Clinical Guidelines for Implementing Relapse Prevention Therapy

A Guideline Developed for the Behavioral Health Recovery Management Project

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Relapse Prevention Therapy (RPT): An Overview

"Quitting smoking is easy. I've done it hundreds of times."

- Attributed to Mark Twain

Relapse, broadly defined as an *act* or *instance* of backsliding, worsening, or subsiding, may be the common denominator in the outcome of treatments designed to address psychological problems and health-related behaviors especially those related to alcohol and drug misuse. That is, most individuals who make an attempt to change health-related behaviors (e.g., lose weight, spend more time with family, stop smoking, etc.), will experience set-backs or slips (lapses) that will sometimes worsen and become relapses. As evidenced Mark Twain's quote, people usually report that quitting is not nearly as difficult as staying quit, i.e. the maintenance of change.

Relapse Prevention Therapy (RPT) is a cognitive-behavioral approach to the treatment of addictive behaviors that specifically addresses the nature of the relapse process and suggest coping strategies useful in maintaining change (Marlatt & Gordon, 1985; Parks, Marlatt, & Anderson, 2001). It is based on the idea that addictive behaviors are acquired, over-learned habits with biological, psychological, and social determinants and consequences. Engaging in an addictive behavior typically provides immediate rewards that increase pleasure and/or decrease pain. In other words, people engage in addictive behaviors to "feel good" (enhanced pleasure) or to "feel better" (self-medication of pain) although both motives can exist at the same time. The rewards of following addictive behaviors serve to maintain their excessive frequency, intensity, and duration, despite the delayed negative consequences, which can be quite severe and long lasting.

From a cognitive-behavioral point of view, the same learning process are involved in the development of both addictive (maladaptive) and non-addictive (adaptive) behaviors. Given the development of an addictive behavior is a learned process, changing addictive behaviors can be seen as a combination of extinguishing the connection between pleasure seeking and/or pain reduction and subsequent alcohol or drug use and helping clients to build a new behavior repertoire in which more adaptive coping behaviors replace addictive behaviors for the pursuit of pleasure and pain relief.

Utilizing this cognitive-behavioral analysis of addictive behaviors, Relapse Prevention Therapy (RPT) begins with the assessment of a client's potential interpersonal, intrapersonal, environmental, and physiological risks for relapse and the unique set of factors and situations that may directly precipitate a lapse. Once potential relapse triggers and high-risk situations are identified, cognitive and behavioral techniques are implemented that incorporate both specific interventions to prevent lapses or manage them if they do occur and more global strategies to address lifestyle balance, craving, and cognitive distortions that might set-up exposure to high-risk situations where relapse is most likely.

The initial therapeutic component in RPT is the identification of a client's unique profile of high-risk situations for relapse and evaluating that client's ability to cope with these high-risk situations without having a lapse. Where coping deficits are recognized, it is important to determine if they are due to a lack of knowledge and skills or if adequate coping skills are being interfered with by factors such as low motivation, low self-efficacy, or anxiety. Following this assessment of coping capacity, coping skills training is undertaken to develop missing skills or to address factors that interfere with the

performance of skills already in the client's repertoire. An extensive overview of coping skills training for substance dependence is provided by the Cognitive-Behavioral Therapy (CBT) for Substance Dependence clinical guideline available at this website (Kadden, 2001).

In addition to teaching more effective coping responses, a major component of RPT is the enhancement of self-efficacy. Self-efficacy is defined as the extent to which an individual feels capable of performing a specific task (Bandura, 1977; Bandura, 1986). Higher levels of self-efficacy are predictive of improved treatment outcomes. The collaboration between the client and therapist plays a critical role in the encouragement of self-efficacy. RPT encourages practitioners to engage clients actively in the therapeutic process which tends to increase the client's sense of ownership over successful therapy outcomes and willingness to persist when obstacles arise. Positive feedback from the therapist concerning the successful completion of substance use and non-substance use related tasks may help to increase a client's sense of general self-efficacy which may further motivate the client's efforts to change their problematic thoughts and behavior.

As in most cognitive-behavioral treatments, RPT incorporates topic-focused psychoeducational components and cognitive restructuring techniques to correct misperceptions and challenge and replace maladaptive thoughts. Eliminating myths related to positive outcome expectancies and discussing the psychological components of substance use such as self-efficacy and attributions for substance effects may provide a client with opportunities to make more healthy choices in high-risk situations. Positive outcome expectancies play an particularly influential role in the relapse process. Many clients glorify their alcohol and drug use experiences by focusing only on positive

expectancies such as euphoria and excitement or pain relief and relaxation, while the more negative consequences of the experience (e.g., hangovers, health risks, and legal consequences) are not acknowledged or are rationalized or minimized.

One potential impact of positive expectancies on relapse occurs after a client has been abstinent from drinking or drugs for some period of time beyond acute withdrawal. Fantasies about future use may be influenced by memories of the positive effects of past drinking and drug use creating a shift in attitudes and beliefs about the effects of the foregone pleasure and associated feelings of deprivation. In this way, positive outcome expectancies for the immediate effects of a substance may provide a motivating force leading to the resumption of drinking or drug use.

A lapse becomes more likely when a client is faced with substance-related cues in a high-risk situation and is beginning to feel unable to cope effectively (low self-efficacy) without resuming the addictive habit. In a more global sense, this "desire for indulgence" may be a reaction to an unbalanced lifestyle. Clients in RPT are taught to recognize and cope with substance use triggers and related high-risk situations that may precipitate a lapse. This first component of RPT is called "relapse prevention" because it focuses on self-efficacy and coping effectively with high-risk situations to prevent a slip or a lapse from occurring.

If a client does lapse then "relapse management" procedures for dealing with this *crisis* or emergency situation are implemented, including specific strategies to stop or reduce further use to prevent a single lapse from developing into a full-blown relapse. These strategies for coping with a lapse are tailored to a particular client's unique resources and needs. It is critical that clients are taught to restructure or reframe their

negative thoughts about lapses and learn not to view them as a "failure" or an indication of a lack of "willpower." Clients are taught to attribute lapses to specific, predictable, and potentially controllable events (both internal and external) rather than to personal failings and character flaws. Education about the *relapse process* and the likelihood of a lapse may better equip clients to navigate the rough terrain of the multiple cessation attempts typically necessary to achieve stable changes in addictive behaviors

A Cognitive Behavioral Model of Relapse

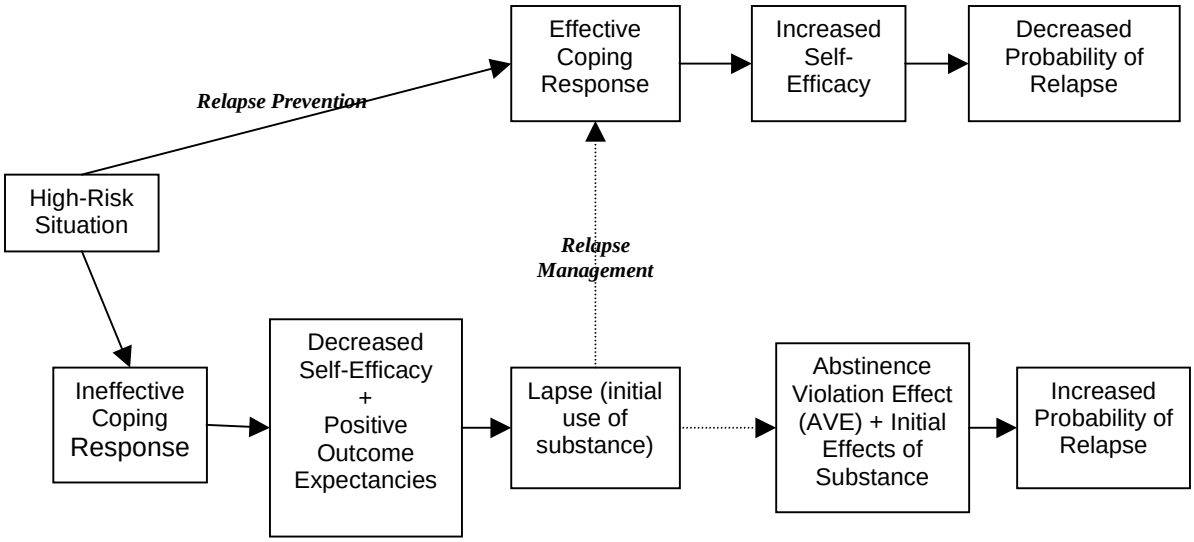
RPT is based on a cognitive-behavioral model of the relapse process developed over the past 30 years by Marlatt and his colleagues (Marlatt and Gordon, 1985; Parks, Anderson, & Marlatt, 2001). This model of relapse addresses several key questions about relapse both as a process and as an event:

1. Are there specific situational events that serve as triggers for relapse?
2. Are the determinants of the first lapse the same as those that cause a total relapse to occur, if not, how can they be distinguished from one another?
3. How does an individual react to and conceptualize the events preceding and following a lapse and how do these reactions affect the person's subsequent behavior regarding the probability of full-blown relapse?
4. Is it possible for an individual to covertly plan a relapse by setting up a situation in which it is virtually impossible to resist temptation?
5. At which points in the relapse process is it possible to intervene and alter the course of events so as to prevent a return to the addictive habit pattern?
6. Is it possible to prepare individuals during treatment to anticipate the likelihood of relapse and to teach them coping behaviors that might reduce the likelihood of lapses and the probability of subsequent relapse?

