

## RELAPSE PREVENTION FOR ALCOHOLISM

**Karen E. Hart**  
**PhD Student**

College of Juvenile Justice and Psychology  
Prairie View A&M University  
**Fulbright Scholar**

**William Allan Kritsonis, PhD**  
**Professor**

PhD Program in Educational Leadership  
Prairie View A&M University  
Member of the Texas A&M University System  
**Visiting Lecturer (2005)**  
Oxford Round Table  
University of Oxford, Oxford, England  
**Distinguished Alumnus (2005)**  
Central Washington University  
College of Education and Professional Studies

---

### ABSTRACT

**This article examines the utility of the Cognitive–Behavioral model for circumventing relapse in the treatment of alcoholism. In addition to providing an overview of the conceptual framework for this approach, the specific techniques used as well as their rationale will be explored. Finally the article will present critiques of this relapse prevention methodology and highlight prospective trend(s) for its use in the future.**

---

### Introduction

**T**he term relapse is used frequently in psychological circles and thus has caused the tendency for many to minimize its complexity. Its use often abounds with negative connotations, which conjure images of failure on the part of the client and even perhaps the therapist. Although not often discussed, there are gradients of relapse in terms of frequency, duration, intensity and causation.

### **Purpose of the Article**

The purpose of this article is to examine the utility of the Cognitive–Behavioral model for circumventing relapse in the treatment of alcoholism. In addition to providing an overview of the conceptual framework for this approach, the specific techniques used as well as their rationale will be explored. Finally the article will present critiques of this relapse prevention methodology and highlight prospective trend(s) for its use in the future.

According to the Webster’s New World Dictionary (1996), relapse is a Latin derivative of *relapsus* which means to slip or slide back. Relapse Prevention (RP) is a commonly employed cognitive-behavioral approach that seeks to identify and prevent situations which place persons in recovery in high risk situations. These are instances in which the person’s attempts to resist engaging a certain behavior are in jeopardy of being compromised. This may include triggers such as people, places or activities/events (Witkiewitz & Marlatt, 2004).

RP is perhaps best defined by Witkiewitz and Marlatt (2004) who saw it as an intervention designed to circumvent and control the relapse of those receiving treatment for additions and/or problem behaviors. Relapse ought to be considered as both an out come as well as a process inclusive of any problems the individual may experience during behavior change efforts. During the person’s efforts to change a behavior, it is very likely that he/she will experience a lapse or pause of some kind in adaptive behavior. This setback is often followed by reengaging in the behavior that was previously identified as problematic which is known as a relapse (Witkiewitz & Marlatt, 2004). RP is deemed by Witkiewitz and Marlatt (2004) to have an invaluable role in the ongoing development of therapeutic intervention. Hence they advise that by the conjoint use of cognitive-behavioral models of relapse and RP techniques, maximum assistance will be provided for persons seeking to abstain or modify for psychological distress and problematic behaviors.

### **History of Relapse Prevention**

RP dates back to Marlatt’s work on alcohol addiction in the 1970s. As cited in Simonelli (2005), it mirrored the disease model that was prevalent during that time, and therefore slighted the role of psychological and situational factors in this phenomenon. He and Gordon later revamped this theory in 1985 in order to account for the client’s exposure to, and coping skills in, high risk situations. This not only aided the initiation and continuation of alcohol use, but also increased the probability for relapse. In 1998, Marlatt and Gordon reconceptualized their approach to Relapse Prevention; with relapse framed now as an inflection point from which the client made a choice about future behaviors there was a greater emphasis on skills training, practice and mastery (Larimer, Palmer & Marlatt, 1999).

In his self control program developed in 1996, Marlatt saw relapse as a failed attempt by the individual to modify a particular (negative) behavior pattern or to develop new optimal ones. Others have used time as a defining trait of relapse, for example re-engaging in  $x$  for  $y$  days/weeks. At best relapse ought to be considered as a continuous variable, rather than a

dichotomous one, to include both time and quantity as pivotal indices in the process. This view facilitates the client taking a greater degree of empowerment, which is beneficial for recovery (Simonelli, 2005).

