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RELAPSE PREVENTION: PAST, PRESENT AND FUTURE

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AN ABSTRACT OF THE RESARCH PAPER OF

TITLE: RELAPSE PREVENTION: PAST, PRESENT AND FUTURE

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Addictive behavior is a difficult behavior to recover from. Luckily, over thirty years ago, researchers and professionals in the rehabilitation field have been able to change the way we treat addictions. This research looks into the past, present and future of relapse prevention to explore how the theories and models have shaped treatment. This overall view will give insight into the history and future of relapse prevention, treatment modalities and how professionals currently and in the future can benefit from past experiences. It is also important to look at the psychosocial implications addiction and treatment recovery can have on an individual and their family. Counselors will work with those who experience substance use disorders and it is important to be fully informed regarding recovery and what is necessary to help our clients do well.

Keywords: abstinence violation effect (AVE), addiction, craving, relapse, relapse prevention, substance use disorder, transtheoretical model (TTM)/ stages of change model

TABLE OF CONTENTS

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CHAPTER 1
INTRODUCTION

Drug use is a pernicious global problem affecting 210 million people worldwide (United Nations Office on Drugs and Crimes (UNODC, 2011; Vanyukov, et al., 2003). It devastates not only an individual's health, wellbeing, and productivity, but also puts his or her family and society in great danger of infectious diseases including HIV, crime, mental agony, and economic hardship. Most drug users return to drugs after treatment, in what becomes a vicious cycle of treatment and relapse (Islam, Hashizume, Yamamoto, Alam, & Rabbani, 2012). For instance twelve-month relapse rates following alcohol or tobacco cessation attempts generally range from 80-95% and evidence suggests comparable relapse trajectories across various classes of substance use (Hendershot, Witkiewitz, George, & Marlatt, 2011).

Based on these findings, relapse is a huge problem within our nation and world. Drug and alcohol treatment is being used at high rates and people are trying to receive help to end the spiral of recovery and relapse associated with addictions. The Treatment Episode Data Set or TEDS system records treatment admissions which at this time, average approximately 1.5 million substance abuse treatment admissions annually. While TEDS does not represent all substance abuse treatment activities, it comprises a significant proportion of all admissions to substance abuse treatment programs and includes those admissions that rely on public funds (Substance Abuse and Mental Health Services Administration, 2012). Because it is impossible to track all treatment episodes including those at private pay or other settings that are not receiving government funds, we can assume that the 1.5 million treatment episodes recorded by TED is a conservative figure at best.

There are many factors that contribute to relapse and multiple treatments. They include the individual's drug of choice, sex, socioeconomic status, gender, age, past treatments, aftercare, co-occurring disorders, and motivation of treatment. Another factor that can play a major role in relapse is the ability to pay for treatment, the length of treatment and the type of treatment. There are a many types of treatment modalities available across the country and the world and advocates report that their form of treatment is the most effective. Establishing which is most effective is beyond the scope of this paper. However three highly regarded and frequently utilized modalities have been featured in addictions research over the past 40 years, during which time interest in research related to the addictions has seen the most growth. Alan Marlatt was the critical factor in creating theories and models for promoting better treatment within the addictions field. Therefore it is fitting to start at this beginning, to better understand how prevention modalities have changed and been re-invented to better help recovery relapse. Taking a look at the past, present and future of relapse prevention can help us better understand the way we have progressed within our field in addition to gaining an understanding of how addiction and recovery from addiction has changed lives.

BACKGROUND

During the early-1970's a psychologist by the name of Alan Marlatt challenged the thought that addictions were incurable (Donovan & Witkiewitz, 2012). For more than twenty years, Marlatt and a colleague Judith Gordon became well-known advocates for addictions treatment and relapse prevention strategies. Initially, this model was used and developed as a behavioral maintenance program for use on the treatment of addictive behaviors (Marlatt & George, 1984). Together they created the Relapse Prevention Model. This model is based on social-cognitive psychology and incorporates both the conceptual model of relapse and a set of

cognitive and behavioral strategies to prevent or limit relapse episodes (Larimer, Palmer & Marlatt, 1999).

PURPOSE

The purpose of this research is to explore relapse prevention and treatment as a whole, in addition to considering the psychosocial impact of addictions on the individual and those they interact with (e.g. family, friends, work, and school). Exploring relapse with a holistic approach is the essence of the philosophy of rehabilitation. Over the years, the philosophy of rehabilitation has remained focused on the belief that all people are unique and possess dignity and worth. In 1970, Jaques discussed the philosophy of rehabilitation as having five parts: holistic nature of man, assets and residual capacities of individuals, the development of social skills, unified efforts of professionals directed toward client goals, and importance of active participation of clients towards rehabilitation goals (Tarvydas, Addy, & Fleming, 2010). This philosophy is an important aspect in the foundation and overall practice of the Rehabilitation profession.