In order to investigate these key questions about relapse, it is helpful to engage in a microanalysis of the relapse process. This approach focuses on the immediate precipitating circumstances of relapse as well as on the chain of events that may precede and set-up a relapse. In this analysis, particular attention is paid to situational,

interpersonal, and psychological factors that precede a relapse and to the individual's expectations and attributions in reaction to a lapse. This analysis is consistent with the view that the maintenance stage of habit change is a time when mistakes are expected, but can be overcome with renewed effort. As the old adage goes, *we can learn much from our mistakes*. In this sense, a lapse can be seen as a *crisis* involving both the *dangers* of full-blown relapse and the *opportunity* for *new learning* to occur from the slip to avoid a future relapse.

A Cognitive-Behavioral Model of the Relapse Process: Immediate Precipitants



The cognitive-behavioral model of relapse flowchart (above) refers to the immediate precipitants of relapse that occur once a client is exposed to a high-risk situation. In RPT, it is assumed that clients who have successfully avoided alcohol or drug use for a period of time will begin to feel a sense of self-efficacy regarding their ability to maintain abstinence. If a client has not learned an effective coping response to avoid a lapse in response to high-risk situations, or if an effective coping response is not implemented due to a lack of motivation or anxiety, then there is an increased likelihood of a lapse. This increased probability of relapse is mediated by positive expectancies for the initial use of

a substance coupled with a decrease in self-efficacy created by a lack of ability to cope with the high-risk situations. Low self-efficacy to cope without drinking and drug use combined with positive outcome expectancies for alcohol and drug effects are the immediate precursors to a lapse.

Even if a lapse does occur, the incorporation of relapse management strategies may prepare a client to implement damage control skills to reduce further harmful consequences and prevent the situation from escalating into a full-blown relapse. After a lapse, clients may experience the abstinence violation effect (AVE) that involves a loss of perceived control experienced after the client's failure to adhere to his or her self-imposed rules of conduct regarding alcohol and drug use (Curry, Marlatt, & Gordon, 1987). On an emotional level, the AVE increases the probability of relapse because once a lapse has occurred, the shame, guilt, self blame and other negative feelings motivates further drinking or using drugs. In addition, the AVE affects the likelihood of relapse on a cognitive level because a lapse is also followed by an internal conflict over the inconsistency of one's efforts to abstain from alcohol and/or drugs combined with the reality of just using a substance. Finally, the AVE also leads the client to attribute their "failure" to stay sober to stable internal factors within their character that demonstrate that they are flawed or beyond redemption.

At the same time that the cognitive and emotional reactions that characterize the AVE are operating to disturb and upset a client about their lapse, the client is also beginning to experience the intoxicating effects of the substance just used (e.g., enhanced pleasure and/or reduced pain) further contributing to the likelihood of continued use which may ultimately lead to a full-blown relapse.

The reinforcing aspects of the initial use of the substance are based in part on the principles of operant conditioning. An individual who experiences a positive consequence (e.g., euphoria) from drinking or using drugs is more likely to do so in the future due to the principle of positive reinforcement. Similarly, if engaging in substance use behavior results in the reduction of negative consequences (e.g., pain or negative emotional states) the person is also more likely to use in the future due to the process of negative reinforcement. Because using alcohol and drugs is so reinforcing, most clients are unable to make the ultimate trip to abstinence from drinking and drug use successfully the first time.

Instead of reacting to a lapse or relapse with a sense of self-blame and failure, Relapse Prevention Therapy treats these so-called failures as temporary setbacks that may ultimately have positive outcomes and become *prolapses.* Prolapses are defined as mistakes that clients learn from that improve their eventual chances of success. For some clients, the change process is slow and laborious and it takes many attempts before the goal is attained. Others may find that behavior change is less taxing, perhaps based on the experiences they have gained in previous quit attempts or because they are fortunate to have more resources, such as greater coping capacity, stable employment, or social support from family and friends. Whether a client feels they have succeeded or failed in their previous attempts at addictive behavior habit change, the goal of RPT remains the same, *to help clients prevent relapse,* even if they "slip" and drink or use drugs at some point after setting out on the trip, through *relapse management strategies*, ultimately the journey of habit change can still be made!

An Empirically Derived Taxonomy of High-Risk Situations

The initial source of the category system of high-risk situations for relapse that has been used in research and clinical practice for the past 20 years came as a result of questions asked following a study on aversion therapy for alcoholics. A key aspect of the study was to conduct detailed interviews with the 48 out of 65 patients (74%) who consumed at least one drink during the first 3-months following the end of the aversion treatment. At the 3-month follow-up, descriptions of the first lapse (the first drink after discharge from the program) were obtained by interviewers who administered a follow-up version of the Drinking Profile, a questionnaire designed to measure the quantity, frequency, and situational patterning of alcohol use. Interviewers asked the following four questions:

1. "Now I would like you to briefly describe the important features of the situation which led you to take the first drink. Complete this sentence in your own words: “When I took my first drink, the situation was as follows...”
2. What would you say was the main reason for taking that first drink?
3. Describe any inner thoughts or emotional feelings (things within you as a person) that triggered off your need or desire to take the first drink at that time.
4. Describe any particular circumstances or set of events, things that happened to you in the outside world that triggered off your need or desire to take the first drink."

Responses to these four open-ended questions probing determinants for the initial lapse were classified and assigned to an eight-category typology based on a content analysis approach. Reliability of the categorization system was assessed by asking two raters to independently assign 20 descriptions to the appropriate category; percentage of agreement between the two raters was 95%. This initial category system was revised and expanded in subsequent studies that included other addictive behaviors such as smoking

and heroin use in addition to alcohol use. In this final version of the coding system, descriptions of initial lapses (first alcohol or drug use following treatment) were first categorized in one of two major classes.

The first category of relapse determinants, *intrapersonal-environmental determinants*, was used whenever the initial lapse episode involved a response to primarily psychological or physical events (e.g. coping with negative emotional states, giving in to "internal" urges, etc.) or a response to an environmental event (e.g. misfortune, accident, financial loss, etc.). Here the emphasis was on events in which another person or group is not reported to be a significant precipitating factor. The second major class, *interpersonal determinants*, applied whenever the relapse episode includes the significant influence of other individuals (e.g. interpersonal conflict, social pressure) either during or preceding a slip. The eight categories of high-risk situations for relapse (five within the interpersonal/environmental class and three within the interpersonal class) are described below.

I. INTRAPERSONAL-ENVIRONMENTAL DETERMINANTS

The first category includes all determinants that are primarily associated with intrapersonal factors (within the individual), and/or reactions to non-personal environmental events. It includes reactions to interpersonal events in the relatively distant past (i.e. in which the interaction with others is no longer of significant impact).

A. *Coping with negative emotional states.* Determinants involve coping with a negative (unpleasant) emotional state, mood, or feeling.

   (1) *Coping with frustration and/or anger.* Determinants involve an experience of frustration (reaction to a blocked goal-directed activity), and/or anger (hostility, aggression) in terms of the self or some nonpersonal environmental event. Includes all references to guilt, and responses to demands ("hassles")

from environmental sources or from within the self that are likely to produce feelings of anger.

(2) *Coping with other negative emotional states.* Determinants involves coping with emotional states other than frustration/anger that are unpleasant or aversive including feeling of fear, anxiety, tension, depression, loneliness, sadness, boredom, worry, apprehension, grief, loss, and other similar dysphoric states. Includes reactions to evaluation stress (examinations, promotions, public speaking, etc.), employment and financial difficulties and personal misfortune or accident.

B. *Coping with negative physical-physiological states.* Determinants involve coping with unpleasant or painful physical or physiological reactions.

(1) *Coping with physical states associated with prior substance use*. Coping with physical states that are specifically associated with prior use of drug or substance, such as "withdrawal agony" or "physical craving" associated with withdrawal.