Originating from Marlatt's groundbreaking work with alcoholics in 1978, RP as a cognitive-behavioral model of the relapse process has been widely accepted as it focus on both the factors at work high risk situations but also the person's response in it. If there is a low level of self efficacy the individual may be persuaded into giving in to the craving/desire which is unfortunately followed by feelings of self blame due to a perceived loss of control (Witkiewitz & Marlatt, 2004).

RP makes use of role-play techniques in order to assess a person's response in overt and covert high-risk situations. This also has secondary gain as it educates the individual about the potential for relapse, the process and habits/tendencies that bring aid in relapse. RP has been useful in addressing numerous psychological problems including mood disorders, substance use, eating disorders, sexual offending and anxiety disorders just to name a few (Witkiewitz & Marlatt, 2004).

Research on RP indicates that it has a delayed emergence effect with continuous improvement over time as opposed to other methods. This is best explained by the possibility that there is a *lapse-relapse learning curve* where the high risk of a lapse in the wake of treatment is followed by advances in coping skills which counteract the likelihood of relapse further on. A study by Irvin et al (1999) showed that in terms of treating substance abuse RP works better for alcohol users (cited in Witkiewitz & Marlatt, 2004).

## **Treatment Considerations**

### **Socio-Demographic**

The literature proffers several socio-demographic antecedents which must be considered when designing a RP program. Related to relapse is the amount of education namely less than 12 years with obtaining a GED as the highest, lower socioeconomic status, and ethnicity (non-Hispanic women). Additional variables cited by Larimer et al, (1999) include low self efficacy or the lack of confidence in one's ability to succeed at a task; negative emotions such as anger, depression, anxiety and boredom; the lack of a social support network; and the original level of addiction and withdrawal symptoms.

### **Intrapersonal Variables**

Witkiewitz and Marlatt (2004) enumerate several intrapersonal determinants that make one susceptible to relapse during treatment. They include the following:

1. Self-efficacy which is the extent that individual feels confident and able to execute the behavior required during the treatment process. Despite the usefulness of this concept, it continues to be elusive to measure as the self reports traditionally employed fail to measure it in circumscribed contexts.
2. Outcome expectancies where the individual's expectations of the future affects how he/she will respond. This is based on the anticipation of positive versus negative outcomes, the cogency of the belief and results of this expectancy in the past.
3. Cravings have been widely studied in addiction but its role in addition continues to be misunderstood. In moving beyond the subjective feeling/craving to the cue exposure mechanisms that fuel it RP has been met with success.
4. Motivation is pivotal to RP as it encompasses both the motivation to engage in the problematic behavior as well as the motivation to change. DiClemente and Hughes' 1990 transtheoretical model of motivation, cited in Witkiewitz and Marlatt (2004) aptly delineate the five stages of readiness for change: precontemplation, contemplation, preparation, action and maintenance.
5. Coping, in particular behavioral approach coping via meditation exercises have been linked to decreased addictive behaviors, interpersonal and psychological problems within a year of treatment. Despite this success the foundational cognitive behavioral processes of coping continue to be elusive.
6. Emotional States, in particular negative affect, has been inextricably tied to relapse and the perpetual engagement in problem behaviors.

### **Interpersonal Variables**

The interpersonal determinants which include the quality, availability and functionality of social support have proven predictive of RP. One should be reminded though that many of the psychological issues to which RP has been applied have social isolation as a major contributing factor for its initiation and maintenance (Witkiewitz & Marlatt, 2004).

### **Theoretical Cornerstones**

Cognitive-Behavioral Coping Skills Therapy (CBST) has evolved since its introduction by Marlatt in 1970. It is now a collaboration of treatment approaches aimed at increasing a client's cognitive and behavioral for the lasting change of problem behaviors such as alcohol dependence and psychiatric disorders. Despite the variation in CBST in terms of duration, modality, content and treatment setting it is known for two cornerstones. Firstly, they adhere to Bandura's social learning theory and see coping deficits for life and alcohol cues as precursors for substance dependence. Secondly, it utilizes individualized skills training by modeling, role

playing, instruction and behavioral rehearsal to compensate for deficits (Longabaugh & Morgenstern, 1999).