IMPORTANT TERMS

Abstinence Violation Effect (AVE): Is a key cognitive/emotional event in the relapse cycle; it is hypothesized to occur following a lapse. Simply put, the AVE refers to an individual's response to the recognition that he/she has broken a self-imposed rule: that is, by engaging in a single act of substance use, his/her commitment to abstinence has been violated (Wheeler et al., 2006).

Addiction: Addiction is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors (American Society of Addiction Medicine, 2010). Characteristics of addiction are as follows; inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors

and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (American Society of Addiction Medicine, 2010).

Craving: Craving is a complex construct, and operational and conceptual definitions vary widely, yet clinicians, researchers, and clients agree that the subjective experience of craving is an essential facet of substance-use disorders (Witkiewitz, Lustyk, & Bowen, 2013). Craving can also be described as a subjective experience of an urge or desire to use substances as stated by Witkiewitz, et al., 2013.

Relapse: A setback that occurs during the behavior change process, such that progress toward the initiation or maintenance of a behavior changed goal (e.g., abstinence from drug use) is interrupted by a reversion to the target behavior (Hendershot, et al., 2011). It is important to remember that relapse is a dynamic and ongoing process.

Relapse Prevention (RP): A self-management program designed to enhance the maintenance stage of the habit-change process. The goal of RP is to teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse (Donovan & Witkiewitz, 2012). Relapse prevention is all about self-control that combines the use of cognitive interventions, lifestyle change procedures and behavioral skill training (Marlatt, 1985).

Substance Use Disorder: A substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited

in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment (DSM-V).

Transtheoretical Model (TTM) or *Stages of Change Model:* The stages-of-change model is not another theory but a framework that explains the process people use to change themselves- with or without professional assistance. It is important to note that the model does not explain why people change, but, rather, how they do so (Flavo, 2010). Originally developed by Prochaska & DiClemete (1992) this model consists of five stages; Precontemplation, Contemplation, Preparation (or Determination), Action, and Maintenance (Flavo, 2010)

CHAPTER II

REVIEW OF THE LITERATURE

ETIOLOGY AND PREVALENCE

According to the U.S. National Institute on Drug Abuse, approximately 22.6 million people have used or experimented with some form of drug or medication between 2002 and 2010 (National of Health, 2012). In 2013, an estimated 21.6 million persons aged 12 or older were classified with substance dependence or abuse in the past year (8.2 percent of the population aged 12 or older). Of these, 2.6 million were classified with dependence or abuse of both alcohol and illicit drugs (SAMSHA, 2013).Treatment data during the period of 2000-2010, revealed that males represented 68% of admissions, 59% of admissions were white, 20.9% were African-American and 13.7% were Hispanic Origin. The average age at admission was 34, and 40% were unemployed (Substance Abuse and Mental Health Services Administration, 2012).

Treatment and related costs for substance use disorders costs the United States health care system $30 billion. Including abuse of tobacco, illicit-drugs and alcohol, addictions are a costly problem for the United States. In addition to treatment costs; addiction costs the U.S, approximately $600 billion annually in relation to crimes, lost work productivity and related health care (National Institute on Drug Abuse, 2011). While these findings make it very apparent the overuse of these substances causes a great economic hardship on our country and health care systems, the human cost is greater still. According to the Center for Disease Control (2014) Excessive alcohol use led to approximately 88,000 deaths and 2.5 million years of potential life lost each year in the United States from 2006 – 2010, shortening the lives of those who died by an average of 30 years. Further, excessive drinking was responsible for 1 in 10 deaths among working-age adults aged 20-64 years.

Rates of relapse following substance abuse treatment are estimated at over 60%, consequently substance use disorders are often described as chronic relapsing conditions (Bowen, et al., 2009). However, in contrast to other chronic diseases, funding for addiction treatment disproportionately comes from government sources. More than three quarters—77 percent—of treatment costs are paid by federal, state and local governments, including Medicaid and Medicare. Private insurance covers only 10 percent of addiction treatment costs, with out-of-pocket expenditures and other private funding making up the remaining percentage. In contrast, private insurance pays for approximately 37 percent of general medical costs. The passage of federal parity and health care reform legislation should help address this imbalance in the future. On an individual level, nearly half of those receiving treatment reported using their own money to pay for their care (Open Society Foundation, 2010).