(2) *Coping with other negative physical states*. Coping with pain, illness, injury, fatigue and specific disorders (e.g. headache) that are not associated with prior substance use.

C. *Enhancement of positive emotional states.* Use of substance to increase feelings of pleasure, joy, freedom, celebration and so on (e.g. when traveling or on vacation). Includes use of substance for primarily positive effects-to "get high" or to experience the enhancing effects of a drug.

D. *Testing personal control.* Use of substance to "test" one's ability to engage in controlled or moderate use; to "just try it once" to see what happens; or in cases in which the individual is testing the effects of treatment or a commitment to abstinence (including tests of "willpower").

E. *Giving in to temptations or urges.* Substances use in response to "internal" urges, temptations, or other promptings. Includes references to "craving" or intense subjective desire, in the absence of interpersonal factors.

(1) *In the presence of substance cues*. Use occurs in the presence of cues associated with substance use (e.g. running across a pack of cigarettes, passing by a bar, seeing an ad for cigarettes).

(2) *In the absence of substance cues.* Here, the urge or temptation comes "out of the blue" and is followed by the individual's attempt to procure the substance.

II. INTERPERSONAL DETERMINANTS

The second category includes determinants that are primarily associated with interpersonal factors: reference is made to the presence or influence of other individuals as part of the precipitating event. It implies the influence of present or recent interaction with another person or persons, who exert some influence on the user (reactions to events that occurred in the relatively distant past are classified in Category I). Just being in the presence of others at the time of the relapse does not justify an interpersonal classification, unless some mention is made or implied that these people had some influence or were somehow involved in the event.

A. *Coping with interpersonal conflict.* Coping with a current or relatively recent conflict associated with any interpersonal relationship such as marriage, friendship, family patterns, and employer-employee relations.

(1) *Coping with Frustration and/or Anger*. Determinants involves frustration (reaction to blocked goal-directed activity), and/or anger (hostility, aggression) stemming from an interpersonal source. Emphasis is on any situation in which their person feels frustrated or angry with someone and includes involvement in arguments, disagreements, fights, jealousy, discord, hassles, guilt and so on.

(2) *Coping with other interpersonal conflict*. Determinants involve coping with conflicts other than frustration and anger stemming from an interpersonal source. Feelings such as anxiety, fear, tension, worry, concern, apprehension, etc. which are associated with interpersonal conflict, are examples. Evaluation stress in which another person or group is specifically mentioned would be included.

B. *Social pressure.* Determinants involves responding to the influences of another individual or group of individuals who exert pressure (either direct or indirect) on the individual to use the substance.

(1) *Direct social pressure*. 'Here is direct contact (usually with verbal interaction) with another person or group who puts pressure on the user or who supplies the substance to the user (e.g. being offered a drug by someone, or being urged to use a drug by someone else). Distinguish from situations in which the substance is obtained from someone else at the request of the user (who has already decided to use).

(2) *Indirect social pressure*. Responding to the observation of another person or group that is using the substance or serves as a model of substance use for the user.

C. *Enhancement of positive emotional states.* Use of substance in a primarily interpersonal situation to increase feelings of pleasure, celebration, sexual excitement, freedom and the like. Distinguish from situations in which the other person(s) is using the substance prior to the individual's first use (classify these under Section II-B, above).

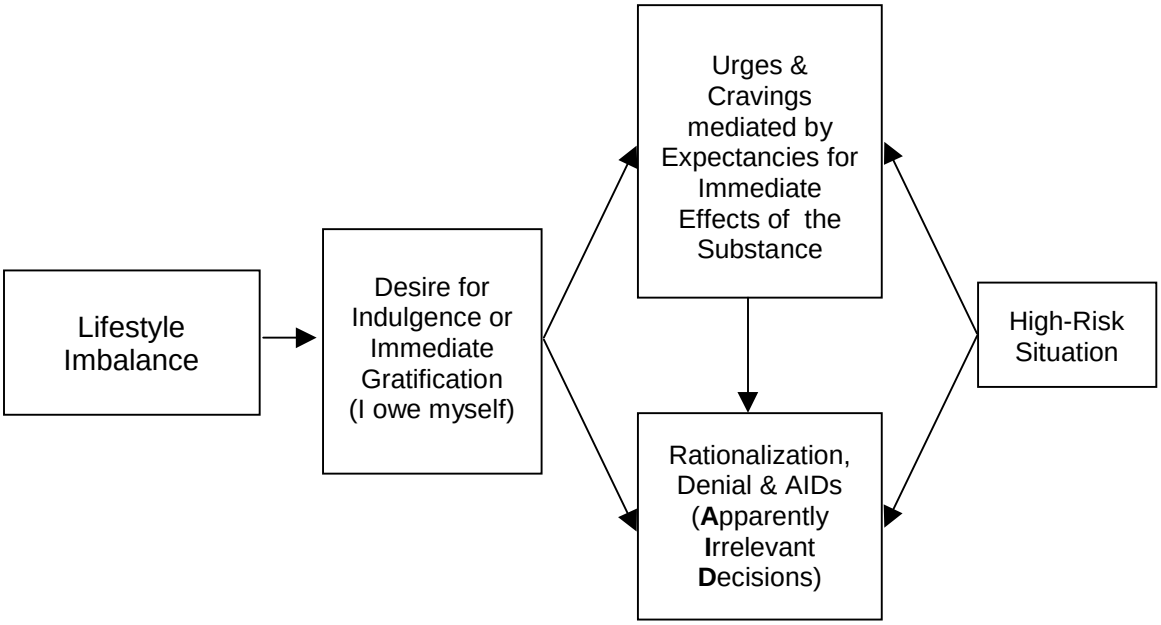
Relapse Set-Ups: Covert Antecedents of Relapse

In many, perhaps most of the relapse episodes we have studied in our research, or worked with in our clinical practice, the first lapse a client experiences is precipitated by an experience the client was not expecting and/or was generally unprepared to cope with effectively. Often, our clients report finding themselves in rapidly escalating scenarios they could not deal with effectively. When we debrief and analyze a lapse or relapse episode with clients, the lapse or subsequent relapse often appear to be the last link in a chain of events that preceded the client's exposure to the high-risk situation itself. It seems as if, perhaps unknowingly, even paradoxically, some clients set themselves up for relapse.

Cognitive distortions such as denial and rationalization make it easier to set up one's own relapse episode without having to take personal responsibility. Not only do

individuals deny they had any intent to resume use or relapse, but they also often discount the importance of any long-range negative consequences of their indulgent actions. The process of relapse is often determined by a number of covert antecedents that eventually lead to the exposure to a high-risk situation. This often allows the individual to deny any responsibility by saying, “This is not what I expected or wanted to happen and it’s not my fault.”

Relapse Set-Ups: Covert Antecedents of Relapse Situations



Evidence for the Efficacy of Relapse Prevention Therapy

The cognitive-behavioral model of the immediate determinants of relapse, the taxonomy of high-risk situations, and the covert antecedents that set up lapses provide the conceptual basis for Relapse Prevention Therapy as a clinical approach to help clients avoid relapse and thereby maintain the changes in addictive habits gained through treatment or their own efforts. Over the past 25 years, RPT has provided an important heuristic and treatment framework for clinicians working with several types of addictive behavior (Carroll, 1996). Incorporating studies of RPT for smoking, alcohol, marijuana, and cocaine addiction, Carroll concluded that RPT was more effective than no-treatment control groups and equally effective as other active treatments (e.g., supportive therapy, social support group, interpersonal psychotherapy) in improving substance use outcomes.

In her review, Carroll (1996) also discusses three areas that emerged as having particular promise for the effective application of Relapse Prevention Therapy. First, Carroll notes that while relapse prevention may not always prevent relapse better than other active treatments, several investigations suggest that RPT is more effective than available alternatives in relapse or lapse management, i.e. reducing the frequency, intensity, and duration of lapse episodes (slips), if they do occur. Second, several studies, especially those comparing RPT to other psychotherapies, have found RPT to be particularly effective at maintaining treatment effects over long-term follow up periods.

Based on the qualitative results from Carroll, Irvin and colleagues conducted a meta-analysis on the efficacy of RPT techniques in the improvement of substance abuse and psychosocial outcomes (Irvin, Bowers, Dunn, & Wang, 1999). Twenty-six studies representing a sample of 9,504 participants were included in the review, which focused

on alcohol use, smoking, polysubstance use, and cocaine use. The overall treatment effects demonstrated that RPT was a successful intervention for reducing substance use and improving psychosocial adjustment. In particular, RPT was more effective in treating alcohol and polysubstance use than it was in the treatment of cocaine use and smoking, although these findings need to be interpreted with caution due to the small number of studies evaluating cocaine use. RPT was equally effective across different treatment modalities, including individual, group, and marital treatment delivery, although all of these methods were most effective in treating alcohol use.

