National Institute on Drug Abuse

Clinical Report Series

Relapse Prevention

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CONTENTS

1. INTRODUCTION

As every drug abuse treatment practitioner knows, relapse—the resumption of substance use after a period of abstinence—is a frustrating but frequent part of the recovery process. Several substances, including opiates, cocaine, and alcohol, have particularly high relapse rates, with the majority of clients relapsing within 1 year following treatment. The first 90 days after treatment are an especially vulnerable time (Hunt et al. 1971).

While many people with chemical addictions eventually achieve and maintain permanent sobriety (often after repeated treatments), others do not. Research shows that fewer than half of all treatment clients achieve permanent abstinence, even though treatment does result in substantial decreases in drug use (Hubbard et al. 1989). This high rate of relapse has a profound impact not only on the clients being treated but also on both the counselor providing the treatment and program administrators, clinicians, and support staff.

The purpose of this clinical report is to describe relapse prevention strategies that can be applied after, or in conjunction with, primary treatment. In general, these strategies focus on training clients to anticipate and cope with the possibility of relapse, and helping clients modify their lives to reduce their exposure to high-risk situations and strengthen their overall coping abilities. While considerable additional research is needed regarding the best approaches to relapse prevention—especially in the areas of women's treatment, minority services, 12-step programs and pharmacotherapies—research has clearly shown that practitioners should integrate relapse prevention into their services.

G. Alan Marlatt has developed the most elaborate and influential model of the relapse process yet researched (Marlatt and George 1984; Marlatt and Gordon 1980, 1985). His conclusions regarding relapse prevention have significant implications for treatment delivery:

- Abstinence, not controlled use, must be the ultimate goal.
- Clients should be helped to recognize that one or more temporary lapses are likely to occur. This recognition must be instilled in a way that does not appear to give permission for occasional drug use.
- Clients should be taught skills for anticipating, avoiding, and coping with their personal high-risk situations.
- Clients should be taught constructive responses to cope with lapses when they do occur.
- Any positive expectations that clients have about drug use should be countered with reminders about the lows that follow the highs and about the long-term negative consequences of substance abuse.

Being a client should not be a lifelong condition. Ultimately, recovering addicts must be prepared to manage on their own. They must learn a program of self-management to cope with drug cravings and social pressures to use drugs. They must find new ways of responding to emotional stress and physical pain. They must integrate themselves into a new social network and learn to find pleasure in drugfree activities. In short, they must develop a new way of life. Helping recovering addicts meet these challenges is the essence of relapse prevention.

Two systematic relapse prevention approaches presented in this paper have been empirically tested and found to help prevent relapse. One approach, called Recovery Training and Self-Help (RTSH), was tested in Hong Kong; Boston; Worcester, MA; and Providence, RI, with substance abusers who had been in treatment several times and had experienced several relapses. The study subjects and a control group of addicts who did not participate in the program were followed for a year after they completed the program. The addicts who participated in the program were more likely than those in the control group to remain abstinent or use drugs less often, more likely to find jobs, and better able to reintegrate into the community (McAuliffe 1990). To date, the RTSH program has been successfully replicated in a number of treatment facilities in the United States, including Spectrum Addiction services in Massachusetts, Project Return in New York, and the Center for Alcohol and Drug Treatment in Minnesota.

A second relapse prevention approach, called Cue Extinction, has been tested at the University of Pennsylvania Addiction Research Center and the Substance Abuse Treatment Unit of the Philadelphia Veterans Administration Medical Center since 1982. More than 50 male inpatient and outpatient cocaine addicts have participated in the study, along with a control group of cocaine addicts who did not receive Cue Extinction training. The results show that addicts receiving the Cue Extinction treatment have had more clean urine specimens, reported less craving, and stayed in treatment longer than those who did not (Childress et al. 1986; O'Brien et al. 1990). Decreases in conditioned craving in response to drug-related stimuli have also been produced with opioid addicts (Childress et al. 1986; McLellan et al. 1986).

Self-help programs, a third major relapse prevention approach, have not been empirically tested, largely because such research is precluded by the anonymity guaranteed to members of 12-step groups. However, researchers believe that the available clinical evidence indicates that self-help programs help many substance abusers cope successfully with threats to recovery. In addition, self-help programs have attracted millions of members in the past 60 years, and most clinicians believe they are very helpful—even essential—in assisting clients to avoid relapse.

Medications are a fourth approach to relapse prevention. While considerable research has documented the effects of disulfiram (Antabuse) to help alcoholics avoid relapse, much less is known about the usefulness of medications for helping other drug addicts stay clean. However, a number of studies have presented promising results regarding the effectiveness of a few medications administered to prevent relapse among opiate addicts, most notably naltrexone (Kosten 1989, 1990; Kosten and Kleber 1984).

The first section of this report presents the theoretical basis of relapse prevention, focusing on the nature of the relapse experience and factors that seem to be associated with relapse. The second section describes general strategies used in current relapse prevention programs: social support strategies (securing help from other people), lifestyle change strategies (learning how to participate fully in society without drugs), and cognitive/behavioral strategies (recognizing and learning how to avoid or cope with threats to recovery.) Section three describes four systematic relapse prevention approaches: Recovery Training and Self-Help, Cue Extinction, 12-step programs, and medications. Section four discusses issues involved in providing relapse prevention services to women, minorities, adolescents, and gays and lesbians. The final section addresses briefly the key planning and administrative issues involved in implementing a relapse prevention program. The appendix lists additional resources for learning more about implementing systematic relapse prevention efforts.

2. THE THEORETICAL BASIS OF RELAPSE PREVENTION

Attempts to prevent relapse are based on a common understanding of the concept of relapse and specific theories of why and how substance abusers relapse.

Concept of Relapse

Relapse may be defined in several ways:

- the resumption of drug use after a period of abstinence;
- a return to previous levels of use;
- the return to addiction; and
- an unfolding process in which the resumption of substance use is the last event in a long sequence of maladaptive responses to internal or external stressors or stimuli.

All of these definitions reflect the same essential concept: a resumption of frequent, perhaps uncontrolled, substance use.

Lapse versus Relapse

Most treatment specialists distinguish between a lapse and a relapse. A lapse is considered a single incident of substance use. A lapse (or "slip") may or may not result in a relapse—regular use—depending on how the client responds to the initial incident. In fact, reacting to a lapse as if it represents or will inevitably lead to a full relapse can be a self-fulfilling prophecy. A lapse should instead be viewed more productively as a mistake and an opportunity for intervention and further learning. Even a fullblown relapse may not be accompanied by the complete resumption of a "drug abuse lifestyle" but may instead result in the drug user seeking renewed treatment. For this reason, relapse must be further distinguished from a total regression back to drugs that includes all the features of the "drug life."

There is no sharp definitional line between the concepts of lapse and relapse. If a person smokes one marijuana cigarette, that constitutes a lapse. If he or she immediately smokes a second, does that signal a relapse, or is it part of the original lapse? A distinction can also be made between a "binge"—that is, a time-limited episode of heavy use—and a full relapse. With these shadings in mind, some researchers argue that relapse should be considered on a continuum, with the extent of renewed substance use defining the degree of relapse (McAuliffe et al. 1986).

Multiple Drug Use

Another complicating factor in defining relapse is multiple drug use. The focus of a clinical assessment is usually whether an exuser resumes use of the specific substance for which the person was originally treated. However, polydrug use is now the norm among individuals seeking treatment (Rounsaville 1986). Moreover, it is common for recovering persons to rely on other substances to suppress cravings for their drug of addiction (Jorquez 1984).

> *A woman with a 14-year history of marijuana dependence decides to stop using the drug. The woman never had a problem with alcohol and, in fact, drank only on rare social occasions. She would go to a bar to socialize with friends and drink ice water, with no desire to drink alcohol. However, once she stopped using marijuana, she found that she would go to the bar and drink to get drunk. Upon exploring this experience, she was able to see that she drank in order to gain a brief respite from her constant craving for marijuana. If she continued this behavior, she would probably end up having substituted an alcohol problem for her marijuana problem.*

Clinically, the use of any substance is a lapse and may lead to a fullblown relapse. To effectively prevent relapse, intervention programs teach persons in recovery to abstain from all substance use in order to prevent the substitution of one "drug of choice" for another. To reflect this goal, intervention programs may wish to apply a broad definition of relapse that takes into account the possibility of drug substitution (Rounsaville 1986; Schonfeld et al. 1989).

Marlatt's Relapse Model

G. Alan Marlatt has developed the most elaborate and influential model of the relapse process to account for relapse among alcoholics (Marlatt and George 1984; Marlatt and Gordon 1980, 1985). The principles of the model apply to several addictions, even compulsive gambling and overeating.

Instead of focusing on criminal history, severity of addiction, or other personal characteristics associated with relapse, Marlatt's model focuses on *the events surrounding initial drug use after a period of abstinence*. The starting point in the process from abstinence to relapse is when a client is exposed to a high-risk situation that threatens sobriety. A lapse is more likely to occur if the individual:

- has not learned any effective coping responses to deal with the situation; or
- expects beneficial effects from substance use in the situation.

Whatever its causes, a lapse can ultimately result in relapse through a process Marlatt calls the "abstinence violation effect," or AVE.

Abstinence Violation Effect (AVE)

The AVE has two components. First, the addict's knowledge of having used a substance again directly contradicts his or her self-image as a recovering person who has vowed to remain abstinent. Because this contradiction is perceived as a threat to that image, the client may experience guilt, shame, or anxiety about not having been able to remain abstinent. The nature and strength of these feelings depends on how long the client has been drugfree, the person's overall level of effort to remain abstinent, and his or her previous level of confidence in being able to maintain sobriety. In order to obtain relief from these negative feelings, the client may then continue to use drugs. In this situation, the initial lapse becomes the precipitant of a fullblown relapse.

The second component of the AVE postulates that relapse is more likely to occur when the client attributes the lapse to a cause that is internal, stable, and global—and, therefore, is perceived to be uncontrollable. Explaining the lapse this way results in feelings of hopelessness. For example, if the client believes that the lapse is due to personal lack of willpower, and that this lack of willpower is a permanent characteristic of his or her personality, the lapse will reduce the client's confidence that he or she will be able to resist temptation on future occasions (Bandura 1982, 1984; Curry et al. 1987). In contrast, coping effectively with a lapse increases the client's feelings of self-efficacy (see below), making it more likely that the person will be motivated to take actions to cope successfully with future situations in which relapse might occur.

The Concept of Self-Efficacy

The self-efficacy concept is another important element of Marlatt's model. Self-efficacy is the conviction that one has the capacity to execute a behavior that will result in desired outcomes—that is, a person's perception about his or her ability to engage in or avoid a specific behavior at a particular time and place. Whether people believe they have this capacity partly determines their ability to engage in subsequent behavior change—be it the suppression of existing behaviors or the acquisition of new ones (Strecher et al. 1986).

Self-efficacy expectations influence whether the recovering addict initiates coping behaviors when a lapse occurs and how long and how vigorously he or she will sustain the coping behaviors in the face of obstacles.

> *A 16-year-old boy begins his first attempt to abstain from cocaine use in summer. Because he does not trust his ability to stop smoking cocaine if he is in a situation where others are smoking, he believes he needs to avoid his old cocaine-using friends. The boy has confidence he can do this, and he is able to make excuses when they telephone him and avoid places where he expects to encounter them. As the boy repeatedly copes successfully with his friends' approaches, he feels more and more confidence in his ability to break off ties with them. By the time school begins in September, he has developed enough confidence in his ability to*

resist his friends' approaches over the telephone that he can now turn them away in face-to-face encounters. The boy begins to spend time with old friends who do not use cocaine.

Then, one day, he goes to a party with one of his nonusing friends. They enter a room in which people are smoking cocaine. The boy has not prepared himself for this particular encounter; as a result, he does not believe that he can resist this direct a temptation. He gives in and uses. The next day, he feels terribly guilty and blames himself for his failure, attributing his use to an inability to resist temptation. Since his best efforts to avoid exposure to temptation were unsuccessful, he now believes that it is impossible to avoid every situation where he might encounter cocaine. He concludes that his attempt at abstinence is doomed to failure. His feelings of hopelessness in the face of this conclusion are more than he can tolerate; as a result, he calls one of his old cocaine-using friends and his lapse becomes a relapse.

