

Chapter 10

Preventing Relapse

“It’s easy to stop smoking- I’ve done it hundreds of times.” When Mark Twain made this humorous remark, he was referring to the problem of relapse as applied to his own nicotine addiction. In this one simple statement he described a major dilemma encountered by people trying to overcome addictions; specifically, that stopping an addiction in the short term is relatively easy and not nearly as difficult as staying stopped over the long term. In other words, quitting may be fairly easy, but staying quit tends to be a more formidable challenge. Many addicted individuals are able to stop for a few days, weeks, or months (sometimes even years), but many if not most fall back into using again despite their best intentions to quit for good. This experience is so common among addicted persons that it is safe to say that one of the most distinguishing features of an addiction- whether to drugs or something else- is the proclivity for relapse, especially during the weeks and months immediately following cessation of use.

This phenomenon was demonstrated quite dramatically in a study comparing relapse rates in cigarette smokers, alcoholics, and heroin addicts, Hunt, Barnett, and Branch (1971) found that relapse rates, based on the numbers of subjects who returned to using their substance of choice during successive weeks after quitting, were nearly identical to one another. This study suggests that the relapse dynamic cuts across different substances of abuse and may be a fundamental aspect of all addictive behaviors.

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Marlatt and Gordon (1985) proposed a cognitive behavioral theory of relapse and formulated a set of specific relapse prevention (RP) strategies and interventions designed specifically to prevent a resumption of addictive behaviors. High relapse rates have long been the nemesis of attempts to treat alcohol and drug dependencies. But prior to the appearance of Marlatt's work, relapse and its prevention had not been given much attention in addiction treatment programs. This can be attributed partly to clinicians' fears that even raising the topic of relapse with patients might communicate an expectation of failure and promote a self-fulfilling prophecy of failure by giving patients "permission" inadvertently to use alcohol and drugs again. However, as the RP model became more widely accepted and its efficacy was supported by empirical research (Rawson, Obert, McCann, & Marinelli-Casey, 1993), addiction treatment programs began to incorporate RP strategies more routinely into their work with patients. During the past two decades, RP strategies have been applied to many different types of chemical and behavioral addictions (Washton & Boundy, 1989) and different substances of abuse, including alcohol (Gorski & Miller, 1986; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002), cocaine and other stimulants (Rawson, 1999; Rawson, Obert, McCann, Smith, & Ling, 1990; Washton, 1988, 1989), opioids (Zackon, McAuliffe, & Ch'ien, 1993), and nicotine (Fiore et al., 2000).

Although in addiction treatment programs, RP is often provided as a distinct component or phase of the program delivered in a group format, RP strategies are embedded in all good treatment of SUDs and are easily integrated into individual sessions provided in office-based practice. RP strategies rest on the premise that the factors that help to *initiate* abstinence from addictive behaviors are different from those needed to *maintain* abstinence. These techniques involve a combination of education, therapeutic confrontation, and skill development. Educating patients about the relapse process and helping them acquire problem-solving and affect

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management skills are essential components of the RP approach, as described more fully in this chapter.

In this phase of treatment, as in all other phases, one of the key elements in working with patients who have SUDs is the attitude and stance of the therapist towards these individuals. Therapists must be cognizant of their personal attitudes and beliefs about relapse and their countertransference reactions to patients who return to using alcohol and drugs despite the therapist's best efforts to help prevent this from happening (Imhof, 1995; Kaufman, 1994). Negative, judgmental, controlling attitudes by therapists are likely to fracture the therapeutic alliance and cause patients to drop out of treatment prematurely. The therapist must never downplay the potential dangers of relapses or ignore them, but it is essential to show empathy, concern, and a positive problem-solving attitude that reframes relapses as avoidable mistakes, not tragic failures. A genuine belief that patients can learn from these mistakes and move forward in their recovery, must be communicated unequivocally.

UNDERSTANDING THE RELAPSE PROCESS

“Relapse”, as the term is traditionally used in the addiction treatment field, refers to returning to substance use after a period of abstinence. More recently, however, relapse has come to be seen as a complex phenomenon involving much more than the act of using mood-altering chemicals again. Relapse is now seen as a process or dynamic that is set in motion by certain forces and as involving both overt and subtle shifts in patients' attitudes, behaviors, and choices that move them progressively closer to the point of using again. Thus, individuals can be in a backsliding or relapse mode, caught up in the process of heading for relapse, before they actually use alcohol and drugs again. In reviewing relapse experiences, many patients can identify

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specific clues or warning signs that preceded their return to alcohol and drug use. Typically, they were either totally unaware of these warning signs or paid little attention to them while heading for relapse. Thus, a significant aspect of relapse prevention strategies is helping patients to become aware of the earliest signs that they are in a relapse mode and learn how to take appropriate action to short-circuit this process before it culminates in a return to alcohol and drug use.

Although relapse can occur at any point after initial abstinence has been established, most relapses occur within the first 3-6 months. A wide range of variables contribute to the relapse process and in most instances the actual causes of relapse are determined by a multitude of factors. Rarely does one factor alone precipitate relapse to alcohol and drug use. Several categories of relapse precipitants have been defined by previous investigators (Marlatt & Gordon, 1985), some of which were mentioned in the preceding chapter. These include: (a) both positive and negative mood and affect states; (b) environmental cues or triggers associated with prior substance use; (c) inadequate coping and problem solving skills; (d) sexual triggers; (e) unrealistic expectations and other “mind traps” or cognitive distortions; (f) lingering withdrawal including post-drug anhedonia and dysphoria; and, (g) conscious and unconscious motivations to use mood-altering substances again including shame, guilt, and residues of earlier trauma and abuse.

Patients in early stages of the relapse process usually exhibit a variety of changes in thought, emotion, attitude, and behavior. At this point, the clinician can intervene to help short-circuit the relapse process before it leads to resumption of substance use. However, this depends on the ability of the clinician to recognize the warning signs coupled with the patient’s ability to receive feedback and make the necessary preemptive changes. Sometimes the warning signs are subtle

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and, therefore, very difficult to recognize as such. Adding to the difficulty is the fact that different patients show different warning signs. Also, since behavior is at times unconsciously motivated, the client may actually be unaware of warning signs that are apparent to other people.