The Relapse Replication and Extension Project (RREP), initiated by the Treatment Research Branch of the United States National Institute of Alcohol Abuse and Alcoholism (NIAAA), was specifically designed to investigate the cognitive-behavioral model of relapse developed by Marlatt and colleagues (Marlatt & Gordon, 1985). The RREP focused on the replication and extension of the high-risk situation taxonomy in relation to relapse, and the reliability and validity of the taxonomic system for classifying relapse episodes. The results from the RREP are provided in the 1996 supplement to the journal *Addiction*. As in the original studies of relapse episodes in alcoholics, the RREP found that negative emotional states and exposure to social pressure to drink were most commonly identified as high-risk situations for relapse (Lowman, et al., 1996).

Note: Currently, a second edition of *Relapse Prevention* (Marlatt & Gordon, 1985) to be edited by Marlatt & Donovan is being prepared for publication by Guilford Press. The 2nd edition will include a review of existing research on RPT, an updated conceptual model of relapse, and individual chapters which focus on RPT applications to a variety of addictive behaviors. The major components of the original RPT model, presented will likely remain. This guideline will be updated periodically to reflect new formulations.

Relapse Prevention Therapy in Clinical Practice

Traditionally, treatment programs for addictive behaviors tended to ignore the relapse issue altogether. There seemed to be a general assumption in many programs that even to discuss the topic of relapse was equivalent to giving clients permission to use alcohol or drugs. The rationale that we present to our clients, administrators, and clinicians is that we already have numerous procedures in our society that require one to prepare for the possibility, no matter how remote, that various problematic and dangerous situations may arise. For example, we have fire drills to help us prepare for what to do if a fire breaks out in public buildings or schools. Certainly no one believes that by requiring people to participate in fire drills the probability of future fires increases; quite the contrary, in fact, the aim is to minimize the extent of personal loss and damage should a fire break out. The same logic applies in the case of relapse prevention. Why not include a *relapse drill* as a prevention strategy as routine part of substance abuse treatment programs? Learning precise relapse prevention skills and related cognitive strategies may offer clients the help they need to find their way on the highway of habit change. Most contemporary substance abuse treatment programs now incorporate relapse prevention in their protocols.

General Approach to Working with Clients

Contrary to traditional approaches in the treatment of addictive behaviors in which therapists often initiate treatment by using confrontation techniques designed to "break through the denial system" and force the client into accepting a diagnostic label such as “alcoholic” or “drug addict”, the RPT approach attempts to foster a sense of objectivity or detachment in our clients' approach to their addictive behaviors. By relating

to the client as a colleague or co-therapist, we hope to encourage a sense of cooperation and openness in which clients learn to perceive their addictive behavior as something they *do* rather than as an indication of someone they *are.* By adopting this objective and detached approach, clients may be able to free themselves from the guilt and defensiveness that would otherwise bias their view of their problem and their accurate reporting of urges, craving, and lapses. We also encourage clients to take an active role in treatment planning and decision making throughout the course of treatment and to assume personal responsibility at every stage of the program. The overall goal is to increase the clients' awareness and choice concerning their behavior, to develop coping skills and self-control capacities, and to generally develop a greater sense of confidence, mastery, or self-efficacy in their lives.

Which of the various RPT techniques described in this clinical guideline should be applied with a particular client? It is possible to combine techniques into a standardized multi-modal "package," with each client receiving identical components, if the purpose is treatment outcome research (Kadden, Carroll, Donovan, Cooney, Monti, Abrams, Litt, & Hester, 1995; Carroll, 2001). In contrast with the demands of treatment outcome research, those working in the clinical arena typically prefer to develop an *individualized* program of techniques, tailor-made for a particular client or group of clients. Selection of particular techniques should be made on the basis of a carefully conducted assessment. Therapists are encouraged to select intervention techniques on the basis of their initial evaluation and assessment of the client's problem and general lifestyle pattern.

To increase the overall impact of the individualized approach, a number of points should be kept in mind. First, in order to enhance the role of the client as colleague or co-therapist, every attempt should be made to assist the client in selecting his or her own combination of techniques. The rationale for selecting one technique over another should follow logically from the assessment phase in which the client plays an active participatory role. Second, the therapist can facilitate the client's general compliance with the self-control program by focusing attention and energy on a few carefully selected techniques introduced one at a time. Clients are likely to be overwhelmed by being asked to comply with a plethora of procedures which are all introduced at the same time. Along these same lines, adherence to the RPT will be enhanced if the client is able to experience small, but progressively incremental successes as the time goes on. Self-efficacy is enhanced by the client's gradual progress, in which each new phase of the process is taken “one step at a time.” Finally, successful RPT creates a balance between verbal procedures (education & instruction) and nonverbal techniques (imagery & meditation).

Therapeutic Components of the RPT

RPT is designed to equip clients for the journey of habit change by providing them with the necessary tools and skills to reach their destination and to guide them through the early stages of the trip. *Specifically, the RPT consists of the following components:*

1. RPT *teaches coping strategies* (constructive ways of thinking and behaving) to deal with the immediate problems that arise in the early stages of the habit change journey such as coping with the urges and craving for alcohol and drugs.

2. RPT provides clients with *maps* showing the location of various temptation situations, pitfalls, and danger spots along the way that can throw clients off course with the lure of temptation. RPT will give clients information on detours to avoid temptation situations where possible and to help them to acquire the skills to cope with challenges

successfully without giving in to temptation or giving up on the habit change process altogether.

3. RPT helps guide clients through the *tricks their minds* sometimes play on them when they have doubts in the journey of attitude and behavior change. RPT teaches clients to recognize the *early warning signals* that alert them to the danger of relapse including the psychological tricks of making *Apparently Irrelevant Decisions* (AlDs) that are secretly designed to set them up for trouble by bringing them closer to situations that are extremely tempting and difficult to resist. RPT also shows clients how their minds often play tricks on them such as denial and rationalization that increase the danger of relapse. RPT teaches clients how they can learn to identify and cope with these cognitive distortions.

4. RPT helps clients make important *changes in their day-to-day lifestyle,* so that the gratification they have obtained from alcohol or drugs is replaced with other nondestructive, ultimately more satisfying activities. Alcohol or drugs become an addiction or dependency because clients use them as a means of *coping* with life's continual ups and downs. It becomes increasingly difficult for clients to just *let things be*, without increasing or decreasing the intensity of their experiences by getting drunk or high. When clients stop drinking or doing drugs they begin to learn that they can trust their inner feelings and experiences without trying to hide them behind a fog of intoxication. RPT teaches clients new methods of coping with stress and how to increase the number of "wants" or desirable, self-fulfilling activities in their daily lifestyle.

5. Finally, RPT helps clients *anticipate and be prepared in advance for possible breakdowns* or relapses along the route. Many people begin their journey of habit change with very high expectations and demands for themselves. They frequently expect themselves to act perfectly without a single error, so that if they have *any* difficulty they think this proves they do not "have what it takes." Although many clients hope they will make it through the first time without any problems, an unrealistic expectation of perfection may set them up for failure; they may be tempted to give up altogether the first time they have a problem or a slip along the way. RPT encourages clients to take a more realistic approach, *to learn to anticipate and cope with the road conditions that might otherwise cause a slip or a breakdown.* And, if all precautions fail and an accident occurs, RPT teaches clients how to do repair and maintenance, to learn from the experience, and to continue on the path ahead.

Available evidence indicates that most clients will not experience successful maintenance of change the first time through the stages of change process. Instead of reacting to the inevitable problems encountered with a sense of self-blame and failure, RPT teaches clients to treat these seeming setbacks or relapses as *prolapses*. Whether a

client feels they have succeeded or failed in their previous attempts on this particular journey, the goal of RPT remains the same: *to help clients prevent relapse*—even if they "slip" and drink or use drugs at some point along the way.