Seemingly Irrelevant Decisions

Another concept of the Marlatt model, "seemingly irrelevant decisions," also has important implications for relapse prevention. This concept postulates that the recovering addict makes a series of apparently innocuous behavioral choices that eventually expose the person to drug stimuli and risk of relapse. For example, a person might elect to drive down a certain street, thinking nothing of it, then decide to visit a familiar bar, then have a few drinks, and then seek out drug-using friends. Clients need to learn how to recognize and interrupt these "decision chains" but are often unaware of these early indicators of possible relapse. Counselors need to train clients to analyze carefully their previous relapses for the earliest signs that they may be on the road to relapse.

A woman who had been addicted to heroin for 10 years and had been through two intensive treatment programs followed by periods of abstinence of several months entered treatment for the third time. A great deal of effort was spent going over the periods prior to each relapse. A number of signs of impending relapse were detected of which she had been unaware, including feeling angry when her boyfriend asked where she was going even if her destination was innocent, canceling counseling sessions she might have attended with a bit more effort, and being unwilling to spend money on her children. Several weeks later when she called to cancel an appointment, her counselor asked if there was any possible way she could make the session; the client did manage to arrange to be there. During the session, the counselor probed for other signs of impending relapse that they had previously identified. The client burst into tears when she realized that she had set things up so that she could use heroin on the upcoming holiday weekend if she felt the urge to do so. Without realizing it, she had put aside the money and made the kind of plans that would have allowed her to "cover up" her whereabouts had the need arisen.

Limitations to The Marlatt Model of Relapse

Research has supported several features of the Marlatt model of relapse. One study asked people who were trying to stop smoking to predict their ability to cope when they felt restless, experienced negative emotions, or faced stressful situations. Overall, clients with higher self-efficacy expectations had more successful treatment results, at least in the short term. Of those exsmokers who relapsed, over 80 percent experienced mild to severe guilt following their first lapse, which in turn reduced their confidence in being able to cope with future urges to smoke. In contrast, some degree of guilt was experienced by under 40 percent of those who lapsed but did not pick up their smoking habit again (Condiotte and Lichtenstein 1981). Other studies have confirmed this relationship between experiencing guilt and suffering relapse (Curry et al. 1987; McIntyre et al. 1983).

By contrast, clients in these studies who were most likely to show the AVE were not, as predicted, those who had previously been the most confident about being in control of their smoking behavior. In fact, preexisting confidence seemed to shield clients from this phenomenon rather than exacerbate it. Again in contradiction to the Marlatt model, research has shown that exsmokers who were on the brink of relapse experienced a drop in feelings of self-efficacy whether they had lapsed or not. Rather than feeling more self-confident as the model predicts, exsmokers who successfully coped and did not start smoking again still became concerned about their ability to manage relapse crises (Shiffman 1984).

Despite these limitations to the Marlatt model of relapse, the empirical underpinnings of the theory appear promising. Furthermore, recent empirical studies suggest that the model may apply to abusers of other drugs as well as alcoholics and cigarette smokers (e.g., Tulkin et al. 1989; Myers and Brown 1990; Carroll et al. 1991; McKay et al. 1992).

Other Models of Relapse

Other theoretical models of relapse have concentrated on what leads up to the initial lapse.

- *Classical Conditioning*

Classical conditioning theory has been especially important for understanding the impact of both external and internal cues on cravings. Also known as Pavlovian conditioning, this model hypothesizes a form of learning in which a normally innocuous stimulus, called the conditioned stimulus, acquires the power to elicit a behavioral response through its association with a significant stimulus, called the unconditioned stimulus.

Two types of classical conditioning effects can result in cravings (Ludwig 1986). Some conditioned stimuli can trigger *unpleasant emotional states*—even withdrawal symptoms—that substance use might temporarily relieve. For example, a client who has stolen money and jewelry from his parents to purchase drugs might find that receiving a letter from home arouses

feelings of shame and guilt which then stimulate the desire to smoke cocaine. Other stimuli can trigger *positive expectations* of anxiety reduction, pleasure, or even euphoria. For example, a client who was abstaining from marijuana use had to leave a movie which he had previously seen while using with friends because he found himself dwelling on the memory of the pleasurable high and began to experience an urge to recreate it.

While the stimuli that trigger conditioned cravings are highly individualized, the following situations arouse craving in many addicts:

- the presence of drugs, drug paraphernalia, or drug users;
- places where drugs were previously bought or used;
- suddenly having a lot of cash;
- having nothing to do;
- strong negative or positive feelings; and
- physical pain (McAuliffe and Ch'ien 1986; O'Brien et al. 1990).

The importance of these conditioned cravings is that they can persist long after physiological dependence has ended.

Relapse Syndrome

The relapse syndrome model of relapse emphasizes the role of personal distress in the failure to stay off drugs (Gorski 1986, 1990). The precipitating cause can be internal (e.g., irrational thoughts, distressing emotions, painful memories) or external (e.g., serious life problems, chronic daily stress, physical pain). In the absence of active coping skills, the individual may regress from stability into a period of increasing distress ending in physical or emotional collapse. This syndrome can be exacerbated by "post acute withdrawal," which can result in an inability to think clearly, memory deficits, and emotional overreaction.

This downward spiral may intensify until the individual turns to drug or alcohol use for relief. Some clients who begin using again fully intend to resume uncontrolled substance abuse. Others attempt controlled use, consuming just enough alcohol or drugs to manage their distressful symptoms, but this initial lapse can lead to the previously discussed AVE and then to a fullblown relapse.

The relapse syndrome model sees relapse as a process whose roots lie in physical, psychological, or social dysfunction. That is, relapse occurs because individuals lack other means besides drugs to cope with stressors in their lives. Some of these stressors may be direct results of previous substance use, while others may predate it. Someone with chronic pain may continuously revert to substance use because it is his or her only source of relief. A woman who has lost her children due to her substance abuse may begin the process of recovery, only to find herself unable to deal with the feelings of guilt and loss that begin to surface. To drown out this

pain, she returns to substance use. A man may find himself too nervous to approach women unless he has had a few drinks; this means of coping with his stress may lead to relapse.

Two key implications of this model are that (1) primary treatment needs to address and resolve dysfunctions the client is experiencing, after which (2) relapse prevention programs should teach clients to be alert for cognitive, attitudinal, emotional, or behavioral warning signs that appear long before actual substance use reoccurs so that they can apply coping strategies unimpeded by their previous dysfunctions (Daley 1986, 1989; DeLeon 1990–91).

Causes of Relapse

Understanding the causes of relapse must begin with two observations. First, relapse cannot be explained solely as a physiological response to withdrawal since it often occurs long after drug use has ceased and physical dependence has ended (Shiffman 1984). Second, relapse is not a problem of lack of proper motivation or sufficient willpower. The vast majority of relapse-prone clients acknowledge their chemical dependence and are strongly motivated to change their lives in ways that will support their abstinence (Gorski 1990).

While no client characteristics predict which addicts will successfully complete treatment, treatment outcome studies (Babor et al. 1986; McLellan et al. 1983; Simson 1984; Simson and Marsh 1986; Vaillant 1988) have shown that opiate abusers are more likely to *relapse* during or after treatment if they have a:

- criminal record;
- weak employment record;
- history of severe addiction, or
- coexisting psychiatric disorder.

Another crucial documented factor in avoiding relapse is the client's commitment to total abstinence, as opposed to controlled use. Interviews with cigarette smokers, alcoholics, and opiate addicts who were completing abstinence-oriented treatment programs found that clients committed to absolute abstinence were not only less likely to lapse but also less likely to relapse if they did have a lapse (Hall et al. 1990).

Research on the events or occurrences that precede relapse involves asking clients to recount the events that led to their initial lapse (Annis 1990; Baer and Lichtenstein 1988; Brandon et al. 1986; Daley 1989; Leukefeld and Tims 1986; Marlatt and Gordon 1980; Schonfeld et al. 1986; Shiffman 1982, 1986; Schiffman and Jarvik 1987; Wallace 1989; Weiner et al. 1990; Wesson et al. 1986). These self-reports indicate that relapse episodes tend to occur under similar circumstances for a variety of substances (e.g., heroin, cocaine, alcohol, tobacco, and other drugs). Significant factors associated with relapse include the following:

- ***Stress.*** Whether due to discrete negative life events or everyday hassles, stress greatly increases vulnerability to relapse.

- ***Negative Emotions.*** A wide range of emotions, including anger, anxiety, depression, and frustration, can precipitate relapse. The need to blot out these emotions is a much stronger determinant of relapse than the desire to feel good.

- ***Positive Emotions.*** Good feelings that come from socializing can sometimes trigger relapse. In other cases, drug use might be used as a reward or a means of celebration.

- ***Interpersonal Conflict.*** Relapse is often associated with conflict with family members and other individuals brought on by poor communication, unresolved conflicts, and other factors.

- ***Social Pressure.*** Sometimes social pressure is overt, as when someone offers the addict a drug. Often it is not. Being enmeshed in a social network in which other people abuse substances is especially risky.

- ***Use of Other Substances.*** Use of another substance can trigger cravings for the primary drug of abuse, undermine self-control, or impair a person's ability to respond effectively to a relapse crisis. Taking prescribed medications can also be problematic.

- ***Presence of Drug-Related Cues.*** Environmental cues (e.g., drug paraphernalia, or people or places associated with substance use) elicit strong cravings in some people.

The importance of each of these precipitating factors varies from person to person. In addition, relapse is often the result of several of them acting in combination.

This section has presented several theories for why many addicts relapse even after they have been physically detoxified of all traces of illicit drugs and have participated in a drug treatment program. The following section describes four relapse prevention strategies that hold considerable promise for reducing this high rate of relapse.

3. GENERAL RELAPSE PREVENTION STRATEGIES

Treatment works . . . at least for a while. The challenge to clients is maintaining abstinence when they return to their everyday lives. It is therefore surprising that aftercare programs focusing on relapse prevention have only recently become the subject of widespread examination and study. To prevent relapse, many treatment programs offer graduates only crisis intervention counseling, an unstructured aftercare group, or referral to a self-help group (McAuliffe 1990).

There are several reasons why many service providers have only recently begun to recognize the benefits of focusing major attention on relapse prevention (Baker et al. 1989; Gorski 1989; Weiner et al. 1990; Zackon et al. 1993):

- fear that telling clients they might lapse will give them "permission" to fail, thereby undermining the absolute control that is necessary to prevent renewed addiction;

- the belief that focusing on techniques for avoiding relapse will be ineffective because only attention to the psychopathology believed to underlie craving and addiction will prevent relapse;

- a preference for explaining relapse in terms of psychological resistance, denial, or other characteristics of *active* drug users; and

- the tendency to see relapse as a sign of program failure, which treatment specialists may find difficult to acknowledge; to deflect criticism, practitioners may blame relapse on the client's lack of motivation.

Efforts to improve long-term treatment outcomes have frequently focused on refinements in primary treatment, rather than developing posttreatment relapse prevention programs. These refinements include:

- developing more intensive and comprehensive services during primary treatment;

- adding posttreatment booster sessions designed to reinforce the initial effects of treatment; and

- administering methadone, naltrexone, and other medications to reduce drug craving.

All of these approaches have a common weakness: they frequently do not focus on the skills clients need to maintain behavior change. The following relapse prevention strategies make these skills their primary concern.

Three major strategies are used in current relapse prevention programs:

- ***Social Support Approaches.*** These focus on the client's need for emotional support from family members and friends, as well as the specific help these individuals can provide in reducing interpersonal conflict and stress.

- ***Lifestyle Change Approaches.*** These focus on helping clients develop and sustain new social identities as drugfree individuals, including breaking ties with drug users, developing new interests and social contacts, and learning new methods of coping with negative emotions.

- ***Cognitive/Behavioral Approaches.*** These emphasize identifying internal and external cues associated with craving and relapse and then learning how to avoid them or, if they do occur, to prevent them from turning into a fullblown relapse.

While these approaches are sometimes viewed as alternatives, they can be combined beneficially into a single program. One example of such a combination is the Recovery Training and Self-Help (RTSH) program explained in detail in the following section of this report.

Social Support Approaches

Support from family, friends, and other recovering addicts can play a vital role in relapse prevention (DeLeon 1990; Galanter 1986; Gorski 1986, 1989, 1990; Hawkins and Catalano 1985; Wesson et al. 1986; Zackon et al. 1985). A study of opiate addicts, alcoholics, and smokers completing treatment revealed that time to relapse was strongly related to the amount of social support clients said they had received (Havassy et al. 1987).

Support from other people can help a recovering addict in the following ways:

- by modeling desired behavior;

- by creating a supportive interpersonal environment;

- by eliminating stress or helping the addict avoid or cope with sources of stress;

- by helping the person overcome a specific temptation to lapse;

- by praising and encouraging continued progress; and

- by monitoring the addict's behavior and helping to identify attitudes, behaviors, or situations that might signal an impending relapse.