Regardless of who pays for care, once an individual completes treatment, they must have supportive aftercare or many will relapse. Counseling in the form of after care for relapse prevention which offers the support and resources necessary for persons newly abstinent to fully embrace life outside a treatment center at an appropriate pace for themselves (Duffy & Baldwin, 2013). Focusing on increasing client motivation, confidence and enthusiasm for recovery appears to create the best possible outcomes. Duffy & Baldwin (2013) conducted qualitative research to identify the factors that played a critical role in recovery for people once released from treatment. Common themes reported by the study participants, included rebuilding social supports, accommodations after treatment, employment and finance needs, health and motivation for change (Duffy & Baldwin, 2013). Participants noted that after care planning by agencies and systems, were inconsistent. In fact peer support was most helpful, in that peers already in the community shared information about potential solutions with newly released peers (Duffy &

Baldwin). In summary, relapse places a strain on the individual, their family, the community, and society in general. These factors place the emphasis on relapse prevention that works, and thus the need for counselors to employ evidenced based practices for this purpose.

TREATMENT AND INTERVENTIONS

Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death. (ASAM, 2010). Consequently, substance use disorders should be treated like any other chronic illness; relapse serves as a trigger for renewed intervention. Relapse rates are equivalent in medical terms to the frequency in which symptoms re-occur. Symptom resumption for people with addiction and other substance use disorders are similar to relapse rates for other well-understood chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. For a person recovering from addiction, lapsing back to drug use indicates that treatment needs to be reinstated or adjusted or that another treatment should be tried.

Therefore the abstinence-relapse-recovery cycle represents a common concern among counseling professionals in the field of substance abuse. Many clients will typically relapse more than once and unfortunately continue the cycle of sobriety to relapse to sobriety to relapse. Individuals who are given the opportunity to participate in some form of treatment are taught that typically, there are more issues that need to be addressed in their recovery in addition to the using of their drug choice. An estimate of those will eventually encounter a relapse during their recovery is anywhere from 40-60% (Santa Clara County Department of Alcohol & Drug Services, 2011). Due to this trend, we tend to see a high amount of repeat clients to our substance abuse treatment facilities. There are a multitude of reasons clients relapse and end up back in

treatment facilities for detox, inpatient and or outpatient services from the data conducted gathered by the Santa Clara County Department of Alcohol & Drug Services in 2011. During a study in Bangladesh, the researchers found a variety of precipitating factors that lead to their participant's inevitable relapse. The study found that the greatest precipitating factor was the effect of the users' past drug use, followed by continuous invitation from peers and drug peddlers, low self-motivation, failing to keep in touch with religious practice or with people who were drug-free, mental or emotional health problems, and a lack of awareness about the nature and course of drug use (Islam, et al., 2012). Any one of these reasons can lead a person who is newly sober into relapse or even someone who has been sober for a lengthy time into a relapse.

Marlatt (1980) refers to relapse as the abstinence violation effect (AVE). AVE is a form of black and white thinking. Individuals blame themselves based on internal factors they believe are out of their control. Sensing defeat, they stop trying. The research suggests that understanding and overcoming the abstinence violation effect, is crucial to conquering a problem behavior or dependency in the long term. The nature and quality of the AVE assumes a pivotal role in relapse prevention counseling (Wheeler, George, & Marlatt, 2006).

When looking at relapse and relapse prevention, there are many strategies used to facilitate treatment and recovery. Over the past thirty years, since relapse prevention as a treatment methods was proposed, it has been changed, re-structured, re-formulated and updated to fit our worlds ever changing views and concerns about addiction. Since the creation of this model, it assisted countless professional's help clients learn positive ways to reduce relapse. However, the overall goal has never really changed, which is to create more positive habits for people to learn in order to prevent relapse and create positive changes in their lives. There are many different strategies used today throughout our world to assist in the recovery process. Throughout this

section we will discuss the past, present and future strategies used in treatment and provide brief yet informative backgrounds on them.