RPT Intervention Strategies

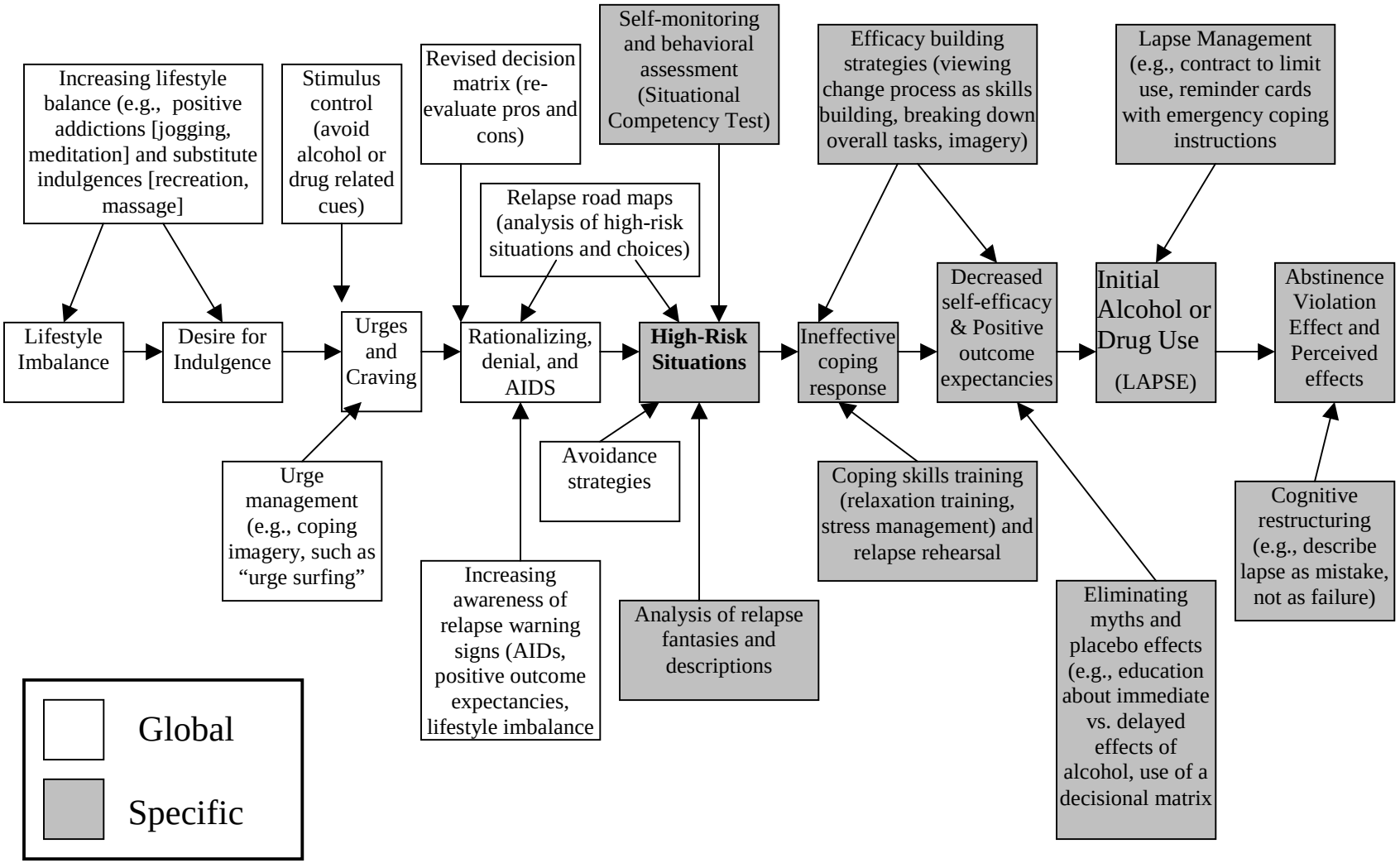
RPT assessment techniques and intervention strategies are designed to teach clients to anticipate and cope with the possibility of relapse. In the beginning of RPT training, clients are taught to recognize and cope with high-risk situations that may precipitate a lapse and to modify cognitions and other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

Both Specific and Global RPT Strategies can be placed in five categories: *Assessment Procedures*, *Insight/Awareness Raising Techniques*, *Coping Skills Training*, *Cognitive Strategies*, and *Lifestyle Modification* (Wanigaratne, Wallace, Pullin, Keaney, & Farmer, 1995). RPT *Assessment Procedures* are designed to help clients appreciate the nature of their addictive behavior problems in objective terms, to measure motivation for change, and to identifying high-risk situations and other risk factors that increase the probability of relapse. *Insight/Awareness Raising Techniques* are designed to provide clients with alternative beliefs concerning the nature of the habit-change process (i.e., to

view it as a learning process) and through self-monitoring, to help clients identify their patterns of emotion, thought, and behavior as they relate to the challenges of the habit change process. *Coping Skills Training* strategies include teaching clients both behavioral and cognitive responses to cope with high-risk situations. *Cognitive Strategies* are utilized to introduce coping imagery and cognitive restructuring to deal with urges and craving, to identify AIDs as early warning signals, and to reframe reactions to the initial lapse (restructuring of the AVE). Finally, *Lifestyle Modification* strategies (e.g., meditation, relaxation, and exercise) are designed to strengthen clients' overall coping capacity and to reduce the frequency and intensity of urges and craving that are often the product of the stress and distress caused by an unbalanced lifestyle.

The RPT intervention strategies presented in this guideline are drawn from a wide array of techniques used in behavior therapy, cognitive therapy, humanistic and existential psychotherapies. Relapse prevention intervention strategies have been used successfully as an alternative to traditional treatment protocols and as an adjunct to programs based on the disease model. Whatever the nature and etiology of addictive behaviors, RPT provides the therapist and client with practical tools for the maintenance of change.

Global and Specific Relapse Prevention Therapy Intervention Strategies



Specific RPT Intervention Strategies

The specific RPT intervention strategies to be summarized in this section focus on coping with high-risk situations in order to prevent a lapse and on coping with a lapse in order to prevent one slip from escalating into a full-blown relapse.

Assessment of Motivation and Commitment

Cognitive-behavioral *relapse prevention* strategies are designed to cope with the high-risk situations that precede a slip or *lapse and relapse management* strategies are designed to prevent a slip or lapse from becoming a full-blown relapse. Since addictive behavior habit change is a cyclical process, most people will not be completely successful on their first attempt to change an addictive behavior. The lessons learned from each lapse or relapse may bring the person closer to stable maintenance if they are viewed as opportunities to learn rather than failures.

Prochaska and DiClemente (1984) have described relapse within a transtheoretical model, incorporating six stages of change: precontemplation, contemplation, preparation, action, maintenance, and relapse. These stages of change have been successfully applied to understanding the motivation of patients receiving treatment for substance use disorders (DiClemente & Hughes, 1990). Motivation for change has been found to be highly correlated with treatment outcomes and relapse. The following relapse prevention strategies may be utilized to assess a client's motivation and encourage their motivation to change. Relapse prevention and relapse management strategies are necessary at the action, maintenance, and relapse stages in order for habit change to be successful over time.

The Decision Matrix (Decisional Balance Sheet)

The decision matrix is administered early in the habit change process. It is similar to the decisional balance sheet developed by cognitive theorists, Janis and Mann (1977). The primary assumption in using this technique is that people will not decide to change their behavior or to continue an ongoing behavior unless they expect their gains to exceed their losses. To complete the decision matrix, the client is presented a three-way table with the following factors represented: the decision to remain abstinent, the decision to resume using alcohol or drugs and both the immediate and delayed positive and negative effects of either alternative.

Decision Matrix for Alcohol Abstinence or Alcohol Use

	IMMEDIATE CONSEQUENCES		**DELAYED CONSEQUENCES**	
	Positive	**Negative**	**Positive**	**Negative**
TO REMAIN ABSTINENT	Improved self-efficacy, & self-esteem; family approval, better health, more energy; save money and time; greater success at work	Frustration and anxiety; denial of pleasures of drinking; not going to bars; anger at not being able to do what one wants without paying the price	Greater control over life; better health & longevity; learning about oneself & others without alcohol intoxication; more respect from others	Not being able to enjoy drinking while watching sports; becoming boring and depressed; not being able to remain friends with heavy drinking buddies
TO RESUME ALCOHOL USE	Automatic pleasure; reduced stress and anxiety; not feeling pain or worrying about one's problems; enjoying sports and drinking buddies	Feeling weak due to indulging in drinking; risk of accidents and embarrassment; anger of wife and family; being late or missing work hangovers; wasting money	Keeping drinking buddies; ability to drink while watching sports; not having to deal with wife and family by staying out drinking	Possible loss of family & job; deterioration of health and early death; loss of non-drinking or light drinking friends; ridicule of others and low self-esteem

Questionnaire and Structured Interviews for the Assessment of the Stages of Change

(1) URICA – The *University of Rhoda Island Change Assessment Scale* is a 32-item questionnaire developed by the Prochaska and DiClemente research group produces scores on four subscales corresponding to *precontemplation, contemplation, action,* and *maintenance* stages of change by McConnaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983).