In some cases, social support may not be available. Family members and friends may be too demanding or too critical. Their own needs may interfere with the client's ability to focus on his or her own recovery. Their behavior may create stress, disappointment, or heartache. Family members or friends who use substances are particularly worrisome. They can compromise the client's ability to change either by actively tempting the client to relapse or by serving passively as a conditioned stimulus for cravings.

Clients must take an active role in structuring beneficial social support. One important step is for clients to announce to family and friends that they intend to stop using drugs and alcohol. In most cases, clients may need to break all ties with drug-using friends. Recovery may hinge on leaving relationships marked by physical abuse or destructive interpersonal conflict. Clients also need to learn specific strategies for refusing direct offers of "recreational" drugs like alcohol from individuals who otherwise can be of significant support.

Family-oriented therapy, family support groups, and family education are considered important adjuncts to aftercare and relapse prevention, even though scientific research has not yet fully established their effectiveness. While these three approaches differ in emphasis, they all strengthen family support for the client's recovery by teaching family members:

- to be aware of problems the client faces;
- to eliminate enabling behaviors and modify interaction patterns that increase the risk of relapse;
- how to respond to client lapses that may occur; and
- how to cope effectively with the addict's recovery process.

Whether or not the addict's family participates in family therapy, there are several benefits to discussing family issues with a client who is beginning the process of recovery. Relationships with family members are often the source of powerful feelings for clients. Feelings associated with difficult experiences from the past, such as physical or sexual abuse, may begin to surface for clients who are no longer using substances to numb their awareness. Current family conflicts also often generate intense feelings among clients, such as guilt and shame over past behavior. Clients unprepared to cope with these feelings may relapse. It is important for relapse prevention programs to help clients identify the family issues that make them vulnerable to relapse and develop healthy means of dealing with them. Clients must also develop strategies for coping with family members who abuse substances and whom it would be difficult to avoid.

The addict in the family often plays a specific role which is comfortable and familiar for family members. When the addict begins the process of recovery, his or her role will change; this will call for adjustment on the part of other family members. A mother who has cared for her addicted daughter's children may find it difficult to give up control of those children to her now-recovering daughter and could become resentful. A younger brother who was always the good child during his brother's active addiction may get angry when his now-recovering brother

begins to get positive attention from their parents. Clients need to be helped to understand and even anticipate the difficulties that family members may have in adjusting to their recovery. Otherwise, family members may consciously or unconsciously interfere with the recovery process or cause the recovering addict to take on another inappropriate role.

Clients should be helped to develop substitute relationships through a buddy system or a self-help group. In one instance, a social network program was developed for clients who were beginning reentry from a residential therapeutic community. The program gave clients:

- an opportunity to be involved in acceptable social activities;
- help in developing better social, problemsolving, and coping skills; and
- a social network that strongly supported non-drug-related activities.

Following 3 weeks of skill training, each client was paired with a drugfree volunteer from the community. Next, 7 weekly sessions focused on planning and assessing the clients' introduction to a new social network through the volunteers. Clients maintained contact with their volunteers during the next 6 months. Roleplay simulations showed that clients improved their skills in:

- avoiding drug use;
- coping with relapse;
- social interaction;
- interpersonal problemsolving; and
- coping with stress (Hawkins et al. 1986).

Twelve-step programs are also designed to give clients an alternative social support network (Leukefeld and Tims 1986; Zackon et al. 1993). These programs often use the term "fellowship" to indicate that they offer clients a sense of belonging and community that they may have not have experienced previously outside the substance-abusing community. New members are encouraged to recruit sponsors and to speak frequently with them regarding the day-to-day struggle to remain clean and sober, as well as whenever the new members may be having difficulty. Members exchange telephone numbers and support each other emotionally or in other ways, such as providing transportation or escorts to meetings. Twelve-step programs often offer drug- and alcohol-free recreational activities, such as dances and athletic events, to provide members with experience in having fun without using substances; these activities also further their ability to socialize with nonusing persons. Active participation in these programs may help members obtain the social support they need to remain abstinent.

Twelve-step meetings frequently discuss relapse issues. The concept that a person who is an addict or alcoholic will always remain one and is perpetually in the process of recovery is a way of reminding members that anyone can relapse at any time. In telling their stories, members often recount the events, feelings, thoughts, and behaviors that led to previous

relapses; they talk about new skills developed to prevent a reoccurrence. Members are encouraged not just to refrain from substance abuse but to use the 12 Steps to cope effectively with and learn from life's challenges, including their own mistakes. Someone who does not actively follow the 12 Steps but manages to remain abstinent is referred to as a "dry drunk." Although drugfree, the person is believed to be still dysfunctional, because his or her ability to deal appropriately with feelings and with life's obstacles remains impaired. This is consistent with the principles of relapse prevention, which require an active attempt by the addict to examine his or her life, identify the events or feelings which have represented threats to recovery in the past, and develop new means of coping with them in the future.

Lifestyle Change to Support Abstinence

Lifestyle change has two components: extrication from a drug-using subculture, and adjustment to living in conventional society. Studies of natural recovery from opiate addiction show that addicts who successfully maintain abstinence:

- break all ties with other opiate users;
- create new interests;
- create new social networks; and
- create new social identities (Waldorf 1983).

A variety of aftercare services are needed to support this kind of sweeping change. In fact, many of the services traditionally associated with aftercare programs serve the objective of increasing clients' involvement in productive roles in the community. These services include:

- remedial education;
- job skills training;
- vocational counseling;
- life skills training (e.g., budgeting, decisionmaking); and
- family assistance.

Another important aspect of lifestyle modification is developing rewarding alternatives to drug use, especially relaxation strategies and healthy recreational activities. If clients have difficulty seeing any activity other than drug use as enjoyable, they might need to be given homework assignments to activate new interests. The key is balance. Clients need to establish a good ratio between obligations ("shoulds") and enjoyable activities ("wants"). An excess of "shoulds" leads to feelings of deprivation, which can translate into cravings for the immediate gratification of substance use. An excess of "wants" suggests the client has not taken on the unavoidable responsibilities of normal adult life.

Another aspect of lifestyle change concerns managing negative emotional states that result from stress, disappointment, interpersonal conflict, and other precipitating factors.

Clients must learn how to identify their emotions and then learn which emotions put them at risk of relapse. Finally, they must learn how to cope with those emotions without resorting to substance use. For some clients, simply learning to share their feelings with trusted persons can provide a great deal of relief. In the case of stress, the client may benefit from relaxation techniques or physical exercise. If the client has difficulty with anger, assertiveness training or conflict resolution techniques might be helpful. It is also important for clients to learn to make changes in their lives that will resolve problems and reduce their exposure to stress.

Cognitive/Behavioral Approaches

A third major approach to relapse prevention involves providing addicts with information and skills they can use systematically to identify and then avoid or cope with feelings and events which can create cravings which may lead to relapse (Annis 1990; Carroll et al. 1991; Daley 1986; Gorski 1986, 1990; Zackon et al. 1993).

Identifying Cues That May Trigger Relapse

Helping the client to identify his or her relapse cues is an essential first step to prevent relapse. Research on relapse prevention underscores the fact that clients must be vigilant for a range of warning signs, including emotions, thoughts, and behaviors, such as anger, unjustified self-criticism, and associating with current drug users. Clients can learn to identify these triggers by reviewing past relapses or by recording when and under what circumstances they currently develop drug cravings. Such self-monitoring in and of itself can operate as a coping strategy by delaying and perhaps shortcircuiting the automatic process of obtaining and using drugs. With knowledge of the cues that trigger their cravings clients can become alert to their presence.

Each warning sign needs to be linked to a specific set of recovery activities. Examples of warning signs and possible coping activities include the following:

	Warning Sign	Coping Behavior
Emotions	Depression	Discuss with friend.
	Anger	Discuss with person at whom anger is directed.
	Boredom	Choose from a list of preferred activities and plan to do two in the near future.

	Warning Sign	Coping Behavior
Thoughts	Self-criticism	Objectively examine progress since sobriety began.
	Preoccupation with using drugs	Reveal these preoccupations in a clinical or self-help group.
	Isolating behavior	Make plans with recovering friends or attend self-help group meetings. Contact self-help sponsor.
	Memories of good times while using drugs	List negative consequences of drug use.
Behaviors	Erratic Behavior	Set up a behavior plan and follow it.
	Going places or being with people associated with drug use.	Create alternative plans to spend time. Connect with sponsor or attend drugfree group activities or self-help meetings.

Some of these activities involve *avoiding* high-risk internal and external cues (e.g., avoiding former friends who still use drugs), while others involve *coping with* unavoidable triggers.

Avoiding Known High-Risk Situations

In general, recovering addicts should try to avoid the people, places, and things that have led to relapse in the past—or are likely to in the future. It is especially important that clients avoid setting up tests of their ability to resist temptation.

The limits of using this strategy of avoidance by itself are obvious. Because of poverty and poor education, many addicts find it impossible to remove themselves from drug-infested home environments, making it difficult for them to avoid the triggers that may precipitate relapse. Even if they can relocate, the current climate of drug use may mean that exposure to high-risk situations is still unavoidable, from television talk shows addressing drug abuse to anti-substance abuse posters on public transportation. Even unpredictable and unavoidable situations like spilling some granulated sugar may stimulate craving in a recovering cocaine addict, or seeing an automobile identical to the one an exaddict's supplier drove may create a strong urge to use heroin again.

Coping with Unavoidable High-Risk Situations

Detection of a warning sign or craving must lead to a self-directed preventive response. There is, in fact, little difference between situations that are followed by relapses and those in which the temptation is resisted. What is critical is whether the recovering addict makes an active effort to cope using an effective technique. Individuals who expect that active coping skills are required to quit successfully appear more likely to be successful in maintaining recovery than persons who do not realize they need to take action (Curry et al. 1987).

It is critical that clients anticipate their upcoming exposure to high-risk situations such as contact with drug users, unstructured time, and stressful work demands. If those situations cannot be avoided, clients should rehearse the strategies they will employ at the time. In some cases, these strategies will include methods for handling stress, anger, disappointment, or interpersonal conflict. In other cases, they will include methods for coping with cravings. By reflecting on which strategies were successful or unsuccessful, clients can refine their repertoire of coping tools over time.

Strategies for coping with cravings can be divided into two categories: behavioral and cognitive.

Behavioral coping strategies include:

- leaving the situation;
- throwing away drug paraphernalia;
- using relaxation skills;
- repeating motivational statements aloud;
- writing down thoughts and feelings in a journal;
- calling a therapist, sponsor, or other individual for support; and
- rehearsing planned behavior in role plays.

Cognitive coping strategies include:

- reviewing reasons for quitting;
- reflecting on progress made to date; and
- using positive mental imagery.

In some cases, cognitive strategies can be enhanced by reminder cards that clients can post in a prominent location or take out and review when needed.

Coping is facilitated when clients understand classical conditioning. Clients can be helped to understand that certain "cues" can automatically stimulate certain feelings and thoughts, just because they have occurred together frequently in the past. This will help clients

interpret their cravings as an automatic process, rather than as signs of personal failure (Marlatt 1990). Clients can be told that if the cues are not followed by drug use, the cues will gradually lose their automatic ability to cause craving as intensely and frequently. It is also important for clients to remember that cravings normally peak and dissipate within an hour. Clients may find relaxation exercises or cognitive strategies helpful during this period to prevent themselves from acting on the urges.

Caregivers can help clients comprehend the nature and source of cravings by using readily understood language and imagery. Poorly educated or learning-disabled clients might find theory-based descriptions too abstract to comprehend. Better means of communicating relapse concepts must be developed and evaluated for these clients. Good ideas might come from addicts themselves. For example, some Southern Californian Latino heroin addicts (*tecatos*) use the metaphor of a parasitic "junkie worm" (*tecato gusano*) that lives in the viscera of addicts and cannot be killed, only pacified. One researcher studying relapse prevention for crack addicts has used metaphorical forms of communication to help clients visualize and remember the determinants of relapse and its course (Wallace 1991).

The key, then, is a combination of strategies for avoiding and coping with high-risk situations. Research has found a consistent relationship between the skills clients possess as of the end of treatment for avoiding and handling drug- and alcohol-related situations and their extent of later drug use (Wells et al. 1989).

