home after treatment or lives at home during outpatient care, it can be tricky to navigate the emotional flare-ups that are inevitable. Loved ones are often hurt by the behaviors associated with untreated substance use and trauma-related disorders, and it takes time to rebuild trust and heal.
The process can be tough, and many relationships will need more time than others if they are able to be repaired at all. The truth is that there is no necessary outcome for any relationship for you to stay sober.

The only thing you need is yourself and your dedication to doing what works.

Here is what you need to know:
· If relapse does happen, it is not the end of the world. It does not mean you have lost all you have gained in recovery, and it does not mean you have to continue drinking or getting high.
· However, relapse is not an inevitable part of the process of recovery or dealing with difficult situations. Though it can and does happen to many people, it does not have to, and if you feel like you are at risk, you can act.
· Sharing what you are feeling is essential but not necessarily with your family member. Rather, talking to a sponsor or your therapist is the best way to come up with actionable ways to decrease stress levels while continuing to work on your relationships with loved ones.
· You do not necessarily have to cut someone out of your life to avoid relapse. You may need to limit communications, set healthy boundaries, and/or take a break until you feel more stable and stronger in your ability to avoid relapse.
· Your loved one may benefit from taking part in their own therapeutic treatment and going through a "recovery" of their own.
The Best Answer to Relapse: Treatment
No matter what the reason for a relapse, if you feel that it is a chronic problem and you are unable to sustain sobriety as a result, one of the best choices is to return to treatment for coping mechanisms that work.

As an example: At American Addiction Centers, their First Responder Lifeline Program offers police officers and their families the support they need to heal in recovery with a comprehensive treatment program that provides:

- PTSD assessment and evaluation
- Access to EMDR therapy and other therapies proven to be effective in the treatment of trauma-related disorders like PTSD.
- Therapists and treatment professionals who are trained to work with first responders.
- Family therapy groups and support for loved ones
- Unique treatment plans designed for first responders.
- Long-term aftercare and support