(2) SOCRATES – *The Stages of Change Readiness and Treatment Eagerness Scale* is 19-item questionnaire developed by Miller and Tonigan based on the stages of change model, but which yields scores on three factors that differ from the original model, but nonetheless are useful in assessing motivation. The three factors are *Ambivalence, Recognition,* and *Taking Steps* by Miller, W. R., & Tonigan, J. S. (1996).

(3) RCA - The *Readiness to Change Questionnaire* is a 12-item questionnaire developed by Rollnick et al designed to measure the *precontemplation, contemplation,* and *action stages* of the Prochaska and DiClemente stages of change model by Rollnick, S., Heather, N., Gold, R., Wayne, H. (1992).

(4) CCA – The *Commitment to Change Algorithm* is a very brief interview designed by Annis and her colleagues used to classify a client into one of five stages of change based on the model by Prochaska and DiClemente by Annis, H. M., Shober, R., & Kelly, E. (1996).

History and Relapse Susceptibility

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

Past Relapses. Most clients in treatment will have tried, either on their own or in previous treatment, to abstain from alcohol and drugs. Asking clients to describe past relapses may provide important clues to future high-risk situations for relapse. The therapist and the client can classify the descriptions of past relapses into the categories previously presented in order to determine the situational or personal factors that had the greatest impact. Cognitive reframing of past relapses will be necessary to reduce the client's fear of the prospect of yet another failure. The therapist can encourage the client to attribute past relapses as due to a lack of skill or effort, not to unchangeable internal

factors such as willpower or addictive disease. The idea that things can be different this time is a good topic to explore and challenges the client to "make it so."

Relapse Fantasies. This guided imagery technique involves asking the client to imagine as vividly as possible what it would take to resume an addictive behavior. How is a relapse likely to happen? Where is a relapse likely to happen? Under what circumstances is relapse likely to happen? Who is a relapse likely to happen with? What will the immediate and long-term consequences of the relapse be? Questionnaire techniques can also be used to gain a better understanding of a client's unique profile of high-risk situations.

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

Questionnaires Assessing a Client's Unique High-Risk Situation Profile

(1) IDTS - The *Inventory of Drug-Taking Situations* is a 50-item self-report questionnaire which provides a profile of a client's high-risk situations by measuring those circumstances in which a client has used alcohol heavily or taken drugs in the past year. This instrument uses the RPT classification system of eight categories of high-risk situations previously described (Annis, H. M., Turner, N.E., & Sklar, S. (1997).

(2) SARA - *Substance Abuse Relapse Assessment* (Schonfeld, Peters, and Dolente, 1993) is a tool for assessing a client's specific high-risk situations and coping deficits. SARA also provides the client and therapist with instructions on how

to develop an individualized substance abuse behavior chain and for describing successful coping skills used by the client to cope successfully with past high-risk situations.

Coping with High-Risk Situations

The Situational Competency Test (SCT) is a role-play technique requiring clients to give a verbal response to a series of high-risk situations presented by a narrator on audiotape. The client is presented with a series of high-risk scenarios drawn from the categories of high-risk situations previously described. Each tape-recorded vignette is followed with the question, *"What would you do or say?"* At the start of the test, the subject is instructed to imagine that the situation is actually occurring and to say the words or describe the action that he would use to respond to the situation.

Stimulus Control. These behavioral techniques are particularly important in the early stages of the maintenance phase of habit change before self-efficacy has increased and before new, more effective coping skills for handling high-risk situations have been learned. The situational and psychological cues previously associated with drinking and drug taking are likely to create craving, urges, and temptations to resume the old pattern of behavior. Several stimulus control strategies can be easily learned and applied while more extensive coping skills training is underway. The first option is avoidance of those high-risk situations that have been identified in the assessment as having the highest problem potential. While this may not be practical in all cases, there are many situations and internal states that can be avoided with some forethought and vigilance. Where avoidance is not possible or when a high-risk situation appears to occur unexpectedly, escape is the probably the best option. Some preparation may be necessary to prepare a client with escape plans for the most probable high-risk situations. Finally, if neither

avoidance nor escape is possible, delay of action may be used to interrupt a sequence of automatic, maladaptive thoughts.

Coping Skills Training. (A thorough discussion of coping skills training is provided by another guideline on this website and will only be summarized here). Once the high-risk situations have been identified, the client can then be taught to respond to these situational cues as discriminative stimuli (highway signs) for behavior change. Taken collectively, the assessment of high-risk situations and coping skills deficits can be used to target areas that require special training or attention during the coping skills training components of the relapse prevention program. Effective coping skills training focuses on those high-risk situations identified in the client's assessment as creating the greatest potential for increasing the probability of relapse. As stated earlier, in some cases, it might be best to simply avoid risky situations, if possible. In most cases, however, the high-risk situations or psychological states cannot be easily avoided, and the client must rely on coping skills or alternative strategies to "get through" the situation without a relapse.

The cornerstone of this approach to maintaining behavior change is to teach the client coping strategies with skill-training procedures (e.g., Chaney, O'Leary, & Marlatt, 1978). For clients whose coping responses are blocked by fear or anxiety, the therapist should attempt to disinhibit the behavior by the use of an appropriate anxiety-reduction procedure such as systematic desensitization and general relaxation training. For clients who show deficiencies in their coping skills, however, the therapist attempts to teach them new coping skills using a systematic and structured approach.

Adopting a problem-solving orientation to stressful situations gives people greater flexibility and adaptability in new problem situations, rather than having to rely solely on the rote learning of a number of discrete skills that may or may not generalize across various settings and situations. Coping skills training methods incorporate components of direct instruction, modeling, behavioral rehearsal, therapist coaching, and feedback from the therapist and other clients in the case of RPT groups. We also find that the modeling of self-instructional statements or adaptive self-talk is particularly useful in teaching clients cognitive self-statements to use independently or in conjunction with performance of overt behavioral coping skills.

Problem Solving. Therapists are advised to help clients identify their style of approaching problems either by eliciting examples from them or by giving them a problem and asking them to outline how they would go about solving it. Changing a maladaptive general orientation to problems is a crucial prerequisite for effective problem solving in relapse prevention. Generating alternatives is perhaps the most important step to effective problem solving. Once a list of alternative solutions has been generated a particular solution can be selected by evaluating the 'pros' and 'cons' of each solution and selecting what promises to be the best available option.

Relapse Rehearsal. Sometimes a therapist and a client can do coping skills training in vivo where the therapist accompanies the client while he or she is exposed in real life to high-risk situations. However, in those cases in which it is not practical to practice new coping skills in real-life environmental settings, the therapist can make use of imagery to represent the high-risk situation. This procedure, called a relapse rehearsal, is similar to the relapse fantasy technique mentioned earlier. In the relapse rehearsal

procedure, the therapist goes beyond the imagined scenario of relapse related to the high-risk situation and includes scenes in which the client actually imagines himself or herself engaging in appropriate coping responses. This behavioral procedure, known as covert modeling, can also be used to help clients to cope with their reactions to a slip by rehearsing cognitive restructuring techniques. Relapse rehearsal can be extended into a role-playing procedure either in individual therapy or perhaps more productively in the context of relapse prevention group work.

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

Increasing Self-Efficacy

Increase Awareness by Teaching the Principles of Self-Efficacy. High levels of both motivation and self-efficacy are important ingredients in a successful RPT program. In many cases, a particular coping response may fail to be executed despite high levels of motivation if the individual has low self-efficacy concerning his or her capacity to engage in the behavior. The converse is equally true, of course; an individual may fail to

engage in a specific behavior despite high levels of self-efficacy if the motivation for performance is low or absent ("I knew what to do, but I just didn't feel like doing it").

Self-Efficacy and Coping with High-Risk Situations. Until a high-risk situation is encountered, there is little threat to the perception of control since urges and temptations are minimal or absent. When a high-risk situation occurs, there is a conflict of motives between a desire to maintain control and the opposing temptation to give in or yield to the impulse. As defined here, self-efficacy is concerned with the person's perceived ability to perform a coping response to deal with the high-risk situation, and not with one's general ability to exercise willpower or sheer resistance to temptation. The probability of relapse in a given high-risk situation decreases considerably when the individual harbors a high level of self-efficacy for performing a coping response. If a coping response is successfully performed, the individual's judgment of efficacy will be strengthened for coping with similar situations as they arise on subsequent occasions. Repeated experiences of successful coping strengthen self-efficacy and reduce the risk that occasional failure or slips will precipitate a relapse.