The relapse process has been described as a progressive chain reaction or set of behaviors, attitudes, and events set in motion most often by negative feelings and/or stressors. This chain reaction can take many different forms, but may look something like this (Washton, 1989):

The Relapse Chain or Progression

1. There is a buildup or onset of stress caused by negative events (e.g., relationship conflict, financial pressures, etc.)
2. The stress activates overly negative thoughts, moods, and feelings that lead the person to feel overwhelmed or emotionally numb
3. Either overreaction or emotional numbing causes failure to take action, leading to continuation and eventual escalation of the problem
4. The person gradually withdraws from his/her established recovery support system and daily routines
5. There is a resurfacing or exacerbation of denial as evidenced by increasingly skeptical and cynical attitudes toward treatment, self-help, and other commitments
6. Feelings of futility about one's ability to manage life comfortably without using alcohol or drugs coupled with an increasing belief that relapse is inevitable, begin to overshadow whatever progress the person has been achieved up to this point

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7. Signs of impaired judgment and impulsiveness become evident as the individual makes poor decisions that result in even greater stress
8. As the person's life becomes increasingly unmanageable, feelings of frustration, despair, and self-pity set in and trigger obsessive thoughts about using again
9. Irresistible urges and cravings lead to drug-seeking and drug-using behavior. The relapse chain is complete.

Mistaken Beliefs about Relapse

Several mistaken ideas and beliefs about relapse are common and should be addressed (Washton, 1989; Washton & Stone-Washton, 1990). They are as follows:

1. *Relapse starts when the person starts using drugs again.* As stated above, the relapse process is activated long before the person actually starts using again. Using is the end point, not the beginning of the relapse.
2. *Relapses are unavoidable, unpredictable, and often appear "out of the blue" without warning.* The fact is that relapses are avoidable and rarely if ever occur without warning signs, if the person knows what to look for and attends to the warning signs.
3. *Relapse is synonymous with treatment failure.* While relapses do suggest that some aspects of the patient's treatment plan may need to be changed, they are best construed as "bumps in the road" or temporary setbacks. Patients sometimes overreact to relapses and in the process make it harder for themselves to get back on track.
4. *Relapse erases all progress achieved up to that point.* Relapse does not mean that all progress achieved up to that point is lost and it does not have to destroy a person's recovery plan. Because many patients are frustrated and discouraged by the prospect of

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having to start all over again from square one and as a result may decide to drop out of treatment rather than face this frustrating situation, they need help in acknowledging the progress they were making before the relapse occurred and how they can use whatever information can be gleaned from the relapse to move forward from that point.

Slips versus Relapses

According to Marlatt and Gordon (1985), one of the most important aspects of the RP approach is to distinguish between a lapse or “slip” and a full-blown relapse. The purpose of drawing this distinction is not to make the idea of using again acceptable or to tacitly condone the use as long as it is not taken too far, but rather to make clear that emergency action can be taken to “put on the brakes” and short-circuit any instance of alcohol and drug use before it “skids out of control” and escalates into a full-blown relapse with all of the attendant dangers. Whether or not a slip leads to relapse depends on how the person reacts to it. Unlike relapses, which tend to have a negative impact on a person’s motivation and commitment to regain abstinence, slips, if handled properly, can be valuable learning experiences that decrease the likelihood of a person using again. Slips should never be recommended or condoned, but the fact is that often they do occur, especially during the early and middle phases of treatment, when patients are still struggling with ambivalence and have not yet acquired sufficient coping skills as substitutes for self-medicating with alcohol and drugs. Although less destructive than relapses, slips also carry significant risks. For example, they can rekindle intense cravings; renew doubts that the addiction truly exists; lead to irresponsible and inappropriate behaviors; adversely affect a person’s health, relationships, and financial well-being; re-establish a person’s contact with

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dealers and other users; impair judgment; and, postpone learning of non-drug coping skills (Washton, 1989).

A slip is defined as a single (isolated) instance of substance use after a period of abstinence. Slips are usually incidental, impulsive, and unplanned. They commonly result from unexpected exposure to a high-risk situation that overwhelms a person's ability to resist temptation. That is not to say that the individual has no personal responsibility for the slip occurring. Often there are unconscious and unrecognized desires to use alcohol and drugs, but patients are not adequately aware of their ambivalence (vulnerability) inside and do not take sufficient behavioral measures to guard against acting on their impulses. Slips may also result from a deliberate attempt to "test control" in order to see whether reduced or controlled use may indeed be possible. By definition, a slip is a momentary setback in the effort to remain abstinent that can be contained so it does not destroy or derail continued progress. It can be viewed productively as a mistake, an opportunity for learning, and as a signal for more careful planning to avoid future slips. A slip can be seen as the behavioral manifestation of a person's ongoing *ambivalence* about giving up chemical mood alteration. How a slip is responded to by the clinician and/or group will have a significant impact on whether the patient responds constructively or destructively. Harsh confrontation is likely to exacerbate the individual's sense of failure and guilt about having "messed up" again and increase the chances that the slip will escalate into a full-blown relapse. How patients react to a slip can be very revealing of their level of motivation and readiness to make the changes required to support abstinence. It is a good sign when patients are remorseful about using again, disappointed in themselves for letting it happen, and receptive to advice and suggestions from others about how to prevent it from happening again. It is not a good sign, however, when they

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express defiance rather than remorse about using, minimize the importance or significance of the event, and are generally unreceptive to feedback.

A relapse can be seen as the result of a slip that has gotten out of control. Instead of being an isolated instance of use, relapses are characterized by a return to the former (pre-treatment) pattern of use and a re-emergence of addictive patterns of thinking and behavior. Relapses, unlike slips, are associated with a regressive attitude shift that erodes or nullifies a person's desire to regain abstinence and often leads to dropout from treatment. Relapses can be very dangerous and in some cases, fatal. The major difference between slips and relapses does not rest on the quantity of drugs used, but on the intent and the outcome. If the person who returns to using fails to re-establish abstinence and get back on track immediately after an episode of use, continues to use, rejects offers of help, and/or drops out of treatment, it is a relapse. Relapses that are allowed to get out of control almost always involve serious backsliding, erosion of progress, and regression to an earlier stage of change.