Marlatt's (1980) original treatment model was the beginning of relapse prevention and everything that has followed has been influenced by this original innovation in some way or another. The Relapse Prevention model is a cognitive-behavioral approach with the goal of identifying and preventing high-risk situations such as substance abuse, obsessive-compulsive behavior, sexual offending, obesity, and depression (Witkiewitz & Marlatt, 2004). Ultimately, this is where all the other strategies started from. This perspective considers only a dichotomous treatment outcome-that is, a person is either abstinent or relapsed (Larimer et al., 1999). The RP Model suggests that both immediate determinant (e.g., high-risk situations, coping skills, outcome expectancies, and the abstinence violation effect) and covert antecedents (e.g., lifestyle factors and urges and cravings) can contribute to relapse (Larimer et al., 1999).

Overall, this model is used to change negative behaviors. The unique characteristic of the Relapse Prevention Model are the classification of the factors or situations that can contribute to episodes of relapse (Larimer et al., 1999). These factors fall into two categories: immediate determinants such as high risk situations, coping skills and outcome expectancies. The second category is covert antecedents which are urges, cravings and lifestyle imbalances.

Following an initial assessment to identify the emotional and environmental characteristics of situations associated with relapse unique to that person, the counselor then works with the clients past and future to analyze the person's responses to situations that can and do increase the drinkers or users of other drugs exposure to high risk situations. Once this examination is completed, the therapist can then create a treatment plan and strategies to decrease the risk of relapse.

Interventions that are both specific and global allow the therapist and client to address each step of the relapse process. Specific interventions are those that address the individuals unique set of thoughts and behaviors that place them at risk for relapse. Specific interventions may include identifying debunking myths about alcohol or drug use, identifying potentially risky situations, enhancing the client's skills for coping with those situations, increasing the client's self-efficacy, managing lapses, and restructuring the client's perceptions of the relapse process. Global strategies focus on management of high risk behaviors, including balancing the client's lifestyle, employing stimulus control techniques and urge-management techniques, and developing relapse road maps (Larimer, et al., 1999; Marlatt 1996).

During the same time Marlatt and Gordon (1980) were creating the RP model, Prochaska & DiClmente (1983) were also creating an addiction treatment model. While these two models were created at the same time and they have both been influential with the continued research and advancement of relapse prevention. The model that is used often with the treatment of recovery and relapse is the Transtheoretical Model with its main component The Stages of Change Model developed by Prochaska & DiClmente (1983). This model is useful for matching patients with treatments based on their readiness for change (Thomas, 2006). This model emphasizes the importance of a wider view of the individual, which allows a more accurate evaluation of patient condition, in comparison with the historic conception that success or failure in changing the addictive behavior is a function of denial (De Biaze Vilela, Jungerman, Laranjeira, & Callaghan, 2009). Use of this intervention provides a framework to help professionals understand the process people use to change themselves, with or without the use of therapy (De Biaze Vilela, et al., 2009). This model is made up of five stages that work together

and help professionals and their clients where they are on the spectrum in regards to motivation for change.

Stage one is called the Precontemplation stage. This stage is described as there is no intention to change behavior in the foreseeable future. Often, precontemplators do not define the behavior as a problem (Thomas, 2006). Not all people who are in this stage are in denial. Some do not understand the risks associated with their behaviors, or they have a strong connection to maintaining their problem behavior.

Stage two is the Contemplation stage. This is generally the stage where people stay the longest. Here, clients are learning to weigh their options, and learning the benefits of changing. Contemplators have an interest in change, but little commitment (Thomas, 2006). This can be difficult for therapists and counselors; yet trying to move the client toward the next stage is a major goal.

Preparation (or Determination) is stage three. During this stage, the client is forming intentions to change a behavior in the near future (Prochaska & DiClemente, 1992). Their determination is often demonstrated by small behavior changes (Thomas, 2006). During this stage, it is important for the counselor to help their client develop realistic plans of action; having this plan in place, will help when dealing with barriers along the way to recovery and sobriety.

The fourth stage is the Action stage. This is when the plan is implemented. During this stage, people will modify their behavior and/or their environment to overcome a problem (Thomas, 2006). For one to be fully classified as in the "action" stage, they need to successfully alter their behavior for a period of 1 day to 6 months. After 6 months of success, they are considered to have moved onto the next stage (Thomas, 2006).

The last stage is the Maintenance stage. During this stage, people will continue their efforts to prevent relapse and to consolidate gains made in treatment (Thomas, 2006). This stage is viewed as a continuation of change, rather than a stopping point. The responsibility of the counselor during this stage is to help the client set up a plan for relapse prevention, that will help the client anticipate and protect themselves against "abstinence violation effects" (Thomas, 2006). During ones sobriety, it can be easy to begin thinking again of your past and start to self-doubt. This plan will help the client be prepared for those feelings and possible relapse.