Efficacy-Enhancing Imagery. Guided imagery techniques may also be used to help clients imagine themselves successfully coping with the challenge and remaining abstinent. In this procedure, the therapist can gently guide the client who is experiencing anxiety or having trouble generating successful coping strategies with subtle prompts that can later be internalized by the client. Efficacy-enhancing imagery is used to augment coping skills training and to assess the client's current level of self-efficacy and coping skills mastery.

Questionnaire Assessment of Self-Efficacy

The *Drug-Taking Confidence Questionnaire* – DTCQ (Annis, Sklar, & Turner, 1997) is available to measure a client's confidence in avoiding heavy drinking or drug use across the same eight high-risk categories and 50 specific risk situations included in the IDTS. Studies of clients confidence, or "self-efficacy" in coping with risk situations have found that clients are less likely to relapse in situations where they have a high level of confidence in their ability to cope. The DTCQ allows therapists to gauge a client's confidence in coping with high-risk situations at different stages in the treatment process, providing a measure of the client's progress. Like the IDTS, the DTCQ can be used for alcohol and other drugs and is available in both computerized and paper-and-pencil formats.

Coping with Lapses

What to Do when a Lapse Occurs. Of course, the occurrence of a lapse cannot be viewed as a totally benign event; nor should it be cause for catastrophizing and giving in to a full-blown relapse. During a lapse episode (slip) the most dangerous period is the time immediately following the event. Since specific coping strategies will vary from client to client, therapists may wish to help a particular client to prepare an individualized reminder card that fits that person unique set of vulnerabilities and resources.

The follow list contains a variety of recommended strategies to employ if a lapse occurs. Clients can be told to think of this list as a set of emergency procedures to be used in case a lapse occurs. The strategies are listed in order of temporal priority, with the most important immediate steps listed first. The main points of this information can

be presented to clients in summary form by the use of a Reminder Card that should be kept handy in the event that a lapse occurs.

(1) *Stop, look, and listen.* The first thing to do when a lapse occurs is *to stop* the ongoing flow of events and to *look* and *listen* to what is happening. The lapse is a warning signal indicating that the client is in danger.

(2) *Carry out Lapse Management Plan.* After a slip, renewed commitments should be turned into a plan of action to be carried out immediately. Therapists can help clients identify *Emergency Action Plans*, which may include a crisis hotline telephone number, an alternative activity, or a trustworthy friend.

(3) *Keep Calm*. Just because the client slipped once does not indicate failure. One slip does not have to make a total relapse. Look upon the slip as a single, independent event, something that can be avoided in the future. A slip is a mistake, an opportunity for learning, not a sign of total failure.

(4) *Renew Commitment.* After a lapse, the most difficult problem to deal with is motivation. The client may feel like giving up and may need reminding of the long-range benefits to be gained from this change. Clients should be encouraged to reflect optimistically on their past successes in being able to quit the old habit, instead of focusing pessimistically on current setbacks.

(5) *Review the situation leading up to the lapse.* Look at the slip as a specific unique event. The following questions may help clarifying the lapse episode: What events led up to the slip? Were there any early warning signals that preceded the lapse? What was the nature of the high-risk situation that triggered the slip? Each of these questions may yield valuable information concerning sources of stress and high-risk situations for the client. The fact that a slip occurred often is an event that tells you that something is going on that needs attending to.

Dealing with the Abstinence Violation Effect The cognitive restructuring process designed to assist clients to cope with a lapse after a period of abstinence or controlled use includes the following points:

(1) Teach clients not to view the cause of the lapse as a personal failure or as a lack of willpower, but instead ask them to pay attention to the environmental and psychological factors in the high-risk situation, to review what coping skills they had available but didn't implement, and to notice how they felt decreased self-efficacy when they couldn't deal with the situation adequately.

(2) Clients may need help to deal with the inevitable feelings of guilt and shame and the cognitive dissonance that usually accompany a lapse. Guilt and shame reactions are particularly dangerous because the emotions they produce are likely to motivate further substance use or other addictive behaviors as a means of coping with these unpleasant reactions to the slip.

(3) After the lapse has occurred, the RPT approach is to react to the client with compassion and understanding, but with the encouragement to learn everything possible about how to cope with similar situations in the future by a thorough debriefing of the lapse and its consequences

(4) Help clients identify any of the cognitive distortions they may have succumb to in exposing themselves to the high-risk situation, limiting their ability to engage in an effective coping response, and finally, making the decision to choose to take that first drink, dose of drugs, or to engage in criminal activity.

(5) Consult and revise the Decision Matrix or Decision Balance Sheet to renew motivation by focusing on the practical advantages for others and the client of continuing on the journey of habit change.

Global RPT Intervention Strategies

Providing clients with behavioral skills training and cognitive strategies to effectively cope with high-risk situations and lapses is vital to the success of any relapse prevention program. These techniques are likely to be the exclusive focus of efforts to abstain and to remain abstinent from the addictive habit in the early part of the maintenance stage of therapy. However, simply teaching clients to cope with one high-risk situation after another is not enough for long-term success in addictive or criminal behavior habit change. This is true because it is impossible for the therapist and client to identify all possible high-risk situations that the client may encounter.

Our experience has shown us that to develop a more comprehensive and effective program of habit change, it is necessary to do two additional things: (1) to help the clients develop a more balanced lifestyle in order to increase their overall capacity to cope with stress and to gradually increase self-efficacy, and (2) to teach clients how to identify and

anticipate the early warning signals that preceded exposure to high-risk situations and to implement self-control strategies designed to reduce the probability of a lapse or a relapse. We summarize these Global RPT Interventions in this section. A detailed description of Lifestyle Modification can be found in Marlatt & Gordon (1985).

Lifestyle Balance

Our research studies and clinical experience suggest that the degree of balance or imbalance in a person's daily life has a significant impact on the desire for indulgence and immediate gratification. Lifestyle imbalance is the first covert antecedent in a chain of events that can lead to a relapse set-up. We define lifestyle balance as the degree of equilibrium that exists in one's daily life between the variety of activities a person engages in and the effects of those activities on one's level of health and well being.

More broadly conceived, lifestyle balance refers to the amount of stress in a person's daily life compared with stress reducing activities such as social support, exercise, meditation, or other stress buffering or relieving activities. Lifestyle balance is also related to diet, social relationships, and spiritual endeavors. In the most global sense, lifestyle balance is based on the principle of moderation. When one experiences lifestyle imbalance because negative factors are greater than positive ones, the RPT model predicts that a desire for indulgence will occur. A common pattern is the individual who spends most of their day engaged in demanding "shoulds" and attempts to balance this disequilibrium by engaging in an excessive "want" at the end of the day to restore balance, including excessive use of alcohol or other substances.

Whatever the cause of lifestyle imbalance, this factor is likely to be the first in a chain of covert antecedents that become relapse set-ups by creating exposure to high-risk

situations that may precipitate a lapse or evolve into a full-blown relapse. The first step in applying Global RPT Interventions is to assess the client's quality of life with a focus on sources of lifestyle imbalance. This discussion of the client's lifestyle is most likely to occur at a time during the therapy process when some progress had been made in identifying and coping with high-risk situations. An unstructured interview is a good place to start assessing lifestyle balance by paying attention to the areas of life previously mentioned by the client.

Increasing Lifestyle Balance

Lifestyle modification procedures are designed to identify and circumvent the covert antecedents of relapse that set-up exposure to high-risk situations and to promote lifelong habit change to create greater mental, emotional, physical, and spiritual wellbeing. The specific lifestyle modifications recommended in the RPT approach depend on the client's unique needs and abilities. A program of exercise such as jogging, hiking, or skiing; meditation, yoga, or reading; enhanced social activities with new friends; or weekly massage to reduce muscle tension are among the many possibilities.

Coping with Desire for Indulgence

Because lifestyle imbalance is likely to create a desire for indulgence, one effective strategy is to search for activities that might be substitute indulgences that are not harmful or addictive, but that over time with repeated practice, can become adaptive wants that provide some of the same pleasure and enjoyment that addictive behaviors have provided without the delayed costs. In this regard, Glasser (1974) described behaviors such as excessive drinking and drug abuse as negative addictions that initially feel good, but produce long-term harm. Conversely, Glasser describes "positive

addictions" (e.g. running, meditation, hiking, hobbies) as producing short-term discomfort or even pain while creating long-term benefits to physical health and to psychological well-being.