In considering the issue of when relapse prevention strategies should be introduced into the therapeutic work, it is important to distinguish between a failure to establish abstinence in the first place and returning to alcohol and drug use after achieving various benchmarks of stability and clinical progress outlined earlier in this chapter. The former may reflect the patient's ambivalence about an abstinence commitment and reluctance to take the steps necessary to remain abstinent for more than a few days at a time. In these cases, instances of alcohol and drug should not be seen as relapses, but perhaps more accurately as a continuation of the former pre-treatment pattern of use interspersed with brief forays into abstinence. Drawing this distinction is important for a number of reasons. First, labeling these forays as relapses is a misnomer that fosters an unrealistic assessment of what stage of change the patient is currently in and thus what

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types of interventions are likely to be effective in moving them ahead in the process. Whereas relapse prevention strategies are appropriate only for patients in the maintenance stage, patients whose behavior is indicative of inadequate commitment to sustaining abstinence are more likely to be in the action stage or perhaps in an even earlier stage. Sometimes the motivation and readiness of patients to do the work required in the maintenance stage does not become evident until they actually try. A second reason for making this distinction is that introducing relapse prevention (maintenance) strategies prematurely before patients are ready to make use of them, can actually encourage rather than prevent relapse. For example, presenting these unstable marginally motivated patients with a long list of potential relapse precipitants and warnings signs is likely to be misinterpreted by them as justifications to use alcohol and drugs again. Instead of using this information proactively to avoid returning to alcohol and drug use, they are likely to see it as evidence that relapse is inevitable and/or expected. Discussion of relapse prevention strategies followed by repeated failure to apply them is a clear indication that the patient's motivation and readiness for change, not their behavior, is the most critical issue to address. A third reason is that the notion of relapse involving a series of events that culminate eventually in alcohol or drug use is simply not applicable to patients who truly are not in the maintenance stage. Returning to substance use for these patients is not the end product of a complex relapse progression, as described earlier, but rather a near instantaneous event, since the person is yet to achieve stable abstinence in the first place.

RELAPSE PREVENTION STRATEGIES

Relapse prevention strategies incorporate a variety of cognitive-behavioral, psychoeducational, and supportive techniques. The major thrust of RP strategies is to teach patients specific

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cognitive, behavioral, and problem-solving skills and to heighten their awareness of potential relapse precipitants, warnings signs, and “mind traps” to reduce the likelihood that they will return to using alcohol and drugs again and to improve the overall quality of their lives.

Educating Patients about Relapse and its Prevention

Education is an important relapse prevention tool. Patients need to be educated about certain attitudes, thinking, and behavior patterns that are characteristic of addiction and often contribute to relapse. The primary purpose of doing this is to help them anticipate the “traps” most commonly faced by people trying to maintain abstinence and learn how to deal with these traps in order to avoid returning to alcohol and drug use. You should provide patients with education about relapse as soon as possible after initial abstinence has been reasonably well established. Even if they are not strongly motivated to maintain abstinence and do not acknowledge the true severity of their addiction, education on relapse can still be helpful. Educational interventions tend to be nonthreatening ways to counteract denial and motivate patients to change. You can provide these interventions systematically in topic-oriented sessions or spontaneously in individual therapy sessions as specific issues emerge. You can also give patients a list of suggested readings or specific homework assignments in RP workbooks designed specifically for this purpose (Daley, 2000; Washton, 1990a, 1990b, 1990c; Zackon et al., 1993). It is important, however, to not make relapse education a purely intellectual or didactic experience. Information about relapse should be made as personally relevant as possible by helping patients apply this information pointedly to their current life problems, circumstances, and experiences.

Relapse Precipitants and Warning Signs

One of the most important RP strategies is to help patients identify and become increasingly aware of variables most likely to initiate or herald an impending relapse. Through discussions during individual therapy sessions as well as homework (workbook) assignments, you can help patients define the specific conditions that are most strongly associated with their prior use and/or most likely to set the stage for resumption of their alcohol and drug use. Relapse precipitants and warning signs have been divided into several categories (Daley & Lis, 1995; Marlatt & Gordon, 1985; Rawson et al., 1993; Washton, 1988), including:

1. *High-risk situations*: certain times of the day or night; people, places, and things previously associated with substance use; idle unstructured time, access to cash, parties, bars, anniversaries, celebrations
2. *Behavioral warning signs*: interpersonal conflict; failure to cope adequately with life problems and stressors; engaging in other addictive and compulsive behaviors; impulsive decision making and poor judgment; returning to secondary drug use
3. *Affective warning signs*: negative moods; emotional lability; anger, frustration, hopelessness, and irritability; identity and role confusion; positive moods and excitement; desire to celebrate; sexual arousal
4. *Cognitive warning signs*: euphoric recall and selective forgetting; repetitive drug using dreams; relapse justification; rationalizations to let up on disciplines and reduce or discontinue recovery-supportive activities
5. *Physiological warning signs*: unremitting PAWS; resurfacing of intense cravings and urges; physical illness; chronic pain

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One way to help your patients anticipate and deal with relapse triggers and warning signs is by asking them to describe in detail a likely relapse scenario. This technique can help to make the possibility or threat of relapse more real for patients and encourage them to become more mindful of forces that may propel them toward using again. Their description of a relapse scenario should include exactly what type of situation might put them into a relapse mode, where and with whom, what thoughts and feelings might be evoked, and what options might be available for avoiding alcohol and drug use. If there have been previous relapses, help the patient conduct a detailed retrospective analysis (“microanalysis”) of early warning signs and other precipitants that led up to the relapses. Previous periods of abstinence ending in relapse provide valuable information about how relapses happened and more importantly how to prevent them from happening again..

Another intervention is to ask patients routinely at each visit if they have been any close calls since the last session and if they have experienced any cravings, fantasies, or dreams about using. If patients report any of these, it is important to discuss in detail specifically what events, circumstances, and feelings may have led up to these occurrences. Careful detailed inquiry can help to focus needed attention not only on environmental, but also psychological and interpersonal issues. Conflict in intimate and work relationships and significant personal losses are common relapse precipitants. Helping patients to be mindful of their increased relapse potential around certain holidays, birthdays, anniversaries, and celebrations of various kinds and learn how to manage whatever feelings are elicited by these events, are essential components of the ongoing therapeutic work.