There are professionals in the field that argue that there is a sixth stage, called the Relapse stage. This is where one has continued through the stages and is currently in the maintenance stage and falters and relapses. This is common and likely to happen during recovery. Now, there is no shame in this stage, it just happens to be a part of recovery and treatment. If this occurs, it is imperative the client speak with a counselor again and beginning at the contemplation stage to start the cycle of recovery again. The intervention in this case focuses on a return to the previous plan, on the reinforcement of self-efficacy and on the renewing of confidence (De Biaze Vilela et al., 2009).

Overall, the Stages of Change Model is very popular when working with people who are abusing drugs and want to quit and become sober. For a long time within our field it was one of the most popular models to use while working with clients during recovery. Over the years, there has been a new style of therapy geared towards recovery and sobriety that has become a more widely used technique referred to as mindfulness based relapse prevention. .

The future of relapse prevention seems focused on the addition of Mindfulness-based relapse prevention strategies, which complement the theory underlying Marlatt's Cognitive-Behavioral Model. A recently developed cognitive-behavioral treatment for addiction,

mindfulness-based relapse prevention MBRP was designed to target experiences of craving and negative affect and their roles in the relapse process (Witkiewitz, Bowen, Douglas, & Hsu, 2013). The core beliefs underpinning the program are the interconnectedness and wholeness inherent in human life, the understanding that, regardless of what is happening there is in any person' always more right than wrong in any person's life, and the recognition of the boundless inner resources available at all times that could be used for healing (Vallejo & Amaro, 2009).

Marlatt dedicated the last decade of his career to research in mindfulness-based treatments for addictive behaviors, often remarking that it was a culmination of his research and clinical interests to date, and of his own life's journey (Bowen, 2012). The mindfulness practices of MBRP (mindfulness-based relapse prevention) are intended to increase discriminate awareness, with a specific focus on acceptance of uncomfortable states or challenging situations without reacting "automatically" (Witkiewitz et al., 2013). MBRP is a model that utilizes and emphasizes on the intentional awareness and acceptance of any experience. These experiences include the uncomfortable and unwanted ones. While doing this, you teach skills to better relate to those experiences. These practices differ from the traditional cognitive-behavioral interventions and 12-step groups. While learning these skills to relate to their experiences, clients are also taught to practice a curious and nonjudgmental approach to discomfort, learning to investigate emotional, physical, and cognitive components of experience as they occur in the present moment, rather than attempting to suppress or ameliorate the discomfort, fostering approach- versus avoidance-based coping (Witkiewitz et al., 2013).

MBRP was designed to be an 8-week aftercare treatment, with weekly sessions lasting approximately 2 hours (Bowen, 2012). The program is designed to integrate both informal and formal mindfulness practices along with cognitive behavioral skills and exercises (Bowen,

2012). Each session is designed to build upon skills and practices learned the previous weeks. The sessions as a whole focus on increasing awareness of physical experiences of internal and external triggers, physical, cognitive and emotional reactions that follow those triggers, coping with urges and cravings, cultivating and maintaining a lifestyle that is supportive of recovery and continued mindfulness practices. MBRP shows great effectiveness as well as clients who go through this treatment report greater increases in awareness and acceptance.

PSYCHOSOCIAL IMPLICATIONS

Over the years treatment has changed, however some things do stay the same. There are many circumstances that can affect someone's treatment. While the overall aspect of someone's treatment is important, psychosocial factors also play into one's treatment. Treatment has to be conducted in a holistic approach for someone to obtain recovery and sustain it. Doctors, nurses, counselors and case managers need to take into consideration the type of treatment being provided as well as how someone's psychosocial implications will play into their treatment. Since the overall discussion through this paper has been the history of relapse prevention and how it has changed and been utilized, it only seemed fitting to discuss the other factors related to treatment. Factors that should be considered in the implementation of treatment services for substance disorders are related health factors, social support implications and vocational concerns and issues.

Individuals who are addicted to a legal or illegal drug often may also qualify for other co-occurring mental health disorder and vice versa (Prodromou, Kyritsi, & Koukia, 2014). There are many related health risk factors associated with constant use and abuse of substances. The effect of a drug on the body is highly dependent on the interactions between the individuals' specific characteristics and the specific pharmacologic agent (Flavo, 2010). There are a few substance-

induced disorders related to the over-use of substances; substance intoxication and withdrawal. The clinically significant problematic behavioral or psychological changes associated with intoxication (e.g., belligerence, mood lability, impaired judgment) are attributable to the physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance (DSM-V).