Positive addictions often become wants as the individual begins to gain mastery and looks forward to engaging in these activities as source of pleasure and misses the enjoyable effects of the positive addiction, if the activity is not engaged in on a regular basis. An added benefit of positive addictions is that they often are associated with the development of related skills and new social relationships which often increase a person's self-efficacy and can create social networks with peers that model and support a more healthy lifestyle. The regular practice of these behaviors is associated with a greater sense of ease and relaxation and improved physical, mental, and social well being.

Coping with Urges and Craving

The desire for indulgence alone does not set up a relapse, instead relapse is also promoted by affective and cognitive processes that mask a person's true intentions and move the person closer to a high-risk situation. On the affective side, the desire for indulgence may be experienced as an urge or craving for the prohibited substance or behavior. Most people experience urges and cravings as somatic states, strong emotions, or nonverbal impulses. RPT defines an urge as the relatively sudden impulse to engage in a pleasurable act. Craving is defined as the subjective desire to experience the expected effects of a given behavior. Various techniques for coping with craving and urges are:

(1) *Stimulus control.* Despite one's best attempts to modify lifestyle and to learn and practice positive additions and substitute indulgences, occasional urges and cravings, sometimes of great intensity, may still surface from time to time. On some occasions, urges and craving are triggered by external cues such as the sight of others engaged in drinking or drug use or by simply finding a joint of marijuana tucked away in some forgotten hiding place. The frequency of these

externally triggered urges and craving can be reduced by using stimulus control techniques designed to minimize exposure to these cues. In some circumstances, simply avoiding the situation is the best strategy especially situations filled with multiple cues for indulgence. For a time, before coping responses are strong, this may mean curtailing certain activities until exposure to these cues can be mastered without precipitating a lapse.

(2) *Cue Exposure*. Stimulus control techniques such as avoidance are at best short-term solutions to the problems posed by urges and craving. Eventually, the client will have to learn and master effective techniques to cope with these tempting situations. One emerging approach in this regard is cue exposure (Drummond, Tiffany, Glautier, & Remington, 1995). Cue exposure involves systematically exposing clients to environmental cues for substance abuse or other addictive behaviors in the course of treatment. Cue exposure is most effective when exposure to alcohol or drug cues is paired with strategies and techniques designed to prepare clients to cope with the kinds of temptations they will encounter in course of their everyday lives. Cue exposure treatments have shown some efficacy in reducing relapse to alcohol, nicotine, opiates, and cocaine (Drummond et al, 1995).

(3) *Coping Imagery*. A person experiencing a craving for some substance or activity has a tendency to feel as the though the pressure is building up inside them and that it will mount precipitously until their resolve to abstain and their resistance collapses under the overwhelming pressure of a rapidly inflating balloon that will eventually explode. Using a wave metaphor, we have developed a Coping Imagery technique, "Urge Surfing", to help client's gain control over these seemingly unmanageable events. In this technique, the client is first taught to label these internal sensations and cognitive preoccupations as an urge or craving that is beginning to develop and to foster an attitude of detachment and disidentification regarding this wave of desire. Clients are initially taught the urge surfing technique through guided imagery and then to try it on their own whenever they are exposed to substance cues.

(4) *Self-Monitoring of Urges and Craving – The Craving Diary*. Another way to foster detachment from urges and craving is to have clients use Self-Monitoring Procedures to keep track on these experiences. The Craving Diary is a technique used in a number of RPT programs to gain information and to help cope with craving. The client is asked to keep track of the internal and external cues that stimulated a craving, their mood, the strength of the craving, how long it lasted, coping skills such as urge surfing used to cope with the craving, and how successful or unsuccessful these coping strategies were.

Coping with Rationalization, Denial, and Apparently Irrelevant Decisions (AIDs)

In addition to the affective processes related to urges and craving just described, covert antecedents of a relapse episode are also influenced by three cognitive constructs: Rationalization, Denial, and Apparently Irrelevant Decisions (AIDS) which are associated with the chain of events preceding exposure to a high-risk situation. A rationalization is an explanation or an ostensibly legitimate excuse to engage in a particular behavior. Rationalizations are used to allow the individual to approach a given situation or behavior without acknowledging to themselves or to others the real purpose or intention of their actions. Our use of the term rationalization is consistent with the psychoanalytic use of the term as a defense mechanism in which the individual attributes false, but credible motives as the cause of a proposed behavior without paying attention or giving credence to the "true" or underlying reasons for the behavior. Denial is a similar defense mechanism where the individual refuses to recognize selected aspects of their motivations, decisions, or certain characteristics of a situation or set of events. The person will usually deny the existence of any motive to engage in a relapse and may also deny awareness of the delayed negative consequences of resuming the addictive habit or criminal activity.

Both rationalization and denial are cognitive distortions that occur with minimal awareness and may underlie an individual's covert planning of exposure to a high-risk situation. These two cognitive distortion mechanisms are usually combined to influence an individual to make certain choices or decisions that ultimately become part of a chain of events ending in relapse. A person influenced by these cognitive processes makes a number mini-decisions over time, each of which seems innocent or irrelevant in and of

itself, but which in combination bring the person closer to the brink of exposure to a relapse triggering high-risk situation. These mini-decisions or Apparently Irrelevant Decisions inch the person closer to exposure to a high-risk situation where a subsequent lapse is likely and where the potential for relapse is greatly increased. One of the primary goals of the RPT program is to train individuals to recognize early warning signs that precede exposure to a high-risk situation and to execute intervention strategies before it is to late to do anything because the temptations are too compelling to resist.

Urges and cravings usually do not operate at a conscious level, but are likely to be masked by the cognitive distortions and defense mechanisms described in our discussion of covert antecedents of high-risk situations. As such, these dimly perceived sensations and strong emotions fueled with forbidden desires set-up the possibility of relapse by bringing the person closer to exposure to a high-risk situation. Teaching clients to become vigilant for these early warning signals and to engage in explicit self-talk which questions their motivations and intentions can help them to recognize and acknowledge the direct relevance of these Apparently Irrelevant Decisions to the increased risk of relapse. This may allow the client to begin to see through their rationalization and denial by recognizing the true meaning and likely outcome (relapse) of the decisions they may not be taking responsibility for making.

Conclusion

In this RPT Clinical Guideline we have provided an extensive description of how-to implement a RPT program. The strategies described here can be used as a stand-alone treatment or in combination with other treatments, such as twelve-step approaches, coping skills training, cue exposure, motivational interviewing, or community

reinforcement approaches. While we have attempted to present the empirical evidence supporting relapse prevention, more research and clinical investigation needs to be conducted on the active components of a RPT intervention. The development of more precise assessment instruments for identifying high-risk situations and the main components of the cognitive behavioral model of relapse will advance our understanding of why individuals relapse and how we, as clinicians, can prevent a relapse from occurring.

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1. *Cognitive Behavioral Therapy* in the General Psychology Course Outline, Southern Arkansas University—Magnolia. Updated: January 13, 2001. Instructor: Edward P. Kardas
   http://www.peace.saumag.edu/faculty/Kardas/Courses/GPWeiten/C15Therapy/CogBeh.html

2. The CBT Web Site: http://www.cognitivetherapy.com/fuller.html or
   http://www.cognitive-behavior-therapy.org/

3. Center for Cognitive Therapy at the University of Chicago Department of Psychiatry:
   http://psy-svr1.bsd.uchicago.edu/cct/

4. The Cognitive Therapy Pages by Robert Westermeyer, Ph.D.:
   http://www.cts.com/crash/habtsmrt//cogtitle.html

5. Beck Institute for Cognitive Therapy and Research: http://www.beckinstitute.org/

6. Albert Ellis Institute - Rational Emotive Behavior Therapy (REBT):
   http://www.rebt.org/

7. National Institute on Drug Abuse: Therapy Manuals for Drug Addiction: A Cognitive-Behavioral Approach: Treating Cocaine Addiction by Kathleen M. Carroll:
   http://165.112.78.61/TXManuals/CBT/CBT3.html or
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8. National Institute of Corrections: Cognitive-Behavioral Programs: A Resource Guide to Existing Services. Marilyn Van Dieten,. 1997.:
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9. Thinking for a Change: NIC Cognitive Behavioral Program for Offenders: An integrated, cognitive behavior change program for offenders that includes cognitive restructuring, social skills development, and development of problem solving skills. The curriculum was developed in the late 1990s by Barry Glick, Ph.D., Jack Bush, Ph.D., and Juliana Taymans, Ph.D., in cooperation with the National Institute of Corrections.: http://www.nicic.org/services/special/t4c/default.htm

10. Minnesota Cognitive-Behavioral Network: http://www.maccac.org/mncognet.htm

11. EFFECTING CHANGE:
    A Cognitive Behavioral Approach to Working with Youths in Custody
    http://www.lfcc.on.ca/effect.htm