Substance-Specific Relapse Factors

Although the basic principles and strategies of relapse prevention apply equally well to all substances of abuse, it is important to take into consideration some of the unique features of different substances when developing specific relapse prevention plans. Knowledge of key differences between drugs can help therapists attend to certain details that might otherwise seem insignificant and be overlooked. For example, with regard to alcohol, key relapse factors include its social acceptance and legality, widespread availability, low cost as compared to illicit drugs, and social pressures to drink. Thus, effective relapse prevention strategies for alcohol-dependent patients must include teaching them how to comfortably and politely refuse offers to drink and how to cope with abundant opportunities in which, whether requested or not, alcohol is going to be quite literally put in front of their face. For stimulants such as cocaine and methamphetamine, the awesome power of urges and cravings triggered by conditioned cues and the strong connection between drug use and sex are common relapse factors. Accordingly, effective relapse prevention strategies must attend pointedly to identifying and managing drug triggers, learning how to cope with cravings, and addressing the connection with sexual arousal and behaviors. A high level of structure and frequency of contact is essential, especially in the early phases of trying to establish abstinence. For opioids such as heroin and prescription narcotics, relapse factors often include physical discomfort or pain which in some cases can be due to protracted withdrawal, low energy, and intense anger or rage. Relapse prevention strategies include dealing with protracted withdrawal, appropriate use of opioid antagonists such as naltrexone, stress reduction and anger management techniques, and alerting physicians

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responsible for providing medical care to these patients about the dangers of prescribing opioids unnecessarily to these patients and the need to have significant others retain possession of prescription opioids and dispense them according to doctor's orders if and when these medications are truly needed to alleviate intolerable pain. There are countless examples of individuals who have relapsed to opioids after receiving narcotics to alleviate intolerable suffering related to surgery, kidney stones, gall bladder attacks, back and nerve pain, dental pain, broken bones, and other traumatic illnesses and injuries. For benzodiazepine users, relapse factors include generalized and/or panic anxiety and chronic insomnia. Sometimes these are rebound symptoms are due primarily to protracted withdrawal.. As with opioids, physicians can inadvertently contribute to relapse by prescribing sedative medications unnecessarily to these patients or without implementing appropriate precautions to prevent abuse. Relapse prevention strategies include cognitive and behavioral techniques for coping with insomnia, using physical exercise to reduce stress and anxiety, and teaching progressive relaxation, medication, and thought-stopping techniques.

Dealing with Slips and Relapses: Avoiding the Abstinence Violation Effect

Patients must be prepared to deal with the reality of slips and relapses, if and when they occur. As mentioned earlier, one of the most important strategies is to teach patients how to prevent a slip from developing into a full-blown relapse. Cognitive reframing of a slip from a tragedy into a learning opportunity and making the effort to "put on the brakes" helps to reduce the shame, guilt, and exasperation often experienced by patients when they start using again.

The Abstinence Violation Effect, or AVE (Marlatt and Gordon (1985), is one of the cognitive distortions or "mind traps" elicited by a slip. .Essentially, the AVE is an overreaction, a strong

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defeatist response to the slip. Using again contradicts the person's identity as an abstainer and instantly transforms him/her back to the identity of an active user- thus the term "abstinence violation effect". The person often attributes the slip to personal weakness, instead of viewing it as an avoidable mistake. When immersed in this cognitive distortion with its attendant self-loathing, frustration, and self-blame, the individual is more likely to give up on abstinence and the slip is more likely to escalate into a full-blown relapse. Clearly, an important component of relapse prevention is warning (educating) clients about the AVE and more, importantly, helping them to plan strategies to prevent this reaction from escalating to the point where it completely derails their recovery.

It can be very helpful to outline for patients responses to slips that can help prevent them from turning into relapses as compared to responses that are unhelpful (Washton, 1990b). For example, people who slip without relapsing are likely to: (a) take the slip seriously and regret that it happened, but do not become demoralized and learn whatever they can from it; (b) discuss it openly and honestly with members of their recovery support system; (c) carefully examine what aspects of their attitude, lifestyle, behavior, and moods may have contributed to the slip; (d) re-establish routines, structure, support, and positive activities to prevent further slips; and, (e) redouble their commitment to maintaining abstinence and working a good recovery program. By contrast, those who let slips turn into destructive relapses are likely to: (a) feel shamed, humiliated, and demoralized by the slip; (b) become secretive, withdrawn, and uncommunicative; (c) blame others and external circumstances for the slip and fail to take adequate personal responsibility for it; (d) feel pessimistic about stopping and justified in continuing to use; and (e) reestablish contact with drinkers, users, and dealers.

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Another important strategy is to debrief patients after a slip or relapse. As mentioned above with regard to relapses that may have occurred prior to the current treatment episode, conducting a “microanalysis” (Daley & Lis, 1995) or relapse debriefing can provide valuable information that can be used to help prevent relapses from happening again.

Heightening Awareness of “Seemingly Irrelevant Decisions”

This phenomenon is an example of how forces out of an individual’s conscious awareness can lead him/her insidiously back to using again. Individuals headed for relapse sometimes unknowingly make a series of self-defeating choices including “accidentally” exposing themselves to high-risk situations that are likely to cause relapse. Through a series of subtle self-sabotaging acts and “seemingly irrelevant decision” (Marlatt & Gordon, 1985) they end up in situations that virtually guarantee exposure to drug-related cues that overwhelm their impulse control. For example, a person who has been abstinent for several months might “unintentionally” find himself driving down a certain street ignoring that this is the very street where his former drug dealer lives. Similarly, patients might accept an invitation to a party overlooking the fact that people who drink excessively and use drugs will be there and that the temptation to join in probably will be overwhelming.

Dealing with Fantasies of Returning to “Controlled” Use

Success in establishing abstinence can bring a return of ambivalence; a feeling that life has improved so greatly that controlled use might be possible now. Stimulant users, in particular, are likely to experience euphoric recall, in which memories of adverse consequences seem to

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evaporate, along with the lessons of their painful struggle to rebuild their lives. It is as if a cloud comes over them and they are preoccupied with re-experiencing the intense pleasure of the early stages of their stimulant use. This particular phenomenon manifests in different forms with other types of alcohol and drug users. It does not appear to be as distinct, yet there is often a longing for the “fun” of the hard drinking days, particularly in those who have not developed alternative recreational activities in recovery. Those with untreated depression are particularly vulnerable, as their dysphoria makes recovery seem gray to them. Those who have made substantial progress may be particularly vulnerable to the seductive idea that their accomplishments have put them in a position to control their use now. Participation in a recovery group or in self-help meetings can be an important influence to offset relapse drift, as others can almost certainly describe traveling down that path. There are times, however, when no intervention seems effective, and the therapist must maintain a firm therapeutic alliance so that the patient will not drop out of treatment if a relapse occurs.