Managing Lapses

If clients are taught about the abstinence violation effect, they are less likely to make self-defeating attributions. That is, instead of blaming themselves as "weakwilled" or "lacking self-control," which might lead to further substance use, clients will see a lapse as an isolated failure to use effective coping strategies on a specific occasion. Rather than feeling helpless, clients will be able to analyze what happened in order to prevent a reoccurrence.

A lapse does not necessarily lead to relapse. Even when it does, the time between the first lapse and subsequent substance use can be hours or even days. Thus, it is essential that clients be told that, while lapses can occur, every addict can learn self-management strategies that will prepare them for that possibility.

While clients should not treat lapses as a disaster, they should take every slip very seriously and follow each one with four immediate actions:

1. stop drug use after the initial lapse;
2. remove themselves from the situation;
3. call someone for support; and
4. employ other behavioral or cognitive strategies.

Clients can be encouraged to sign a contract that spells out these steps. They can also carry a reminder card that fleshes out the specific steps they will follow if an initial lapse occurs (for example, whom they will call for support, what other strategies they will use). The final step in managing a lapse is for clients to recommit themselves to abstinence and recovery.

Disclosing Cravings

Obviously, for relapse prevention efforts to be effective, clients must feel free to tell their counselor or self-help group about lapses or cravings they have experienced. Clients on probation or parole and women with children may be especially fearful of disclosing this information. While it is important to encourage clients to be honest with all service providers involved in their recovery, they must be made aware of the rules and limitations on confidentiality regardless of whether they sign release forms that allow service providers to share information. A jurisdiction may have regulations regarding the types of information that *cannot* be shared—even if a release has been signed—as well as the types of information that *have* to be shared—even if a release has not been signed. It is general clinical practice to share only information that is relevant to the services sought for the client from the other human service agency. If relapse prevention programs do not share pertinent personal information with a collateral agency, they may not be in a strong position to advocate for their clients and to educate other service providers about the meaning of relevant relapse information.

As an alternative to sharing personal information, the counselor may offer to provide inservice training to criminal justice or social service providers on specific clinical issues, such as the distinction between a lapse and a relapse, or discuss these issues in general terms without relating them to identifiable clients. Such training should make future collaboration between agencies easier if a counselor later on needs to point out that a particular client is having difficulty avoiding a relapse, and is attempting to report the problem and asking for help without being punished. Crosstraining will improve the ability of all service providers to work together to come up with a service plan that best supports each client's recovery. A consistent attitude toward lapses on the part of every agency should reinforce the message to the client that struggles with relapse are an expected part of recovery and can be dealt with openly and effectively.

4. FOUR SPECIFIC RELAPSE PREVENTION APPROACHES

Because relapse prevention is a relatively new field, there are few evaluated programs. Indeed, the literature describes many programs for which there are only preliminary data (e.g., Baker at al. 1989; Carroll and Ohanesian 1989; Daley 1986; Gorski 1986, 1990; Roffman et al. 1989; Wallace 1991). However, four strategies for preventing relapse appear most effective. Two of these strategies—RTSH and Cue Extinction—have been rigorously evaluated, while the other two—12-step programs and pharmacological approaches—have some empirical support as well as long histories and many committed advocates.

Recovery Training and Self-Help (RTSH)

The RTSH program brings together many of the general relapse prevention strategies just reviewed. The RTSH program seeks to reduce the association of psychological and social cues with substance use by teaching addicts self-sustaining alternative responses to stimuli previously associated with drug use. These new responses are elements of a new pattern of behavior, a recovering addict lifestyle. Researchers have compared the recovering addict to an immigrant:

> Recovery is not just the cessation of drug use; usually it also demands adjustments to a new way of life within the culture of the larger community. To make a truly new way of life and not just relocate the old one, people need much more than grit. People must have guidance, acquire new skills, and make new contacts so that they can cease being immigrants (Zackon et al. 1993).

Clients can find support for that emerging lifestyle by participating in four distinct sets of activities that make up the RTSH program.

Component One: Recovery Training Group

The first RTSH component is a series of 24 90-minute weekly group sessions led by a professional counselor. These Recovery Training (RT) sessions involve the same 6–30 clients. The sessions help members recognize common threats to recovery and train them in techniques for coping with these threats before they occur.

The RT Group sessions combine lectures, case studies, and group exercises that focus on:

- the predictable causes of relapse:
- helpful responses to cravings or a slip;
- alternatives to drug use in order to cope with stress, physical pain, interpersonal conflict, and boredom;

- employment and career development;
- social reintegration into the community; and
- love and family life.

Sessions on general topics like family life, recreation, and employment focus on issues that are directly relevant only to recovering addicts. For example, the sessions on employment discuss finding a job that supports recovery, disclosing past addiction to employers, and coping with on-the-job problems without resorting to drugs.

Each RT Group session emphasizes developing and implementing concrete action plans designed to promote each member's recovery.

Component Two: The Fellowship Group

A second group, the Fellowship Group, usually comprises 8–10 regular members of the RT group who have made progress in recovery, are abstinent, are committed to attending every fellowship session, and whom existing Fellowship Group members agree to accept. These Fellowship Group meetings, also held weekly for 90 minutes, are led by the same counselor who leads the RT Group, by a senior recovering addict (see below), or by both individuals together. Whereas the RT Group concentrates on training in coping skills with elements of self-help, the Fellowship Group focuses on self-help with elements of training. The Fellowship Group provides clients with a personal and organized—but not clinical—meeting where they can support each other in the relapse prevention practices learned in the RT Group.

Specifically, the self-help Fellowship Group sessions provide opportunities for the recovering addict to:

- practice newly developed skills;
- discuss personal issues and share problems in depth;
- review RT Group session training topics; and
- plan weekend and holiday social activities.

Component Three: Group Social Recreation

Participants engage in weekly social activities which they plan themselves during and after RT and Fellowship Group meetings. Friends and relatives are invited to attend, and staff members participate as well. These activities, often scheduled for high-risk times for drug use, such as Friday evenings and weekends, range from bowling to pot luck dinners to movies. They are intended to help clients learn that they can have a good time without drugs, discover how to enjoy themselves in social situations, realize that recovery is more than simply staying clean, avoid boredom and loneliness, and foster new friendships.

Component Four: Senior Recovering Addicts

Former program members and other exaddicts in the community who have been drugfree for at least 2 years and have fully reintegrated into normal social life (hold a job, participate in recreational activities) may lead the Fellowship Group, lecture to RT Group members, and attend Group Social Recreation activities. These "seniors" share the strategies they have used to prevent relapse and serve as role models for successful recovery.

Program Completion

Members are ready to graduate when they have developed a well rounded, drugfree lifestyle. Graduation criteria include:

- living outside an institutional setting for at least 6 months with no slips;
- clearly understanding the principles of recovery discussed in the program;
- being able to anticipate, avoid, and/or handle high-risk situations;
- using outside social support well;
- successfully managing adult roles and responsibilities;
- having home and work environments that support, rather than threaten, recovery;
- having several nonusing friends and engaging in healthy forms of recreation;
- enjoying satisfying activities that have become a routine part of clients' everyday life; and
- using a 12-step group or professional counseling to support recovery, as needed.

Summary

The RTSH program is an outpatient aftercare relapse prevention tool designed for clients who are already completely or largely drugfree and have committed to staying off drugs. It requires clients who can function in a group setting and who have the determination to learn—and apply on their own, with initial support from their peers—specific strategies for meeting the numerous challenges to abstinence they may face. RTSH is *not*:

- psychotherapy;
- a spiritual program;
- a replacement for other treatment or other aftercare programs; or
- a solution for all the recovery problems of clients.

The National Institute on Drug Abuse (NIDA) has published a package of materials on relapse prevention, including a manual of 24 RT Group session units, a curriculum for training counseling staff to do RTSH, and an administrator's handbook that addresses implementation

issues programs need to consider in order to integrate RTSH into their existing activities. The appendix indicates how to order these materials.

Cue Extinction

Cue Extinction programs teach recovering addicts techniques for coping with cravings produced by drug-related stimuli until the power of these cues to evoke the craving is reduced or eliminated.

The Basic Approach

In the approach that has been empirically tested, addicts recreate feelings of craving in the protected environment of a one-on-one counseling session by visualizing their own personal environmental and internal cues which trigger the craving—for example, getting angry after an argument with their partner or seeing an automobile that is the same model that their drug supplier used. The counselor then teaches the client how to use a technique for resisting and, ultimately, extinguishing the craving that has just been aroused. In each of six sessions, the counselor teaches a different Cue Extinction technique after the client has been instructed to imagine a cue that arouses craving. The six Cue Extinction techniques taught are:

- ***Deep Relaxation.*** Two conflicting physiological responses cannot exist simultaneously. Therefore, if the client employs relaxation techniques in response to drug cues, the physical symptoms associated with drug cravings will be inhibited and craving will be reduced. Clients can relax by playing a relaxation tape or meditating.

- ***Delay Plus Behavioral Alternatives.*** The client consciously decides to postpone acting on an early sign of craving for a short period until the intensity of the craving fades. At the same time, the client engages in an available activity, such as isometric exercises, to avoid focusing on drug use during the delay period.

- ***Negative/Positive Consequences.*** The client learns to identify and then focus on the negative consequences of drug use, as well as on the positive consequences of not acting on the craving to use drugs. Negative consequences could be the loss of weight or physique, or the loss of a close person. Positive consequences could include improved health and appearance, or money in the bank.

- ***Negative/Positive Imagery.*** The client imagines his or her drug bottom, followed immediately by the image of what the client can be like if he or she does not use drugs.

- ***Mastery Imagery.*** The client pictures him or herself as a very powerful person or force capable of defeating the craving—for example, the driver of a large tank crushing the craving.

- ***Cognitive Interventions, i.e., Thinking Straight.*** The client detects drug thought traps—thoughts that contain a logical flaw and will lead to using drugs—and answers these thoughts with straight thinking or prepared answers. One drug thought trap is, "a little bit won't hurt," to which the straight thinking reply is, "I never stop at just one."

Clients practice the techniques with the counselor and between sessions on their own. After mastering all six, they identify, in consultation with their counselor, the two or three which work best for them and spend the next few sessions practicing these most effective techniques further.

Tests of this approach with cocaine abusers in treatment have shown that it reduces illicit drug use (as measured by urine testing) and keeps clients in treatment. It has also been shown to decrease conditioned craving in response to drug-related stimuli with opiate addicts (Childress et al. 1986; McLellan et al. 1986; O'Brien et al. 1990).

Limitations to Cue Extinction

Some practitioners may object to the Cue Extinction procedure on the basis that it is cruel to deliberately expose clients to stimuli that evoke conditioned drug-using responses. There are two answers to this concern. First, exposure to cues will occur as a matter of course, since recovering addicts cannot avoid every possible drug stimulus in their natural environment or in their feelings and thoughts (Marlatt 1990). Second, there is proven therapeutic value in learning to deal with conditioned stimuli in a protected environment: as noted, clients who have developed the ability to apply the six Cue Extinction techniques in a counseling setting report they experience craving less often and less intensely than do clients who have not learned the techniques, and they have more clean urines.

A more serious concern with Cue Extinction is that clients might leave the learning sessions with incompletely extinguished cravings and then suffer a relapse. However, this has occurred only once among many hundreds of clients over 7 years of research. Nonetheless, counselors who use the technique must be carefully screened and trained to be able to detect any residual craving after the Cue Extinction technique has been applied and spend extra time "bringing down" any client whose craving has not gone away. This is especially important if Cue Extinction is used in outpatient and day treatment settings.

It is also important to be aware that Cue Extinction is not designed to be a complete relapse prevention approach. It is a supplemental strategy which focuses on helping clients deal specifically with their cravings. It should be incorporated into other comprehensive relapse prevention services.

Staff training and administrator materials for integrating Cue Extinction into existing programs are available from the National Institute on Drug Abuse. (See the appendix.)

Twelve-Step Programs

Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and other self-help programs based on the 12-step philosophy have features in common with relapse prevention programs such as RTSH.

The basic goal of both self-help and cognitive/behavioral/social support programs is the same: to promote abstinence through lifestyle change and peer support. Both kinds of programs maintain that recovering addicts must remain constantly vigilant to the possibility of relapse throughout their lives. Both also feature alternative social support networks. They differ in that 12-step programs promote the use of the steps to cope with and learn from the challenges presented by life. Members are encouraged to remain abstinent one day at a time—that is, to handle cravings by choosing not to act on them today. This philosophy encourages recovering persons to tolerate cravings until they dissipate. By contrast, RTSH and Cue Extinction focus on specific cues and life situations that elicit cravings or drug use and on creating specific action plans that the recovering addict can use to cope with these situations. In addition, while addicts in 12-step programs frequently spend time recounting their past experiences with drugs, RTSH and Cue Extinction concentrate on current problems and future action.