Alcohol is a powerful central nervous system depressant, which can cause a multitude of adverse reactions when consumed in massive quantities. There are a variety of medical conditions that are associated with the over-use, abuse and dependence of alcohol, including the following; Korsakoff's Syndrome, Wernicke's Disease, hypertension, cardiomyopathy, alterations in hear rate and rhythm, alterations of the blood, respiratory system conditions, alcohol hepatitis, esophagitis and gastritis just to name a few. Some alcohol-related medical illnesses are reversible however no alcohol-related illness can be cured if the individual continues to abuse alcohol (Flavo, 2010). While these conditions can be frightening and deter people from using at least temporarily, it remains important to continue to focus on the development of a plan for long term, effective management of alcohol dependence. Combining medical, counseling and support networks, it can be possible to obtain sobriety and continue it to deter these adverse effects.

With regards to abuse of other substances such as caffeine, opioids, cannabis, nicotine, sedatives, cocaine and other stimulants, inhalants and more, can be similar to those of alcohol, yet also include a variety of other health conditions. Adverse effects from the over-use of these substances can cause seizures, bone marrow changes, and susceptibility to infections, overall bodily functioning and even death. There is no true test to know who will be affected medically from the abuse and over-use of any drug, yet it is important to know the adverse reactions from

continued use. Continually seeing a doctor is an important step to management of your own health, but also coming to terms with your abuse and realizing changes need to occur in your life in order to pro-long your life without complications.

Another psychosocial implication to substance use and abuse is the social support implications. What happens when you remove substances from your life and all of your friends still use substances, what happens? This area is very widespread including family relationships, relationships with friends and associates, and general functioning as a member of society (Flavo, 2010). With the increasing use of substances, one's ability to function in society will deteriorate. Some factors that can contribute to social implications are the availability to the substance and of the substance in that given scenario. If the friends you spend time with also drink and do drugs with you, you are more likely to continue those friendships than with those who do not abuse substances like you. Repeated, heavy use of the substance often leads to upheavals in relationships (Flavo, 2010). Most families and relationships are extremely strained and often destroyed when an individual has an addiction due to various factors like becoming abusive, violence, socially unacceptable behavior, etc. With the consequences, one generally loses sight of their role in the family or relationships which can lead to those support systems to become frustrated and disappointed. Feelings of isolation and low self-esteem are common among those facing addiction which in turn will create more turmoil for themselves and their families and friends. The individual can tend to start to feel shameful, and develop feelings of guilt and self-loathing. Regaining these social supports is a common therapeutic goal and can increase one's ability to have positive outcomes within treatment.

Other social implications that can occur from an addiction are criminal consequences. There is a strong correlation between substance abuse disorders and a variety of accidents.

Accidents such as motor vehicle accidents can lead to physical disability not only for the individual with the substance use disorder, but also for others (Flavo, 2010). Accidents such as this can cause someone the loss of a driver's license, or more serious criminal offenses such as jail time, misdemeanors or felonies. Other social implications that can cause complications are people's inability to continue to pay for their addiction which leads them to turn to illegal activities to keep up their habits. Even if criminal charges are not there, these activities can consume an individual and all their time is focused on that. Overall, a therapeutic goal would be to remove the negative influences from that person's life and replace it with positive things and establish new social roles and atmospheres.

The last psychosocial implication that is important to discuss is related to vocational issues. At the beginning of substance use or abuse, an individual might feel their drinking or use of drugs will interfere with their work, however, once an individual has progressed to more serious addiction, they might feel their job will interfere with their addiction. The substance will and can assume a permanent and prominent role in one's life creating other issues. When working with addictions, it is better to receive help at the beginning, however many people can continue to work and be productive for many years before anyone notices there is a problem. If the addiction is not caught soon enough, there can be deterioration in one's work performance, increase in job related accidents and loss of a job. However, the fear that one will lose their job if an employer becomes aware of the addiction could lead to someone obtaining help with their addiction(s).

If the loss of a job occurs, and that individual seeks treatment, it can still be difficult to regain that past employment. There are many factors that can contribute to one being incapable of regaining their previous job. The stress of the job could interfere with that person's recovery,

physical disability associated with their addiction may make it more difficult to perform their old job duties, incarceration or a criminal history could also interfere with regaining pervious employment as well as new employment. There are many factors that can contribute to one not being able to return to their previous employment, however, most individuals who are recovering from substance use disorders return to their original employment and lead full productive lives (Flavo, 2010). Being aware of the problems that may arise from an addiction is a good idea to make sure an individual understands the possible consequences of their actions.