The desire to test control is most likely to occur when patients have been abstinent for several weeks or months, feels stronger, more in control of their lives, and are no longer acutely or noticeably feeling the “sting” of drug-related consequences. In the words of one patient:

“I thought I’d prove my therapist, my wife, and everyone else wrong, so I went out and tested myself with cocaine again. I tried a little experiment just to see if I could handle doing it again without getting crazy and out of control. I figured that if I passed the test, maybe, just maybe, I could go back to doing it just once in a while again. I thought to myself, what an accomplishment that would be! After all my life was back in order, I still had my job, I was making good money, and my wife was still with me. Well, I failed the test miserably and ended up on a four-day binge of cocaine and alcohol. There I was, right

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back in the coke scene, disappearing on a binge and running after prostitutes again.

Looking back I realize how foolish and self-destructive I was to think that I could pull it off, but at the time it all seemed within reach to me. If nothing else, it showed me that my addiction and my potential for relapse were there all along even though I had not used in several months and on the surface everything else seemed okay. I wish I didn't have to learn the hard way and go through the horror all over again. Now, when I get those nutty thoughts about trying to be a "controlled" user, I reach out immediately to people in my support system for a reality check."

Ongoing Resistance to Abstaining from Secondary Drugs of Abuse

As stated in the preceding chapter, one of the most difficult clinical challenges is the issue of abstinence from secondary drugs of abuse. Patients are typically vigilant about desires for their primary drug of abuse, but many minimize the importance of their lesser preferences. Research data and clinical experience supports the view that the widest margin of safety is obtained when the patient maintains abstinence from all intoxicants. Many, however, view their other drug use as insignificant. It is common for stimulant or opioid users to protest that they never had a problem with alcohol prior to their use of these drugs. However, they are often unaware of their escalating alcohol consumption during the periods of drug use; some even suffer serious alcohol withdrawal once they enter inpatient treatment for drug dependence. They would like to believe they can return to normal social drinking once they have had an extended period of abstinence from drugs. This supposition carries great risk. In addition, there is the problem of drug substitution. Alcohol problems usually develop more slowly, but it is common to find former

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users of illicit drugs entering treatment for alcohol dependence, often years after their last use of other drugs.

One part of the difficulty in helping patients fully acknowledge the risk is that the major relapse may take place weeks or months after the use of the secondary drugs. Every stimulant user will readily acknowledge that if they have a few glasses of wine, and someone offers cocaine, there is little chance they will be able to refuse and leave the situation immediately. It is much harder for patients to integrate the idea that the glass of wine or beer today bears on the relapse six weeks from now, though clinicians observe this repeatedly. This is an extension of the principle that drug use consequences that are removed in time are less influential than those that are relatively immediate. We can hypothesize several levels of contribution. On the biological level, the use of any drug stimulates the craving center in the brain, which in turn stimulates the hunger for the primary drug of abuse. On the psychological level, patients long for the rewards they got from intoxicants, and convince themselves there is little danger, because, “after all, I don’t even like alcohol that much.” Again, a recovery group or self-help meetings can provide valuable feedback to the patient entertaining these rationales, but the drift may be inexorable and even those who have been through several relapse episodes precipitated this way may persist in this behavior. It is nonetheless desirable to explore a range of psychological possibilities: rebellion over being good for so long; longing to get high to counteract sustained negative moods; feelings of “I deserve this” for working so hard in recovery; a resurfacing of traumatic material, a desire to be “normal”. The therapist can become exceedingly frustrated at this point, and it is necessary to work to maintain a healthy balance of engagement and detachment. Patients are very sensitive to their therapists’ disgust

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or disapproval, and it is certainly important to avoid power struggles, but excessive detachment can leave the patient feeling without a lifeline.

Dealing with the “Pink Cloud” and Feelings of Being “Cured”

The initial positive effects of stopping alcohol and drug use can be striking- at least for a while until the stress and problems of everyday life reappear full force and burst the patient’s bubble or “pink cloud” and end the “honeymoon” phase of early recovery. Although some patients do not experience this effect, and feel distinctly worse not better after stopping alcohol and drug use, many if not most will show some evidence of being on the “pink cloud”. Related to the “pink cloud” phenomenon are illusions of being “cured” of the addiction or that it no longer exists (and maybe did not exist in the first place) after several weeks or months of abstinence, especially if remaining abstinent has not been very difficult and devoid of crises,

The danger of being in this state is that fosters a sense of overconfidence and a belief that the problem is solved and not likely to return. Having given up alcohol and drugs, the true source of all their problems, so it seems, patients often feel that they can now go on happily with their lives by simply remaining determined to not use again. Patients in this frame of mind are extraordinarily prone to overreacting to almost any negative event that threatens to throw them off of their cloud, no matter how large or small that problem may be. Accordingly, they are at high risk for relapsing in response to feeling disappointed and resentful when problems arise.

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Patients on a pink cloud pose a dilemma for the treating clinician. On the one hand, it is important to applaud the patients' progress and compliment them for making positive changes. On the other hand, it is equally important to not foster unrealistic hopes and expectations that could set patients up for being blind-sided by serious setbacks. The best approach is to complement patients for making progress and also call their attention to the importance of remaining vigilant about dangers that may lie ahead. Reminding patients of their vulnerability to relapse and describing scenarios that others have experienced as a result of not being sufficiently aware and proactive, can be both instructive and motivating.

Creating a Balanced and Satisfying Lifestyle

Achieving a balanced satisfying lifestyle is an essential part of reducing the potential for relapse. Often, using alcohol and drugs has occupied a significant part of the person's time and caused them to give up other healthy pursuits to the point where stopping the use leaves a large void that can be filled too easily by using again. Many individuals have become so accustomed to instantly modifying their mood and mental state with psychoactive substances that the idea of having to plan, expend effort, and engage in physical activity for enjoyment and stress relief may feel daunting at first. Also, some patients are severe "workaholics" whose daily lifestyles are severely out of balance. Often, using alcohol and drugs is the only form of gratification they have allowed themselves on a regular basis. Thus, once stable abstinence has been achieved it is essential to encourage and guide the development of new leisure and recreational activities that serve intrinsically to reinforce a recovering lifestyle devoid of alcohol and drug use. The primary goal is to learn how to have fun and enjoy the rewards and reap the rewards and pleasures of life without relying on alcohol and drugs. Pleasurable activities should be integrated along with work

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and family responsibilities on a regular basis. The particular types of activities should be based on the patient's needs, interests, and preferences and ideally should include activities that can be pursued alone as well as those that involve the participation of others.