Another difference is that while RTSH and Cue Extinction are led by professional counselors, 12-step groups consist only of recovering persons. Members with long periods of sobriety serve as role models for newer members. One potential advantage of this approach is that it reduces the stigma attached to addiction in general and to relapse in particular. If Elaine, currently sober for 15 years, speaks at a meeting about her prior relapses and what she has learned from them, then Peter, who has had his first lapse, may feel less shame and more hope, which may prove pivotal in his recovery. The disadvantage to this approach may be that members with psychological problems in addition to their addiction may not get the assistance they need because no one is designated to recommend professional help and make appropriate referrals.

A third distinguishing feature of 12-step programs is their spiritual component, a belief in a "higher power" in which members can find help in maintaining sobriety. On the one hand, many recovering persons have found belief in a higher power a very important aspect of their ability to remain abstinent. On the other hand, some addicts are uncomfortable with this spiritual component and may drop out of 12-step programs or minimize their involvement. These clients may do better in other types of relapse prevention programs or join another self-help group, Rational Recovery, which does not subscribe to the higher power concept.

The effectiveness of 12-step programs is difficult to demonstrate. Since clients self-select into the programs and participate to different degrees, controlled outcome studies are difficult

if not impossible to carry out. In addition, the anonymity that is a major feature of these programs tends to limit access to the information necessary to do outcome studies. Nonetheless, the weight of clinical evidence appears to support the conclusion that self-help groups facilitate the recoveries of many substance abusers (DeLeon 1990; Vaillant 1988). In seeking to explain the effectiveness of 12-step programs, one study notes that they serve to impose a structure on the addict's life that interferes with conditioned drug-seeking behavior. Twelve-step programs offer recovering persons a set of rules to follow and a social system which provide an alternative to a lifestyle marred by drug and alcohol abuse.

Pharmacotherapies

Antabuse

Several treatment specialists have noted that medications might play an important ancillary role in posttreatment relapse prevention (e.g., Annis 1990). Pharmacotherapies have been used for many years to prevent relapse among alcoholics, although a measure of controversy has always surrounded their administration. Antabuse (disulfiram) and Temposil (citrated calcium carbamide) have been used with alcoholics to induce an immediate and highly unpleasant physiological response if the alcoholic subsequently drinks even a small amount of alcohol. Alcoholics know they have to discontinue Antabuse or Temposil for approximately a week before they can drink without serious side effects. This gives some alcoholics the security of knowing that they will not succumb to impulse drinking, a common stumbling block to maintaining abstinence. After building a more secure and stable sobriety, alcoholics can discontinue these medications, although some have taken them for as long as 20 years with no physical damage. Nonetheless, these drugs have several limitations:

- Strong physiological reactions if clients drink alcohol while using Antabuse may endanger the lives of those with heart, circulatory, and blood pressure problems.

- Clients may depend on Antabuse as their sole means of staying sober, to the exclusion of much more effective long-term means such as lifestyle changes, social supports, and cognitive/behavioral changes.

- Some clients complain that Antabuse induces drowsiness or reduces their physical or mental acuity until the proper dosage is determined.

- These medications are contraindicated for dually diagnosed clients, whose mental illness may impair their ability to consider the adverse physiological effects they will experience if they consume alcohol.

Methadone

Methadone is a synthetic narcotic analgesic that has the capacity, when administered in high enough doses, to block the euphoric effect of other opiates. There have been two

approaches to methadone treatment. One approach, called detoxification, is short term, where clients are maintained for a limited amount of time until they have become sufficiently stabilized to be withdrawn gradually from the drug. This approach sees methadone as a means of enabling clients to reach a comfortable, noneuphoric state during which they can become involved in counseling, lifestyle changes, and social services designed to shift their orientation and lifestyle away from drug seeking and related crime and toward more socially acceptable behaviors. Once these changes are underway and appear secure, the medication can be stopped.

The second approach to methadone treatment is long term maintenance of clients on the drug for months or years. This usage can be considered a form of relapse prevention—addicts who remain on adequate dose levels of methadone do not resume using heroin because it cannot provide them with a high. Clinicians report that many addicts maintained on methadone say they fear the prospect of discontinuing the drug because they know they will relapse.

A recent 3-year field study conducted by the NIDA Addiction Research Center examined the outcomes of methadone maintenance treatment at 6 clinics involving 506 patients in 3 eastern United States cities. Of the 79 percent of patients who remained in treatment for 1 year, 71 percent discontinued their injection drug abuse, while substantial reductions also occurred in patients who did not completely discontinue injection use. In contrast, 82 percent of treatment dropouts relapsed to injection use within 1 year (Ball et al. 1988).

Both approaches typically combine methadone administration with rehabilitative and counseling services, but the quality and intensity of these other services varies considerably from clinic to clinic.

Methadone has several unusual pharmacological properties that especially suit it to a maintenance, or relapse prevention, approach. Unlike many opiates, it is effective orally—a considerably more hygienic form of administration than the needle and more easily titrated than smoke. Unlike natural opiates, methadone takes effect gradually and wears off slowly, yielding a fairly even effect across a period of 24 hours or longer. Methadone in appropriate clinical doses is not behaviorally or subjectively intoxicating and does not impair functioning in clinically detectable ways. Finally, its long-term toxic side effects (as of any other opiates taken in hygienic conditions in controlled doses) are notably benign (Gerstein and Harwood 1990).

Despite its advantages, methadone has been a controversial treatment approach, especially for long-term relapse prevention. Major issues include dosage levels, take-home policies over the weekend, and street diversion. The self-help movement, with its emphasis on abstinence from any drug other than prescribed medications for physical ills, has particularly criticized methadone maintenance treatment. However, treatment for a chronic health disorder often involves long-term, even permanent, pharmacological maintenance using a powerful drug that is nevertheless safe if properly administered. The most obvious examples are insulin treatment for diabetes, thyroxine for thyroid deficiency, and lithium for manic-depressive disorders (Gerstein and Harwood 1990). Furthermore, the dangers of HIV and AIDS have recently renewed interest in long-term methadone treatment as society searches for ways to reduce

injection drug use and potential needle sharing in order to prevent the further spread of AIDS (e.g., Ball et al. 1988).

Other relapse prevention approaches, such as RTSH, Cue Extinction, and self-help programs, can be effectively combined with either methadone detoxification or methadone maintenance. Combining these other approaches with methadone administration is important because many patients maintained on methadone continue to abuse other drugs, such as cocaine, whose effects methadone does not block (Kosten et al. 1987). Furthermore, many clinics prescribe methadone dosages below the threshold necessary to block the euphoric effects of other opiates (D'Aunno and Vaugh 1992). When ineffective dose levels are used, some addicts shoot or snort heroin in addition to taking their regular methadone medication. In addition, some practitioners report that clients on methadone maintenance have successfully used some of the cognitive and behavioral techniques taught in some of these other relapse prevention approaches to help them reduce their methadone dosage levels and ultimately detoxify from methadone.

Naltrexone

In several experiments, recovering heroin addicts have been given naltrexone, a longlasting opiate antagonist like methadone that, by blocking the euphoric effects of heroin and other narcotics, can help addicts deal with a relapse crisis or a marked surge in craving. Administration of naltrexone might also facilitate extinction of conditioned responses by suppressing narcotic euphoria (Kosten 1989, 1990; Kosten and Kleber 1984; Wesson et al. 1986).

5. RELAPSE PREVENTION WITH SPECIAL POPULATIONS

Just as primary treatment must provide specialized approaches for special populations, so must relapse prevention, to be fully effective, also consider the special needs of:

- women;
- ethnic minorities;
- adolescents; and
- gays and lesbians.

Women

Initially, substance abuse treatment consisted of inpatient and ambulatory programs which treated men and women together. However, because men's addictions were more visible, identifiable, and socially acceptable, women constituted a much smaller percentage of addicts in treatment facilities and self-help programs.

The last 25 years have seen an increase in women's programs in response to the realization that many women suffer from substance abuse and have unique issues which treatment must address. Unfortunately, research on how to treat women has lagged. However, considerable clinical experience suggests specific approaches to treating women that may be effective. Hazelton, CASPAR, and Eagleville Hospital, among other programs, have offered a variety of suggestions for women's treatment.

Since women seeking treatment face some differing issues from those men face, it follows that some of the issues regarding relapse prevention with women also differ. The major relapse prevention issues for female addicts are discussed briefly below.

Lack of Support Systems

One of the most significant differences between recovering men and women who relapse is the female addict's relative lack of support from family members and friends (Cusack 1984). The family often finds it more difficult to see a woman as a person with an addiction who has the ability to change and get well. Women are less likely to have family, partners, or friends who forgive them even if they show remorse. In treatment facilities, the relapsing female client is far less likely to have an intact marriage and a concerned spouse as sources of support (Cusack 1984).

If the disrupted family or friendship network that commonly occurs with female addicts cannot be mended, then other support systems must be utilized to help women to avoid relapses. These aids can include recovery homes, where a woman can stay for 6–18 months in a supportive environment, and self-help groups, especially women's 12-step groups.

Guilt, Stigma, and Shame

While progress has been made, society still disapproves much more strongly of substance abuse by women than by men. Women have customarily been expected to live up to a higher standard of moral and social behavior. A number of roles traditionally deemed female—in particular, nurturing and maternal duties—are perceived as incompatible with drug-affected behavior. This stigma is increased by society's perception of female substance abusers as promiscuous, immoral, and unfeminine.

Addicted mothers bear the additional burden of guilt over how substance abuse has interfered with their childrearing responsibilities. If they use drugs while pregnant, the effect on the fetus is an additional concern. Finally, because society places primary responsibility on women for raising children, they often experience shame when seeking and using drugs prevents them from fulfilling this role.

Relapse prevention must address issues of guilt, stigma, and shame head on if the female addict is to avoid relapse. Approaches for dealing with these concerns include women's therapy groups, self-help groups, and individual, couples, or family therapy. Where open communication exists between the female addict and her family, generating family support might be especially productive.

Low Self-Esteem

The guilt, stigma, and shame female addicts usually experience because of the substance abuse lifestyle, coupled with social attitudes toward addicted women, seriously may impair their self-esteem. It may decline further as their addiction destroys their ability to engage in important relationships with other individuals and institutions. Self-esteem for many women is based on successfully being a part of and nurturing various relationships (e.g., mother, wife, daughter, friend) and the nurturing of these relationships. A woman's peers, and society in general, often encouraged her to facilitate and manage communication, caretaking, and feelings. Women are often involved in system-wide relationships with their children's schools, social service agencies, and health care providers. Real or perceived loss of these relationships can often threaten a woman's total sense of being.

It is important to integrate women into a supportive framework involving healthy and important relationships that can help rebuild lost self-esteem. This might entail reinvolvement with the family, a rewarding job, meaningful volunteer work, a self-help sponsor, or a therapy group or individual therapist. Women-only therapy and self-help groups, as well as a female sponsor, are often a good way to help the recovering female addict not have to cope with another common threat to women's recovery—premature involvement in a potentially damaging romantic liaison in response to the need for a meaningful relationship.

Family Violence and Sexual Abuse

Practitioners in the field report that many more substance-abusing women than men report childhood sexual abuse (Weiner et al. 1990). Physical, emotional, or sexual abuse in childhood, in addition to playing a role in the development of addictions, can profoundly affect a woman's ability to function as an adult, by creating difficulty with trust and intimacy in close relationships, for example. Childhood abuse may also result in feelings of powerlessness and low self-esteem, which can contribute to a female addict's risk of relapse.

Women who have survived these traumas may need a forum in which to express their rage and terror about having been abused. This forum may take the form of self-help groups, such as AA or Adult Children of Alcoholics (ACOA), or more formal therapeutic approaches, such as individual, group, or family therapy.

Dependency

Overdependence on unhealthy relationships is a central issue in the lives of many substance-abusing women. Women tend to be introduced to substance use by men. In addition, men who use drugs often create and perpetuate a pattern of drug dependence in their female partners. Feelings of low self-worth may also cause women to develop and maintain unhealthy relationships that further erode their self-esteem.

Women who abuse drugs may already believe, or come to believe, that they have little or no ability to influence life's events. As a result, they may turn to partners to take care of them, keep them sober, support them financially, and make their decisions. Substance-abusing women who attempt to gain self-esteem primarily through relationships with men may display little trust in other women, whom they see as competitors for men or as having little value. Their resultant inability to find support from other women may further reinforce their dependence on men.