TREATMENT OUTCOME DATA

There is a large body of literature related to research and outcome data surrounding relapse prevention treatment and mindfulness-based efficacy. These following research articles were selected as they highlight the positive outcomes and they support continued use of the Relapse Prevention Model more than thirty years later.

Sarah Bowen and colleges completed a randomized clinical trial to show the relative efficacy of mindfulness-based relapse prevention, standard relapse prevention, and treatment as usual for substance use disorder (Bowen et al., 2014). The study took place from October of 2009 to July of 2012 with a total of 286 individuals who had successfully completed their initial treatment. These individuals completed their treatment at a private, nonprofit facility and were randomized to Mindfulness-Based Treatment (MBRP), Relapse Prevention (RP) or treatment as usual (TAU) aftercare services for the next twelve months (Bowen et al., 2014). The interventions that were given to the individuals in the trial were randomly assigned to 8 weekly group sessions of MBRP, RP and TAU. The treatment conditions were a group format and held at the agency sites and adherence to these treatments were monitored by weekly supervision (Bowen et al., 2014).

The outcomes based on this set of data are as follows; across the three groups, the overall rates of substance use and heavy drinking were much lowers compared to other substance use disorders (SUDs) treatment studies (Bowen et al., 2014). Group differences were not found until after the 3-month follow-up. With the MBRP and RP participants, they had significantly reduced risk of relapse to drug use and heavy drinking compared to the TAU participants (Bowen et al., 2014).

The overall findings suggest that the treatments may be equally effective at the 3-month mark, but reaching the 6-month mark MBRP seems to be the better treatment outcome over TAU and RP respectively. The researchers gather that MBRP may be a better option for longer term sustainability of treatment gains for individuals, but that both MBRP and RP are better treatment options over TAU treatments (Bowen et al., 2014).

Based on a meta-analysis article written by a group of researchers from The University of Central Florida in 1999, findings suggested that RP was generally effective, particularly for alcohol related problems (Irvin, Bowers, Dunn, & Wang, 1999). The analysis consisted of 26 published and un-published studies with 70 hypothesis tests representing a sample of 9,504 participants. The goal of the analysis was to evaluate the overall efficacy of RP; and in turn they examined the effects of RP when compared to other active interventions, no additional-treatment controls, discussion controls, physician advice, and psychoeducation (Irvin et al., 1999). With the last follow-up at 12-months the study found that the MBRP participants reported significantly fewer drug use days and higher probability of not engaging in heavy drinking compared to the RP participants (Irvin et al., 1999).

The results of the meta-analysis indicated that RP was effective across levels of moderators and appeared to have more impact on improving psychosocial functioning than on

reducing substance use, treatment effects were strong and reliable for alcohol use and for polysubstance use but dramatically weaker for smoking (Irvin et al., 1999). Overall, this analysis supported the overall efficacy of RP in reducing substance use and improving psychosocial adjustment (Irvin et al., 1999). The findings also showed that RP was more effective when applied to alcohol or polysubstance use disorders with the adjunctive use of medication. This analysis was conducted over 10 years ago, with current data from that time, however, based on the literature based on the efficacy of relapse prevention; it is likely that these data findings still hold true to this current time of treatment strategies and efficacy.

Lastly, before Alan Marlatt passed away in 2011, he was in the process of completing a randomized controlled trail evaluating the efficacy of RP and mindfulness–based RP in comparison to standard aftercare for the treatment of substance use disorders (Donovan & Witkiewitz, 2012).This last piece of research and data was Marlatt's culmination of work over the past thirty years. The preliminary results from the trial look promising and suggest that RP and mindfulness-based RP are both more efficacious than standard aftercare (Donovan & Witkiewitz, 2012). The data also presented that across substances, RP was found to be generally effective compared with no treatment and as good as other active treatments (Donovan & Witkiewitz, 2012). An interesting finding was that some RP treatment outcome studies identified sustained main effects for RP, suggesting that RP may provide continued improvement over a longer period of time (indicating a "delayed emergence effect"), whereas other treatments may be effective over only a shorter duration (Donovan & Witkiewitz, 2012).Other researchers have conducted their own studies based on relapse prevention and cognitive-behavioral treatments that showed positive outcomes and effectiveness. It is evident that over the years, Marlatt's influence on other researchers in this field has been prominent and has assisted with the continued

development and research of addictive behaviors and treatment protocols. McCrady (2011) noted that “Marlatt’s RP model dramatically changed the way the treatment community conceptualized relapse” (Donovan & Witkiewitz, 2012).