For individuals who previously were in the process of establishing a balanced lifestyle, discontinuing regular exercise, self-help meeting attendance, or other self-care activities without thought or discussion should be a warning signal for the therapist. Other warning signs include neglect of stress management techniques such as avoiding or being watchful when one is hungry, angry, lonely or tired. The therapeutic framework offers the advantage of a structure to notice shifts in routine activities and discuss their implications. How did you decide to cut back your exercise regimen? How did you drift into thinking you could manage on less sleep for extended periods of time? This allows the patient to increase awareness and make appropriate behavioral corrections. It is always easier to interrupt relapse drift in the early stages than when the factors have accumulated.

Keeping Ugly Reminders in View

In order to counteract the tendency of patients in early recovery to experience euphoric recall (i.e., idealizing or "romanticizing" the previous good times on alcohol/drugs and selectively forgetting the bad times) they should be encouraged to maintain vivid and where possible visible reminders of the negative consequences caused by their previous alcohol and drug use. For example, one patient was encouraged not to immediately repair the fender of a new car that he smashed into a fire hydrant while under the influence of alcohol. Similarly, another patient pinned a rent eviction notice on the wall of his home office to remind himself of the horrible financial situation he was in as a result of being addicted to cocaine.

Maintaining Drug and Alcohol Monitoring

Although not specifically considered an RP technique, drug and alcohol monitoring can be an effective tool for reinforcing abstinence. The unique benefits of this tool were discussed at length in the preceding chapter, but suffice it to say that continuing the monitoring through at least the first or so of recovery or until the patient leaves treatment is advisable. In fact, patients who have been on drug and alcohol monitoring for a while often feel reluctant and apprehensive about discontinuing it, realizing the significant role it has played in helping them control impulses to use at earlier points in treatment.

Filling Social and Recreational Gaps

Patients typically underestimate how much time they have devoted to using alcohol and drugs and also how profoundly it has affected their social relationships. For those who use alcohol or marijuana, the changes are slow and can be almost imperceptible. Gradually, the person focuses attention on social groups that drink at the same level, and disengages from other relationships. Forming a relationship with a partner who does not drink, or drinks occasionally, can reverse this trend in people who have not progressed to severe dependence, or who are without risk factors such as a genetic predisposition. Those who develop serious problems typically have selected their social networks in ways that camouflage their drinking patterns and allow these patterns to appear normal. Indeed, what passes for normal in many social groups is in fact well above the limits of what is considered non-problematic or responsible drinking. Alcohol problems can take

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a long period of time to show themselves clearly, particularly in men. Women have a more telescoped course, but can also appear functional for lengthy periods.

Marijuana is associated with problems that are difficult to pinpoint until the user stops for a period of time. After three or more months of abstinence, marijuana users report a longer attention span, less forgetfulness, less fatigue and fewer low level symptoms of depression. They are then in a much better position to reconstitute their social networks and focus on improving their quality of life in other ways. This is especially true for those whose marijuana use has promoted social isolation.

The slow and gradual onset of problems results in lengthy participation in a social network in which drinking or drug use seems necessary in order to belong. Patients may need to grieve not only the loss of their substances of abuse, but the social networks surrounding them. Your patient will need to construct a new social network in order to be successful. Understandably, many resist this and may have several relapse episodes before concluding that cannot continue to socialize with heavy drinkers or users and be successful in changing their behavior. Drugs like cocaine and methamphetamine are associated with a rapid downhill course, which often means your patient has more low-risk social possibilities once they have become abstinent. They may not have to regenerate a social network that has been shaped by decades of drinking or marijuana use, but can resume at least some of their familiar contacts.

Coping with Social Pressures to Use

Many patients work in environments where there is strong social pressure to drink together, or where drug use is common. Patients may participate in order to belong, or to achieve performance goals they have set for themselves. Regular drug and alcohol use almost always

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results in reduced performance; the drug effects change over time and the “down time” typically increases. For example, the woman who depends on wine to help her feel comfortable meeting strangers for a business lunch may fail to appreciate the subtle decrease in ability to focus and think clearly that develops over time. Stimulants tend to promote a narcissistic overvaluing of the quality of the work produced; they rarely improve judgment about work products. Medical professionals with relatively easy access may begin using prescription drugs out of curiosity, but then quickly become enmeshed and unable to ask for help while their performance deteriorates.

It is important to assess the many factors promoting drug use in the workplace and in social situations and formulate action plans accordingly. Are the difficulties so daunting that the patient must consider changing his friends, job, or career? What protective factors can be introduced to allow your patient to remain in a job he may value highly? For example, naltrexone, a narcotic antagonist discussed in Chapter 4, allows many medical professionals to continue to work around opioids despite their availability at work. Disulfiram (Antabuse®) may help someone in the restaurant business continue to work there despite the endemic presence of alcohol. However, medications can be only one part of a recovery effort that must include psychosocial changes as well. Changing from an evening to a daytime shift may reduce vulnerability by placing the patient in a situation with more supervision, and eliminating some of the conditioned triggers like fatigue and the presence of drug using co-workers. Developing rituals to prepare for creative activity may allow your patient to get past the conviction that drugs are necessary to open the mental doors to meaningful work. Learning that in the absence of drugs, the quality of one’s work is likely to be just as adequate, or more so, can take time. Interacting with others who have found and developed their creative voice without reliance on intoxicants is invaluable for reassuring your patient that this is an achievable goal.

Learning New Ways to Cope With Feelings

In early recovery, impulse control is a primary issue. Once abstinence is stable, you can address more subtle issues of experiencing and expressing emotions. If possible, it is useful to determine by history your patient's strengths and deficits in this area prior to the onset of their alcohol and other drug use. Substance use distorts behavior, but it is important to know if you are promoting a return to earlier, healthier coping patterns, or helping your patient develop new skills. For example, many patients who are drinking and using become accustomed to expressing their anger freely, whether intoxicated or not. They may come to rely on intimidation rather than communication. Patients who never had good controls need much more attention to skill building than those who can reclaim skills they once exercised. Substance users become accustomed to rapid change in feeling states and relatively instant relief from discomfort, and need to learn to approach their feelings in a different way. The ability to tolerate arousal of difficult emotions, or the experience of any emotion for more than a few moments, can be a challenging task for your patient and may need to be an explicit focus of your work. Some emotions may be taboo, others acceptable. Anger may be expressed quite easily, but sadness or vulnerability is less tolerable and thus less likely to be expressed. Teaching your patient to simply maintain an ongoing awareness of changing feeling states without feeling compelled to alter them is an important task.