In order to prevent relapse, women with dependency problems must learn to make decisions. They also need to learn to distinguish between codependency and healthy love based on mutuality. Many of these women would also benefit from learning how to be more assertive. Relapse prevention programming for these addicts might include a women's issues group, assertiveness training, female self-help sponsorship, and women's self-help groups. Couples or marital therapy may also be indicated.

Concurrent Abuse of Legal Drugs

Many more women than men use and abuse mood-altering prescription drugs, which they often obtain legally through a physician. Antidepressants, tranquilizers, barbiturates, and amphetamines are given to at least twice as many women as men (Finkelstein et al. 1990). Substance-abusing women who use such tranquilizers as Valium, Librium, or Xanax in conjunction with street drugs or alcohol risk life-threatening situations, as well as crossaddiction and crosstolerance. *Crossaddiction* is physical and psychological dependence on a drug with

similar pharmacology; *crosstolerance* is a need for increasing amounts of one or both substances to achieve the same effect. The use of some over-the-counter nonprescription drugs, such as cough medicines and sleeping medications containing alcohol, which a physician may or may not have recommended, should also be of concern.

Relapse prevention with this group of women could involve helping the client establish an honest relationship with a physician knowledgeable about prescription drug abuse and alcoholism as well as illicit substance abuse. Assertiveness training may be useful to help the client refuse prescriptions from unknowing medical personnel. Therapy groups as well as women's self-help groups often address the abuse of legal medications.

Physiological Considerations

Women seem to develop health-related complications from substance abuse at an accelerated rate, a phenomenon called "telescoped development." Women suffer serious health problems such as liver damage after a shorter history of drinking and lower levels of alcohol intake than do men (Finkelstein et al. 1990). Women who drink excessively or use illicit drugs have more gynecological problems than their non-substance-using counterparts. They also experience more infertility, miscarriages, and stillbirths. Substance abuse in women is also a factor in sexual dysfunction and loss of interest in sex (Finkelstein et al. 1990).

All these considerations affect relapse prevention. For example, physiologically, women's bodies may need more time than men's for healing and repair. Women may find that developing intimacy without drugs may create intense anxiety, fear, or anger because of past or present gynecological problems or sexual dysfunctions. When these physical and emotional barriers to recovery are not addressed, women may relapse when they experience their first substance-free intimate encounter. These important issues can best be discussed within the confines of a women's therapy or self-help group, as well as in individual therapy.

Recovering addicts who experience premenstrual syndrome (PMS) may be vulnerable to relapse as a way to counteract depression, irritability, feeling "crazy," decreased energy, sleep disruption, forgetfulness, headaches, and joint pain. Help is available in the form of PMS clinics and support groups, which encourage lifestyle changes involving nutrition, exercise, vitamins, and stress management.

Caretaking Responsibilities

The pressures and inherent conflict of raising children while earning a living can make it difficult for women to attend outpatient relapse prevention programs or self-help groups, or to follow through on aftercare recommendations (Gerstein and Harwood 1990). These women may lack the time or energy to add another commitment to their parental and occupational responsibilities. Because of the real and pressing needs of their children, they may also find it difficult to accept the concept that their own recovery must come first.

Recognizing this dilemma, more and more treatment agencies offer inpatient and outpatient programs where women's children either may live or be present, or where child care is available. Some programs offer weekend or evening relapse prevention sessions to accommodate addicts with busy schedules. Relapse prevention sessions include discussions of the pressures of recovering and caring for oneself while caring for children—for example, by pointing out how a mother who relapses will be of even less help to her children than a mother who takes some time away from them in order to attend a relapse prevention program and remain abstinent.

Improving Women's Programming

As noted, holding special relapse prevention sessions for women only is one approach to addressing female addicts' special recovery needs. However, some programs may not have enough staff or enough female clients to run such sessions. In addition, some programs believe that mainstreaming the special-population client will prove more beneficial in the long run than forming homogeneous groups, because recovering addicts will still have to function in a larger diverse society.

Even without running separate groups for women, programs can take several other steps to make sure that counselors address women's special recovery, such as the following:

- Make sure that all counselors, men as well as women, are familiar with women's special barriers to and problems in recovery, including their special triggers to relapse.
- Make a conscious effort to help women feel comfortable in raising issues of sexual abuse, codependency, and other threats to recovery with which they are trying to cope—especially in group counseling sessions.
- Instruct counselors to be careful about even the most innocent physical contact with female clients because of the possible previous abuse these women may have experienced.
- Assist female clients to find and join—or even form—support groups for women in the community.

Cultural Minorities

Some counselors believe it is best to ignore the client's culture: "Addiction is a democratic illness that strikes every group," or "All addicts have the same types of problems and needs." However, most treatment experts and practitioners argue that a client's minority status and ethnic and cultural background cannot be overlooked, because his or her cultural context, values, and perceptions may influence both retention in aftercare and relapse rates.

Few studies present the results of research into effective substance abuse counseling approaches with minority clients. However, many people in the field have suggested cultural characteristics that may influence the effectiveness of relapse prevention and have proposed ways to address these traits in order to improve the usefulness of aftercare counseling (Marin and Marin 1991; Sue and Sue 1990).

Selected Cultural Characteristics That May Hamper Relapse Prevention

Mental health practitioners often identify distinctive cultural characteristics of minority and cultural groups that may require special attention in a relapse prevention program. Of course, most of the characteristics found in a particular culture can usually also be found in most other cultures—just not as often or perhaps not as strongly. For example, while in some cultures family loyalty is paramount, this characteristic can also occur among nonminority families. In addition, specific subcultures within a dominant ethnic population (for example, among Latinos, Cuban Americans, Central Americans, Puerto Ricans, Mexican Americans) often have different values and perceptions from each other. The point of focusing on special characteristics among minority groups in this report is to highlight traits that are found more frequently among some clients than others which counselors need to anticipate and be responsive to when providing relapse prevention services. Below is a list of some characteristics prevalent among some minorities which may have implications for how relapse prevention should be done (Marin and Marin 1991; Sue and Sue 1990; Sweet 1988-89).

Poverty and unemployment. Some ethnic and racial groups are disproportionately burdened with poverty, unemployment, substandard housing, low education, and other socioeconomic barriers to success. These conditions may contribute to a sense of hopelessness and powerlessness that may make relapse more likely among these populations and require extra attention to the formulation of an effective relapse prevention plan.

Obviously, a significant part of effective relapse prevention with these clients is to explore job training and employment opportunities. Some studies have shown that relapse is less likely among gainfully employed addicts (Simpson 1981; but see Rounsaville et al. 1987), perhaps because work increases self-esteem and enables the person to fulfill the parental role of providing for the family. By establishing a schedule and minimizing free time, work also provides structure that addicts in recovery often need.

Drug-infested environment. Minorities are sometimes concentrated in neighborhoods where drugs are rampantly used and easily available. Recovering addicts who return to such a neighborhood have a higher relapse rate then exaddicts surrounded by people who abstain from drugs (Vaillant 1966; Maddux and Desmond 1982, 1986). Self-help groups may provide a forum, supplemented with recreational and social activities in a drug-free atmosphere, that can relieve the constant temptation to use drugs in environments of pervasive substance abuse.

Racism and discrimination. Most minorities have experienced racism; all are aware of its existence. As a result, they may regard social and political institutions, including the drug treatment system and individual counselors, as representatives of an oppressive society or as bigoted on an individual level. Clients may view the counselor as prejudiced until proven otherwise. Some members of minority groups who are still individually poor may also suspect that counselors of the same cultural background who have achieved substantially greater socioeconomic success look down on them.

Counselors need to learn about clients' experiences with bigotry that could affect their willingness to trust the counselor's objectivity and competence. Developing trust may require counselors to disclose information about themselves to the client that they ordinarily would not consider appropriate to communicate in the drug treatment setting (for instance, their own personal experiences with minorities), openly express feelings (for example, anger, frustration), and make a special effort to explain how confidentiality will be maintained (for example, emphasize to clients who are under court supervision that a lapse will not be mentioned to anyone outside the program).

Family closeness. In some ethnic groups, the family is a very close knit entity, and sharing family matters with outsiders is considered betrayal. Merely seeking help with personal problems from any source outside the family may be seen as a violation of the family bond. Members of such families are likely to feel obligated to provide material and emotional support to their kin, rely on them for help and support, and regard them as models for how to behave and think.

While important for many addicts, family treatment may be particularly critical for minorities with powerful family attachments so that family members can understand the addict's needs as he or she recovers and participate constructively in the relapse prevention effort. Counselors also need to consider what the consequences of behavior change among minority clients may be on such a family—and therefore on the client—and what it may mean to the client to go outside the family to seek help—for example, to attend self-help.

Extended families. Some cultures often consider an extended family network the basic unit of family structure, with children raised by relatives—such as aunts, uncles, and grandparents—as well as by their parents. As a result, counselors may need to consider involving more than just nuclear family members in any family therapy provided.

Special communication styles. Different cultures emphasize different styles of communication—for example, rational (proceeding logically by identifying the sequential steps that need to be taken to achieve a given goal, such as preventing relapse), emotional (expressing feelings openly and perhaps as a substitute for action), elliptical (conveying in euphemisms and subtleties one's true feelings and intentions), and behavioral (showing what one means and feels through body language). Counselors may be accustomed to using relapse prevention approaches that conflict with these client communication styles. For example, helping clients to plan in advance the logical steps they will take to recognize and cope with triggers to relapse may feel

alien to individuals who are accustomed to communicating through the expression of feelings, confrontation (e.g., with exhortations, arguments, threats), or subtle suggestion (hinting at what needs to be done).

Counselors need to be sensitive to which style each client is comfortable using and, to the extent possible, tailor their relapse prevention approach to conform to it. For example, counselors may need to temper their tendency to urge clients to talk openly about themselves and their family with addicts whose culture frowns on frank displays of feelings and open communication of personal matters. Counselors may also be able to improve their effectiveness if they learn to recognize nonverbal communications and their cultural meanings, from a client's pounding the table and yelling "I will never relapse again!" to avoiding eye contact when the subject of lapses is broached.

Concepts of masculinity and femininity. More men in some cultures than in others exhibit the trait of machismo, which involves specific ideas about how a man should act—for example, never to display fear and to act tough when contradicted. Such men may also consider it unmanly not to drink heavily or smoke marijuana. By contrast, the ideal woman may be seen as faithful, submissive, and obedient—and abstaining from alcohol and drugs. Relapse prevention can be especially difficult with a male client who feels unmanly if he never drinks or uses drugs or for a woman who feels she has irremediably disgraced herself and her family by ever using drugs.

One approach to addressing these values and perceptions is in group relapse prevention sessions where men and women can constructively confront each other's stereotypes of what it takes to be a man or a woman and discuss how some perceptions of masculinity and femininity can encourage relapse. It may also be helpful to work with the addict's family members so they can learn to accept total abstinence from alcohol as well as drugs and to forgive past addiction.

General Guidelines for Counseling Minority Clients

Individual counselors can take at least three steps on their own to improve their cultural sensitivity.

Individualize Treatment. As described above, there are several approaches to relapse prevention. Some approaches work better with some clients than with others for reasons unrelated to ethnic or racial background, such as the client's stage of recovery. In a similar manner, counselors can shift their helping styles to match the cultural needs and receptivity of each minority client. For example, if a nonwhite client suspects a white counselor is prejudiced, or if a client from a culture that emphasizes unemotionality refuses to discuss personal feelings until the counselor has "opened up," disclosing some of his or her background and experiences to such clients may help a counselor build trust.

Avoid Assumptions: Listen, Ask Questions, and Be Alert for Expressions of Cultural Dimensions. Counselors should avoid jumping to conclusions based on their own experiences regarding statements, body language, and expressions of feeling presented by any client. For example, some minorities do not look a person in authority in the eye and do not speak until spoken to because direct eye contact is a sign of disrespect. Counselors can misinterpret these behaviors as reflecting dishonesty, guilt, lack of verbal ability, depression, or other emotions. Instead, counselors should allow the client to explain what the behavior or statements mean, consult with family members, or review the case with informed colleagues.

Develop Awareness of Their Own Cultural Values. Counselors can benefit from identifying and examining their own values and perspectives. Counselors should pay particular attention to values they may hold which could influence their acceptance or understanding of the values of clients from different cultural backgrounds. For example, a counselor who believes that clients must learn to make decisions independently of what other family members think may assume that a minority client who plans to consult with other family members regarding techniques for coping with triggers to relapse is exhibiting a dependency that will hamper his or her ability to recover. Having identified their own values, counselors will be better able to avoid making inappropriate judgments about differing client values.