There are many more articles and data sets which support the effectiveness of relapse prevention therapies and associated therapy techniques. Since the use of relapse prevention therapies over thirty years ago, this body of literature has continued to grow in the areas of substance use treatment and reduction of substance use. It is anticipate that research will continue to be conducted in our future to further support that relapse prevention strategies continue to be beneficial to the population who needs this help.

CHAPTER III

DISCUSSION OF IMPLICATIONS

FUTURE

While Alan Marlatt's Cognitive-Behavioral Model, The Stages if Change Model and mindfulness-based relapse prevention will continue to be used within our field, within the last few years there has been a broader focus on evidence-based psychosocial treatments for substance abuse and dependence. Within the last few years there has been more progress and expansion within the development of these evidence-based psychosocial treatments for substance abuse and dependence (Jhanjee, 2014). There are a few psychosocial interventions that have recently been studied and show promising results for substance abuse treatment.

The interventions found to be effective across many drugs of abuse are; motivational interviewing, cognitive behavior therapy and relapse prevention. Consensus exists that several psychosocial treatments or interventions for substance use disorders are "evidence based." These include cognitive-behavioral therapy (CBT), including relapse prevention, contingency management (CM), motivational enhancement/motivational interviewing (MI) and brief interventions (BIs) for alcohol and tobacco (Jhanjee, 2014). We will go into these briefly to give you an idea of how the relapse prevention field is growing to fit our population.

Brief Interventions have been primarily used for alcohol use problems, but have been utilized for other substances. The World Health Organization (WHO) defines brief interventions as 'practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it' (McCambridge & Cunningham, 2014). The overall goal of BI is to help the client learn and understand that the substances they are abusing and using are putting them at risk. While doing this, encouragement is utilized to try to get them to reduce use or give up the

substance altogether. BI's are generally not intended for the use on someone who have a serious substance use/problem, but on someone who has problematic or risky use. Brief Interventions have been shown to be effective due to their features; feedback, responsibility, advice, menu of options, empathy and self-efficacy (confidence of change) (Jhanjee, 2014). While being effective at treating patients, BI's are also highly cost effective in regards to treatment options. Overall, BI's are an effective first level of treatment offered.

Another type of psychosocial interventions is being utilized more is Motivational Interviewing. Motivational Interviewing is a humanistic a, client-centered, psychosocial, directive counseling approach that was developed by William R. Miller and Stephen Rollick in the early 1980's (Corey, 2012). MI works by activating clients' own motivation for change. During sessions, the client is the one who has to believe they can change and heal; they hold all the responsibility, not the counselor. A theme throughout MI is that clients have the capacity within themselves to generate intrinsic motivation for change. The overall goal of MI used in treatment is to help people explore and resolve their ambivalence about their substance use and being to try and make positive behavioral and psychological changes (Harris, Smock & Wilkes, 2011).

Cognitive Behavioral interventions also called CBT is a group of approaches based on the learning principles and theorize that behavior is influenced by cognitive-processes (Harris et al., 2011). CBT utilizes a multitude of behavioral strategies to better help the client overcome their addiction. Strategies utilized are as follows; coping with cravings for substances, relaxation training, Contingency Management (CM), cue exposure, promotion of non-drug related activities, coping with relapses and preparing for emergencies, social skills, training, problem solving skills and more. CBT is one of the most effective approaches to substance abuse

treatment and generally accepted by all clients. With that being said, its benefits can and generally do continue once treatment is over and the client is in recovery.

Contingency Management is another psychosocial intervention that is beginning to be utilized more with our field. CM is based on principles of behavior modification. The approach used in treatment is aimed at encouraging positive behaviors by providing positive reinforcements when the patient is progressing towards their treatment goals, as well as withholding the positive reinforcement or providing punitive measures when the patient engages in undesirable behaviors (Harris et al., 2011). CM has been shown to be effective when used while treating opioids, tobacco, and polysubstance use. Sadly, it has not been used often due to its perceived high costs.

Currently, psychosocial interventions have been found to be effective, but, more research will continue to be done and continue to add to the long list of effective treatment models and theories. Along with more general research, more research will be conducted on specific populations to also better educate professionals as well as society on the appropriate treatment options available. With the research and continued effort to find new ways to treat addictive behaviors as well as re-create old treatment styles, professionals within our field will continue to better help our clients and continue to be positive support systems during their road to recovery.

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