It is also important for you to help the patient determine when feelings reflect symptoms of mood or anxiety disorders and medication should be considered. Overwhelming anxiety or sustained periods of low mood increase vulnerability to relapse and interfere with learning new skills, developing new relationships, and building confidence in new ways of coping. Although

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some therapists prefer to have a sustained period of psychosocial intervention before considering medication, this can promote demoralization over lack of progress, or allow a major depressive episode to get underway before medication is initiated. Depression is more easily treated if medication is initiated at the onset of an episode, so it is important that the therapist avoid the position of referring patients for medication consults only when all else has failed.

Timing is best decided in collaboration with your patient. The patient must understand that learning to experience and express feelings appropriately is a part of recovery, but extended distress is not necessarily useful. Does depression interfere with mobilizing to attend self-help meetings? Does anxiety promote social isolation, or fearfulness about trying new ways of handling relationships? Medication is not always useful, but patients can be asked to consult a psychiatrist whether they are prepared to begin medication or not. An addiction medicine psychiatrist is particularly likely to have a productive discussion on the potential benefits or contraindications. Patients may agree to a medication trial, or may want time to digest new information and consider a change in approach.

You should explore and address any resistances to psychotropic medication, as therapists spend more time with patients than physicians and other treating professionals and are more likely to have relevant information about the patient's history. Patients with family members who have severe psychiatric disorders may view medication as a sign of "being crazy." Use of medication to feel better is a charged issue for people in recovery, especially if they have abused prescription drugs. This must be sensitively handled, and it may take time to work though. Fortunately or unfortunately, many psychotropic medications take time to begin working, so that medications gradually become distinguishable from drugs of abuse. This can

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be framed as part of the larger issue of learning to invest time and effort in the service of later improvements, rather than expecting instant results. The issue of control may also be important. Considering that substance use is often an important if not primary activity that gives your patient an illusion of control, and it is common to resist sharing this control with a physician. Patients often stash supplies of anti-anxiety and other medications just so they won't be at the mercy of a physician if they reach a period of desperation. It is important to discuss and monitor your patient's willingness to build a good team relationship with the prescribing physician, one in which the parameters of patient decisions about dose changes and frequency are explicit and it is clear when the physician should be included in deviations from the agreed upon plan.

Moving Beyond All-Or-None Thinking

It is important to keep in mind that a rigid, yes-or-no thinking style is quite adaptive in early recovery. No drinking or drug use, no exceptions, gives the widest margin of safety. This often extends to rigid rejection of certain social gatherings, determination to maintain specific schedules around 12-step attendance, and devotion to particular exercise regimens. Any disturbance of the protective routine is threatening. As recovery progresses, it is important for your patient to increase ambiguity tolerance and be able to handle complex considerations.

Some are inherently rigid in their character structure and may do best if left unchallenged. Others need encouragement to expand their perspectives and test out more flexible coping strategies. For example, a 30-year old methamphetamine user who regularly engaged in sexual adventures while using the drug understood that sexual arousal was a powerful trigger and rigidly avoided sexual encounters and other forms of intimacy in his first year of recovery.

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Sexual arousal was frightening because of the associated cravings for methamphetamine, and he felt insecure about any attempts to connect with a woman. Although his rigid posture helped him achieve a year clean and sober, it was clear this coping strategy had decided limits as a permanent solution. His therapist encouraged him to form friendships with women with whom he did not have intense sexual chemistry. He also began to air his fears that sex would be awkward without using the drugs he had relied upon since he became sexually active as a teenager. Sharing experiences with members of his small recovery group, as well as in his self-help meetings, reassured him that he was on a well-traveled path that many have navigated successfully.

Learning New Interpersonal Skills

Recovery will challenge your patient to learn new interpersonal skills in a variety of ways. Those who are captive to social approval will need to adopt refusal skills quickly as long as they remain in environments with those who drink and use. Setting boundaries is both an immediate challenge and a topic for long-term exploration, as it typically has roots in early childhood experiences. How deeply you probe is a function of stage in recovery. For the patient in early stages, it is sufficient to “flag” the issue as an important theme to be addressed, while remaining focused on specific behavior changes, such as the need to say no to stay safe.

Once alcohol and other drug use are not a primary focus in a relationship, other difficulties emerge more clearly and deficits in communication skills become apparent. The partner who drinks and uses may feel at a disadvantage in voicing dissatisfactions with the relationship, and may have relied somewhat on substance use to manage the situation. Abstinence brings destabilization. Alternatively, alcohol and other drug use may have promoted an abusive

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dynamic, in which anger and irritability intimidated others into submission. Once these substances are out of the picture, the power balance changes and communication skills become the tool to renegotiate relationships. Conflict resolution skills become important at this point.

Managing Anger

Because anger is one of the most common and compelling relapse precipitants, anger management techniques are an essential component of RP strategies. Anger management skills focus on helping your patient identify signs of anger, particularly in the early stages, and find appropriate and constructive modes of expression. Some have to get furious in order to set a limit, and have to learn to monitor their own signals of discomfort so they can assert themselves before anger builds up. Patients also learn to evaluate whether they are overreacting or displacing anger from one situation to another. They learn to recognize when their anger is a cover for fear and anxiety. In many situations, it is important for your patient to identify someone who is not part of the problem who they can use as a sounding board. In early recovery, it may be important that they are able to reach someone immediately. Members of their self-help group, particularly sponsors, are good candidates. Substance abuse treatment settings often use cognitive behavioral techniques in groups focused on anger management. These can be adapted to individual sessions if your private practice is not conducive to offering group treatment (Reilly & Shropshire, 2002).

In the beginning stages it is desirable for your patient to dilute his or her dependencies rather than concentrate them on the therapist, partner or spouse. Many patients cannot tolerate intense

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feelings of vulnerability and dependency concentrated on one individual, and either abruptly withdraw or display storms of ambivalence. The self-help system is ideal to provide a support system that is diffuse enough to be well tolerated.

Patients in anger management also identify strategies for cooling off. Physical exercise is excellent, as it helps dissipate arousal. "Time outs" also define a cooling off period for patients, who become increasingly able to use this structure with frequent practice. Patients are encouraged to wait before responding, organize their thoughts and consider their options. They are encouraged to avoid solutions that have created problems in the past.