Steps Programs Can Take to Be Culturally Sensitive

Drug treatment program administrators can increase staff awareness of the importance of cultural sensitivity in a number of ways, such as addressing cultural issues at staff meetings, at formal meetings devoted to counselor orientation, supervision, and evaluation, and during informal conversations with counselors. Administrators can establish a library of culturally relevant materials, circulate new materials as they arrive, and mention movies they may have seen that accurately depict minority culture. More generally, administrators can by these and other actions set a consistent tone that indicates that (1) cultural sensitivity is important in their program and (2) they will gladly assist staff in becoming familiar with minority cultures.

Other steps administrators can take include the following:

- ***Encourage staff specialization.*** Set up an arrangement whereby each counselor will become somewhat knowledgeable in one or two cultures and serve as a resource on these cultures to other staff.
- ***Provide staff training.*** Arrange for counselors to take local courses on cultural sensitivity and minority and ethnic studies and invite guest speakers to address staff meetings.
- ***Enlist minorities.*** Hire minority and ethnic counselors and develop a pool of minority individuals willing to volunteer their time to help deliver services to clients from their cultural community.

- ***Improve facility access and friendliness.*** For example:
  - — establish satellite offices to make services readily accessible and available to clients in an environment comfortable to them;
  - — display art work from client cultures and offer ethnic food; and
  - — develop brochures or fliers describing the program in several languages and use illustrations that depict clients in situations characteristic of their culture.

Today's minorities confront unique obstacles to assimilation or acceptance into mainstream society. However, conflict and misunderstanding among cultures has a long history in America. As a result, there have always been significant differences in lifestyle, values, and background between counselors and many of their clients. This consideration suggests that much of what counselors need to do in order to show cultural sensitivity is to follow good counseling practices (for example, not jumping to conclusions about the meaning of a client's behavior) that apply to the treatment of any client.

Adolescents

For many youngsters, adolescence is a difficult period when they are trying to define themselves, work out their relationship with parents and siblings, and plan their future. It is also a time when peer opinions may be of paramount importance, and when sexual urges and romantic relationships first develop. This tumultuous time presents great challenges to treatment professionals trying to prevent substance-abusing teenagers from relapsing.

Unfortunately, the treatment specialist has limited clinical research to consult for relapse prevention with this population; most of the literature is anecdotal. Furthermore, because variables such as gender, culture, and socioeconomic status of the client's family may also play a significant role in the course of treatment, it is impossible to adopt a uniform approach to relapse prevention for all adolescents.

What seems generally accepted among treatment professionals, however, is the vital need for aftercare for adolescents. Aftercare provides an environment and consistent set of messages that promote a drugfree lifestyle and values. While this is an important consideration for all recovering substance abusers, it is especially necessary for adolescents because they have not formulated their beliefs and values as firmly as adults have and because peer pressure plays a more influential role in their behavior. Aftercare groups, whether in the form of therapy or self-help groups such as AA or NA, can help create this atmosphere.

A second area of professional agreement is that family involvement is critical in relapse prevention with adolescents. In adolescence, teenagers begin to separate from their parents and develop their own identity, value system, and personal relationships. As a result, testing occurs in which teenagers struggle over the limits of parental control. How the family handles the teenager's need for both independence and supervision will create an atmosphere which may

either foster or help prevent relapse. A constructive family atmosphere that successfully addresses this tension will be marked by:

- effective communication;
- clearly defined rules about who makes which decisions;
- good cooperation in the family;
- clearly communicated consequences for inappropriate behavior; and
- a specific contract committing the family to treatment.

Prior to discharge from an inpatient treatment center, or while the adolescent is still participating in outpatient treatment, it is often helpful to the family to have a written recovery plan drawn up with participation of the treatment staff and the adolescent. The recovery plan should be a contract that states specifically how the youth will behave and schedule his or her time, and what rules will be followed in the family. The contract should specify what constitutes a lapse and indicate what steps will be taken by three parties—family, adolescent, and counselor—if a lapse or relapse occurs. These specifications will help parents differentiate between healthy detachment from their teenager's chemical dependency and the need to set reasonable limits.

Finally, a uniform approach to relapse prevention for all adolescents will not be effective because of widespread differences of gender, ethnicity, and economic position.

Being Young and Female

Literature on female adolescent substance abusers examines the role male friends play in influencing female teenagers to use drugs (Weiner et al. 1990; Cusack 1984). For example, young women sometimes begin drinking or using drugs in dating situations in which the boyfriend controls when and how much liquor his date will drink. Teenage girls may be especially vulnerable to the influence of boyfriends because, as noted above, self-esteem for many women is often based largely on being part of relationships.

Other literature suggests that young females who begin drinking or using drugs in early adolescence enter treatment appearing mature and worldly when they are actually emotionally immature, vulnerable, and frightened (Finkelstein et al. 1990). Often, these girls have not been treated as still-developing youths because they may have already lived adult experiences as a result of trouble with the law, school, or family or may have acted out sexually.

Relapse prevention for the passive adolescent girl who follows the harmful bidding of her boyfriends must provide her with tools that will enable her to make decisions in her own best interest, including:

- interventions which build self-esteem;
- values clarification; and
- assertiveness training.

For the pseudo-worldly teenage girl, a young women's self-help group, or individual or family psychotherapy, might help prevent relapse by encouraging her to express her underlying fears and anger in an accepting atmosphere, develop self-acceptance, and reduce the need to present an adult image.

Being Young and a Member of a Cultural Minority

A teenager's membership in a minority group may expose him or her to influences that affect relapse prevention. Surrogate parenthood occurs in some minority communities for health, educational, vocational, and cultural reasons. Relapse prevention may need to involve extended family members who are important in the adolescent's life because all these people need to act consistently in order to help the adolescent avoid relapse.

The concept of machismo may affect relapse prevention with teenage boys from various ethnic backgrounds. If a macho father is a role model, the son may find it difficult to give up certain practices, such as drinking and drug use, without feeling he is rejecting his father's male values. For this and other reasons, relapse prevention with the son may need to focus on the father's behavior within the culture and suggest alternative role models or other methods of expressing these cultural values.

The Role of Poverty

Adolescent substance abusers who come from a background of poverty may have added difficulties in avoiding relapse.

- Impoverished living conditions and poor schools can create feelings of hopelessness in youths. Part of relapse prevention, however, involves helping adolescent addicts develop a sense of optimism about how satisfying life can be without drugs. Relapse prevention may need to focus on providing these adolescents with vocational and educational opportunities that will change their perception that their current economic condition will never improve.

- Poor teenagers live disproportionately in areas where the drug dealer, pimp, or prostitute may be seen as an attractive role model because of their visible signs of financial success. Relapse prevention efforts must help these youths come into contact with positive role models through self-help groups and sponsors.

- Poverty sometimes forces minority families to change residence several times, often in an attempt to find employment or child care with relatives. Teenagers from such homes may have difficulty making friends and forming consistent work habits and career goals. Counselors must address these two obstacles to recovery.

- Impoverished areas often have a large proportion of single-parent families. The absence of a father in particular may make it necessary for adolescents in the family to assist with child care or earn money, activities that may interfere with attending relapse prevention sessions. Clinicians need to develop ways to make meetings available at times when youngsters can attend, including weekends and early evenings.

- Adolescents in poor communities may lack public and private transportation for attending relapse prevention programs. Other family members may face similar barriers to attending family counseling sessions. One partial solution may be for counselors to use conference calls so that family members can remain involved in treatment. Other solutions may include:

  — finding a more geographically convenient setting for aftercare;

  — offering roundtrip transportation services;

  — home counseling; or

  — making a counselor available by phone during specific hours for posttreatment problems.

Gays and Lesbians

While substance abuse affects about 10 percent of the general population, the rate of chemical dependence in the gay and lesbian population is thought to be over 20 percent (Ziebold and Mongeon 1985). With 1–5 percent of adults in the United States thought to be homosexual, this represents a large number of substance abusers. While there is little relapse prevention research on gays and lesbians, clinical literature suggests some of the distinctive problems they face trying to avoid relapse (Ziebold and Mongeon 1985).

Gay men and lesbian women typically experience significant and ongoing stress whether they keep their homosexuality a secret or make it known. On the one hand, if they remain "in the closet," they must deal with the stress of hiding their sexual orientation when attending family gatherings, socializing with coworkers, and dealing with social institutions such as schools and the social welfare system. On the other hand, if they "go public" with their sexual orientation, gays and lesbians may face family rejection, job and housing discrimination, physical violence, and general homophobia on the part of neighbors and acquaintances.

Another major source of stress for homosexuals is the fear of HIV and AIDS. While the gay and lesbian community has been active in promoting safer sex, the anguish of those individuals who have contracted the virus, as well as the suffering of uninfected gays and lesbians whose friends or lovers have AIDS, has been well documented. All of these special stresses require attention in any relapse prevention effort.

Gays and lesbians face two other unique threats to recovery. First, as homosexuals become clean and sober, they may for the first time have to come to terms honestly with their sexual orientation, a process they may have postponed, carried on intermittently, or done without a clear understanding because their drug abuse prevented them from addressing their homosexuality forthrightly and thoroughly. This confrontation may cause great anxiety, requiring sensitive relapse prevention treatment.

Second, homosexuals' historical difficulty in finding places to socialize and meet each other free from stigma or harassment has made the gay or lesbian bar an important meeting place for many members of this community. There, homosexuals can relax, be themselves, socialize, and, most importantly, feel a sense of belonging. However, alcohol and drugs are a major part of this social scene. Relapse prevention must help gays in recovery to find ways to socialize outside of drug-using environments.

While many gays find self-help groups very beneficial, some have difficulty deciding whether to participate in AA or NA groups or join gay or lesbian AA or NA groups. Not all gay men and lesbian women choose to attend gay meetings, even when they have the choice. However, at some point attendance at a gay and lesbian meeting may be important for the sense of community, belonging, and hope it can provide.

6. RELAPSE PREVENTION IMPLEMENTATION ISSUES

This final section discusses briefly the principal planning and administrative issues involved in integrating formal relapse prevention into primary treatment or aftercare programs. Most of the discussion focuses on implementing the RTSH and Cue Extinction approaches. However, many of the planning and implementation steps for adopting these two approaches also apply to integrating other relapse prevention approaches into a program. The implementation steps involved in linking clients with self-help groups are straightforward, although some of the concerns raised previously in this report about meeting the needs of special populations through 12-step programs will require special administrative attention (for example, helping gay and lesbian clients decide whether to choose self-help groups composed mainly of homosexuals).

Further information about implementing RTSH and Cue Extinction may be found in two administrator's handbooks prepared by the National Institute on Drug Abuse. The appendix provides instructions for ordering these materials.

Programs that have implemented systematic relapse prevention approaches report that involving clinical and supervisory staff early in the planning process—including staff who may never themselves be involved in doing relapse prevention—helps eliminate implementation problems further down the line. Early staff involvement reduces the element of surprise and allows counselors and supervisors to express concerns and suggest modifications to the implementation plan that can improve overall success.

Preliminary Planning

Before developing an implementation plan, program administrators need to complete three preliminary activities.

Assess Client Needs

Program administrators should first determine what relapse prevention services their clients need. This requires a detailed knowledge of the types of clients enrolled in the program, such as male-female ratio, minority membership, age, sexual orientation, drugs of abuse, relapse history, previous treatment experience, access to transportation, living arrangements, and socioeconomic condition. This information, typically available from client files, should be supplemented with newly acquired information that identifies:

- common threats to relapse among clients;
- common triggers for relapse; and
- current strategies clients are using to cope with lapses and relapses.

The needs assessment should also identify the relapse prevention strategies clinical staff are currently using, including:

- how often;
- with what types of client;
- in what circumstances; and
- with what level of success each strategy is used.

Finally, administrators should assess counselors' prior relapse prevention training, if any, and current attitudes toward providing formal relapse prevention.

This information will provide a basis for determining the type of assistance clients will need to avoid relapse and the nature of the training that staff will require to provide the needed help.

Assess Program Resources

Administrators must next determine the resources available to provide the assistance their clients need, such as:

- space for group (for RTSH) and individual (for Cue Extinction) relapse prevention counseling;
- equipment (e.g., overhead projector, duplicating equipment, flip charts);
- budget for purchasing any needed equipment or renting suitable space;
- staff availability to conduct relapse prevention; and
- staff skill levels for doing relapse prevention.

Select the Relapse Prevention Approach to Implement

The third preliminary step is to review the available relapse prevention approaches and select one to start with (others can be added later) that will best meet client needs and can be implemented with available resources. This choice entails comparing the goals and achievements of each relapse prevention approach to client needs and listing and comparing each approach's demands for program space, time, staff availability and skills, and budget to available program resources. For example, Cue Extinction requires few physical resources but demands considerable clinical staff time and skill since it should be conducted one-on-one and assumes considerable counselor sensitivity to client cravings.

Having chosen an approach, administrators may still need to determine which components within the approach to use. For example, while RTSH has proven effective when all four components are used together, programs may only have the resources to implement two or three components. Administrators may also want to substitute or add self-help meetings such

as NA (not available when RTSH was initially tested) for the Senior Recovering Addict component.

Implementation Steps

Having chosen an approach, program administrators can develop a plan to implement it. Although the specific steps and their sequence may vary by program and by type of relapse prevention approach, some of the basic steps likely to be involved are described below in approximate chronological order.

Step One: Develop Client Participation Policies

Administrators and staff need to establish criteria for client participation. For example, administrators need to decide whether clients must be in a certain stage in the treatment program regimen in order to qualify. May clients still in treatment participate, or only those in aftercare? With regard to inpatient programs, many experts recommend beginning at least some parts of RTSH before clients are discharged. One therapeutic community initially ran Recovery Training group sessions at the very end of the program when clients were working full time in the community but still dining and sleeping at the facility. Clients quickly convinced staff that this was too late, often reporting, "If only you had given me this information earlier in my treatment!" Administrators need to establish additional—and more stringent—criteria for client participation in the RTSH Fellowship Group meetings.

While clients must have progressed significantly in recovery to participate effectively in RTSH, Cue Extinction can begin within 5-7 days of abstinence, as soon as the fog of detoxification has lifted.

Administrators might also consider other criteria for participating in RTSH, including:

- level of recovery, including duration of the most recent period of abstinence;
- nature of the home environment (e.g., whether it is drug-free) and willingness to give up drug-using friends; and
- dislike for group sessions.

Most programs exclude from Cue Extinction clients who:

- are dually diagnosed with a major mental illness;
- cannot control feelings of extreme anger; or
- have difficulty imagining and visualizing triggers to relapse.

Both relapse prevention approaches should be used only with clients who have strong motivation to recover and accept complete abstinence as their goal. They should not be used

with clients who have serious psychological problems or cognitive deficits. In addition, program administrators suggest that only clients who volunteer to do so should participate in relapse prevention approaches. Programs thus need to consider how to motivate clients to participate.

Programs also need to plan for dealing with absences and preventing attrition among participants. Some programs use disciplinary measures, including possible termination, to prevent attrition. Others aggressively follow up with clients who miss even one activity. Staff telephone to find out whether the client has a good reason for his or her absence (for example, illness), has run into an obstacle to participating (such as child care or transportation problems), or has had a slip that he or she is too embarrassed to admit. By finding out why the client was absent, staff can often solve the problem and motivate the client to return. Other reasons for dropping out that staff can often address include fears about confidentiality and difficulty finding the time or transportation to attend.

Staff need to develop procedures for assessing client progress and removing clients for whom the relapse prevention approach seems ineffective or harmful. The implementation plan should indicate how to deal with clients who relapse. For example, if a client participating in Cue Extinction uses drugs again, options that the counselor might discuss with his or her supervisor include requiring the client to repeat the entire Cue Extinction process, providing booster sessions, or considering other relapse prevention approaches.

Step Two: Develop Staffing Policies

Key decisions must be made about which staff to involve in running relapse prevention programs. On the one hand, training all staff, or at least several staff members, to provide the service will ensure that there are backups if regular relapse prevention staff become unavailable. On the other hand, training a limited number of staff allows programs to select only the most skilled staff. All programs must develop and apply some minimal criteria in deciding which counselors to use. Procedures are also necessary for determining how to supervise participating staff.

In consultation with staff, administrators need to anticipate objections that counselors and supervisors may raise to implementing the relapse prevention approach and discuss ways to address each concern. Some concerns that staff have expressed about relapse prevention include the following:

- perceived conflict between the 12-step philosophy and the concepts of relapse prevention (e.g., reliance on one's own skills to avoid relapsing versus reliance on a "higher power");

- philosophical disagreement with some of the tenets of relapse prevention (e.g, belief that conformity to the norms of the therapeutic community itself is "the treatment" versus relapse prevention's emphasis on assisting the client to adapt to the outside community);

- reservations based on misconceptions about relapse (e.g., talking about relapse will bring it about; people who slip are not motivated to recover; any slip will result in a fullblown relapse);

- anxiety among recovering staff that focusing on relapse prevention with clients will activate or intensify their own drug cravings; and

- uncertainty about how to meet the needs of women and minorities (e.g., how to address in a mixed group a woman's observation that her memories of sexual abuse trigger relapse for her, or a minority group member's reflection that racist incidents act as cues for him to use drugs again).

Program administrators have successfully addressed all these staff concerns. Below are three general strategies for allaying staff concerns that a large therapeutic community found useful in integrating relapse prevention into its program.

- Top administrators developed a strong belief in the concept of relapse prevention and in the approach they adopted—and expressed their support to staff in word and deed.

- Senior clinical staff conducted the first relapse prevention treatment series so that other staff could see firsthand that clients do not react negatively to learning about relapse and can learn the techniques.

- Program administrators assured all staff that the new approach would be implemented only on a trial basis for 6 months. If at that point it proved too disruptive for staff or produced too many harmful effects for clients, it would be discontinued.

Section five of this report suggests a number of strategies to meet the special relapse prevention needs of female and minority clients. The NIDA administrator's handbooks listed in the appendix discuss still other ways that programs have successfully addressed staff concerns.

Step Three: Determine How to Fit Relapse Prevention into the Existing Drug Treatment Program

Administrators who have introduced formal relapse prevention approaches into their program report having to make some adjustments in order to schedule the new sessions and warn to expect some initial disruption as the existing program makes room for the new component. Below are some decisions administrators have had to make.

- Whether to schedule entirely new counseling sessions devoted to relapse prevention or graft relapse prevention onto existing counseling sessions.

- On what day(s) of the week to hold the new sessions. Many programs hold evening RTSH sessions to accommodate clients who have daytime work, school, or childcare responsibilities; others meet on weekends both to avoid conflicts with weekday activities and to take advantage of days on which clients often have little to do and consequently may be tempted to use drugs. Cue Extinction should be done during the earliest part of the treatment day in day treatment facilities so that counselors have time to talk down clients experiencing craving at the end of a session.

- How the new approach will affect staff hours and schedules, and when, exactly, they will do relapse prevention. Will it require reducing their other responsibilities? If so, which ones, and who will take on those dropped assignments?

- How to handle any extra paperwork (e.g., the craving rating sheets if Cue Extinction is used).

- If RTSH is implemented, whether to allow new clients to join the ongoing relapse prevention component as they become ready in their recovery to participate, or to require them to wait until a new group forms or a counselor frees up the time to provide treatment?

- How to provide such ancillary services as vocational assistance and basic education services.

Step Four: Consider Legal and Funding Implications

Administrators need to determine whether third-party payers will cover clients and consult an attorney to assess any potential legal liability. There may be potential liability issues should a client relapse after Cue Extinction training or after an RTSH group session that focused specifically on a discussion of cravings which aroused the individual's cravings. However, counselors who are sensitive to clients' current moods and behaviors and take the time to assist any individual who might be experiencing cravings will greatly reduce the likelihood of this occurring.

Step Five: Train Staff

Before beginning staff training, programs must select and, if needed, train the person who will train staff. The trainer can be inhouse or an outside consultant. If a staff member is used, he or she needs the initiative to learn everything there is to know about the relapse prevention approach as well as good training skills. Programs unable to afford a consultant may be able to arrange with other area programs to share the costs of using one trainer for all of their staffs. The Single State Agency may be willing to assist this collaborative effort.

One or more orientation meetings should be held with all staff before training begins to explain why the administrators decided to integrate formal relapse prevention into the program, why they selected the approach they have chosen, how the approach will affect program operations and staff schedules, and other matters of concern to staff.

Program administrators report that it is a good idea to train the entire program staff in the relapse prevention approach, including staff who will not be responsible for providing or supervising the effort. To be most effective, relapse prevention requires consistency among all staff in their dealings with clients, and most staff at one time or another will be involved with a client who is troubled by cravings or lapses or has relapsed. On such occasions, these staff can reinforce in their own clinical activities the goals that RTSH staff are trying to achieve. In addition, staff responsible for the formal relapse prevention activities may feel more comfortable and motivated if they know that the other staff understand and support their activities.

Some programs may be able to train their staff in a single, extended all-day or 2-day session, but most will need to space the training over several weeks. The training sessions schedule must neither overload staff with too much information and skill building at one time nor be so stretched out as to lose continuity between sessions. Two NIDA publications, listed in the appendix, provide detailed session-by-session instructions for training staff to use RTSH and Cue Extinction.

Step Six: Implement the Approach

Actually implementing the relapse prevention approach involves several obvious steps:

- announce the approach to clients;
- select clients;
- provide the service; and
- review progress and modify the approach as needed.

When possible, it is advisable to pilot test the approach with one or two staff trained in the techniques. A pilot test can relieve staff concerns about whether the approach will be feasible and effective. It can also indicate whether and how to modify the approach in order to address any unanticipated problems before full implementation begins.

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APPENDIX

The National Institute on Drug Abuse (NIDA) Technology Transfer Support Program aims to build an alliance between the drug abuse research and practitioner communities. The goal is to ensure that prevention and treatment programs incorporate new knowledge gained through research so as to be as effective as possible. To further this goal, NIDA has produced a Relapse Prevention Technology Transfer Package.

The package's seven publications examine two relapse prevention models discussed in the clinical report—Recovery Training and Self-Help (RTSH) and Cue Extinction.

The package includes an introductory brochure that explains the contents and usefulness of the entire package. Readers may want to order and review the brochure before deciding to order the rest of the package.

For a free copy of the materials, write to

The National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345
Rockville MD 20847

OR CALL, TOLL-FREE, (800) 729-6686.

When calling or writing, be sure to provide the NCADI publication order number for each publication you want. To order the entire package, though, you need only request the single NCADI number BKD116.

The following page describes the individual publications in the Relapse Prevention Package.

Relapse Prevention Package

The Relapse Prevention Package, which can be ordered in its entirety using NCADI publication order number BKD116, includes:

— Introducing Relapse Prevention (1993) • Brochure

Reviews common issues and concerns about drug abuse relapse, discusses the benefits of the two relapse prevention models, and describes materials contained in NIDA's Relapse Prevention Package. *Can be ordered separately from the Relapse Prevention Package. (See below.)*

— Relapse Prevention: More Support for Your Clients (1993) • Booklet

Discusses issues related to drug abuse relapse, reviews findings about causes and factors associated with relapse, and describes several relapse prevention models and their use in treatment settings.

— Recovery Training and Self-Help: A Handbook for Program Administrators (1993)

Discusses various implementation issues regarding the RTSH model from a program administrator's perspective. Also describes the major RTSH service components.

— Recovery Training and Self-Help: Relapse Prevention and Aftercare for Drug Addicts (1993) • Group Sessions Handbook

Details an aftercare/relapse prevention program and addresses 24 specific topics related to maintaining recovery. *Can be ordered separately. (See below.)*

— Recovery Training and Self-Help: Inservice Training Curriculum (1993)

Used in conjunction with the group sessions handbook, this curriculum is designed to train counselors and other practitioners who wish to implement an RTSH program. Provides detailed training instructions, exercises, handouts and overheads.

— Cue Extinction: A Handbook for Program Administrators (1993)

Designed to help program administrators decide whether to implement the Cue Extinction model as part of their program's relapse prevention services. Discusses the process for Cue Extinction sessions and clinical intervention tools and suggests strategies to address implementation issues.

— Cue Extinction: Inservice Training Curriculum (1993)

Designed to train counselors and other practitioners to use Cue Extinction as part of a relapse prevention program. Reviews the learning and behavior modification theories upon which Cue Extinction is based and describes the complete Cue Extinction protocol in detail. Provides detailed training instructions, exercises, handouts and overheads.

The following two package components may be ordered separately using the NCADI publication order numbers shown:

— Introducing Relapse Prevention (1993) • Brochure • NCADI #PHD629

— Recovery Training and Self-Help: Relapse Prevention and Aftercare for Drug Addicts (1993) • Groups Sessions Handbook • NCADI #BKD96

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