Accepting the Identity of a Recovering Person

The patient who accepts the identity of a person in recovery has a matter-of-fact acceptance that it is not possible to use intoxicants safely and it is necessary to develop a comfortable and satisfying life without them. Critics of AA have assumed the identity of a recovering person is inevitably negative and argue that it is disparaging and prolongs low self-esteem. The identity of recovering person need not perpetuate a poor self-image. Those well along in a solid recovery process have worked through much of their shame and guilt, while taking responsibility for their behavior, and can acknowledge the importance of abstinence without harsh self-criticism. They also understand they must remain mindful of potential relapse hazards, such as increased stress, interpersonal conflict or loss, or high-risk social situations. Their behavior reflects the changes in their self-image, for example, disengaging from social networks in which drinking is glamorized or viewed as an essential element to having a good time.

Feelings of deprivation often reflect areas in which further therapeutic work is needed, such as management of feelings or development of new social networks. For example, patients who

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have not developed new friendships or attractive recreational activities often miss the lack of camaraderie and excitement they associate with drinking and drug use. Prolonged negative feelings may also reflect untreated psychiatric conditions such as depression. Although they may not completely meet criteria for depression, patients with a personal or family history of alcoholism may benefit from antidepressants, especially if they remain moody, irritable, and dysphoric.

FAMILY ISSUES IN RELAPSE PREVENTION

Working with couples and families can be an essential element in preventing relapse, as this strengthens the support structure among intimates, particularly those in the same household as the primary patient. The term *family* is used broadly here, to include gay or lesbian partners, household members who may have no legal ties, and members of the extended family who are influential though they do not live in the home. You may want to consider including any member of the patient's network who is involved in the addiction or who is likely to play a significant role in the patient's recovery (Galanter, 1994).

The terms "enabling" and "codependency" are frequently used in work with significant others, and it is important to avoid certain pitfalls with these concepts. *Enabling* refers to behaviors that perpetuate the addictive behavior. It can take the form of avoiding, shielding, minimizing, colluding, attempting to control the addict's behavior, taking over responsibilities and otherwise protecting the addict from the consequences of behavior. *Codependency* refers to the unhealthy adjustments made by others in relation to the abuser. Attention shifts from their own needs and activities and they become preoccupied with the behavior of the addict. Individuals gradually abandon their own interests and family functioning becomes organized around the drinking and

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using of the identified patient. The therapeutic task is to restore a healthier equilibrium in which everyone's needs are taken into account.

Both "enabling" and "codependency" have come to be used by patients and therapists to express frustration, anger and disapproval. It is important to keep in mind that significant others who care about your patient are an important positive prognostic sign. Your task is to shape their behavior, not to pathologize their attempts to help. Family members and others are often confused about what constitutes a desirable balance of engagement and detachment. They may label appropriate forms of support as negative. The therapeutic task is to help them get beyond epithets, examine specific situations in terms of what is or is not helpful, and adapt accordingly.

Domestic violence occurs in all social classes and it is essential to include some questions in the assessment process. You can ask your patient and family members: Have you ever been hit, kicked, punched or otherwise hurt by someone in the past year? If so, by whom? Do you feel safe in your current relationship? Is there a partner from a previous relationship who is making you feel unsafe now? Although substance use is typically involved in episodes of violence, it is important to remember that these patterns have a life of their own and may continue into periods of abstinence. Safety questions must always be addressed quickly in the treatment process, so it is important for you to clearly identify resources at your disposal. If continued drinking or using episodes put others at risk, you must formulate a plan that considers the needs of anyone at risk from the outset.

You will have to determine if doing the family work yourself is likely to interfere with your tasks with your primary patient, and include a family therapist in the treatment plan accordingly. It is very important that the family therapist understand stages of recovery, so he or she can synchronize treatment goals with recovery task. Focusing on conflict resolution prematurely is

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likely to precipitate relapse. It is important for the family therapist to be willing to help the family find solutions that protect the newly abstinent patient from excessive stress while giving others an appropriate outlet for their feelings.

On a more practical level, families may feel they previously lost the patient to the addiction and they are now losing him or her to self-help activities. Spouses and family members may feel jealous that their mate, who has created a huge wreckage, now acquires an extensive support system and they are asked not to undermine participation. They feel that they have been the anchor, and ask “What about me?” Helping them be appropriately patient and weather the storms so that recovery rests on a solid foundation is a key task for the treatment team.

In the absence of problems such as domestic violence, it is useful to ask couples not to make major decisions about their relationship during the first year of recovery. Changes can be very dramatic and it is difficult to know which problems will be enduring until a period of stability has been achieved. Many problems emerge from choosing a mate while actively addicted. One or both spouses may conclude they simply don’t like each other and decide to terminate their relationship. In the early stages, encouragement to “focus on your recovery” can lead to a devaluation of the spouse, who is seen as remaining stagnant while the newly abstinent person is changing rapidly. Over time, the recovering partner may actually outgrow their mate due to the extended focus on self-examination. Partners may be involved in Alanon, psychotherapy, or another activity that promotes their own growth and increases their ability to exit an unhealthy relationship. For many, however, couples work allows them to renegotiate their relationship in a way that is satisfying.

FINAL COMMENT

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Relapse prevention strategies have become a standard feature of addiction treatment programs and group therapy approaches to treating addictions over the past two decades and they can be integrated quite easily into individual treatment sessions in office-based practice. RP strategies emanate from the premise that the factors that help to *initiate* abstinence from addictive behaviors are different from those needed to *maintain* abstinence. These techniques are based primarily on a cognitive-behavioral and skills acquisition approach involving education, therapeutic confrontation, affect management, and coping skills development. Although slips and relapses should never be condoned or encouraged, clinicians should not only help patients face the reality that relapse is an ever-present danger, but also respond therapeutically if and when patients return to using alcohol and drugs again. Preventing slips from escalating into full-blown relapses is one of the primary goals of RP strategies. Helping patients to maintain abstinence and prevent relapse involves, among other things, teaching them how to recognize relapse warning signs and how to cope effectively with high-risk situations and other potential relapse precipitants. Therapists must be mindful of the potential for experiencing negative countertransference reactions to patients who relapse repeatedly. While therapists must never downplay the potential dangers of relapses or ignore them, it is essential to show empathy, concern, and a positive problem-solving attitude that reframes relapses as avoidable mistakes, not tragic failures. A genuine belief that patients can learn from these mistakes and move forward in their recovery, should be conveyed to patients routinely. After abstinence has been firmly maintained for several at least months and the potential for relapse is markedly reduced, patients may benefit from more insight-oriented psychotherapy that focuses on a wider range of psychological issues in greater depth, as discussed in the next chapter

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