According to Longabaugh and Morgenstern (1999), CBST views substance dependence and all other forms of psychopathology as maladaptive learning hence it strives to have them unlearned and replaced with adaptive responses. Apart from its historicity in the field of alcoholism treatment CBST continues to be ranked highly for its clinical and cost effectiveness which is attributed to the context that treatment is delivered in and when it is a part of a comprehensive ongoing intervention (Longabaugh & Morgenstern, 1999).

### **Treatment Options**

Several variations of RP have been devised and offer promise for success in the future which reconceptualize relapse as a multidimensional system with complexities that require simultaneous attention to the client's disposition(s), behavioral contexts as well as past and current experiences with the cessation of problem behaviors. As such it concedes that there are numerous considerations for what triggers and influences relapse such as client background, psychological states, cognitive processes and coping skills (Witkiewitz & Marlatt, 2004).

Among the recent psychological tools that have been employed in preventing relapse during the treatment of alcoholism, Coping Skills Training (CST) and Cue-Exposure Treatment (CET) have been met with a great measure of success. According to Monti and Rohsenow (1999) it is opined that these techniques lessen the chances that a client will relapse in urge provoking situations because of feeling overwhelmed.

### **Coping Skills Training**

CST has been a work in progress for several decades and originates from the social learning paradigm. Monti and Rohsenow (1999) postulate that alcohol relapse is likely when the client has limited coping skills to cope with stressful or high risk situations, when it is expected that drinking will be pleasurable and the individual's belief that he/she is unable to cope without drinking. The therapist strives to build the client's coping skills repertoire for subsequent use in high risk situations for the resumption of drinking. This is accomplished by teaching clients which skills to use in such cases, social skills training is given to enable sobriety in relationship selection all which work to build the self-efficacy of the client thereby increasing the continued use and mastery of skills (Monti & Rohsenow, 1999).

These go further to endorse the use of CST given earlier research which highlighted deficits in the coping abilities of alcoholics especially in situations with the risk for relapse. The use of role play exercises have proven useful in reordering behavioral choices and increasing feelings of self-efficacy. In light of the role that negative emotional states play in relapse,

bolstering self efficacy has tremendous utility in ameliorating such feelings (Monti & Rohsenow, 1999).

In terms of the treatment process, CST traditionally commences by assessing the client's area(s) of vulnerability across biological, psychological, intrapersonal and interpersonal domains. Special attention is paid to risk factors for the latter by an inventory of conflict resolution, refusal and primary social skills. Finally the extent of the client's exposure to alcohol cues is determined. Studies indicate that CST enables the client to generate specific coping responses in a shorter period of time which strongly predicted the frequency and duration of relapse – if it occurred at all (Monti & Rohsenow, 1999).

Information obtained from Monti and Rohsenow (1999) indicate that of the CST Techniques, there are four (4) extensively used ones. They are:

1. Relapse prevention training in which a specific high relapse risk situation is simulated and the client is taught appropriate skills for use there
2. Social or communication skills training seeks to build the client's social relationship via interpersonal training to minimize conflict, develop sober support, and/or facilitate lifestyle change
3. Urge-specific coping skills training is a significant component of CET and will be described later
4. Cognitive-behavioral mood management

### **Cue-Exposure Treatment**

Cue-Exposure Treatment (CET) endeavors to educate the client about the various alcohol related triggers that fuel their urge to engage in drinking. During the therapy, the client is taught diverse coping strategies and engages in mass practice while in a safe environment for later generalization to real life (Longabaugh & Morgenstern, 1999).

As an off-shoot of learning and social learning theories, CET acknowledges the relationship between alcohol-related environmental cues and consumption relapse. Classical conditioning purports that the repeated pairing of alcohol with naturally occurring emotions, places, and persons results in a conditioned response that can aid in relapse (Monti & Rohsenow, 1999). Social learning theory suggests that certain cues hold salience and because of this relevance as per positive effects can prompt alcohol consumption. It is these cues that short-circuit the client's coping ability, and beliefs about such, by activating various cognitive and neurochemical reactions. Studies on CET advise that treatment should reduce the client's reactance to the cues by their repeated exposure to it in a safe environment, and offer practice in using coping skills in the presence of alcohol cues (Longabaugh & Morgenstern, 1999).

Various CET program for substance use modulate their level of cue exposure in accordance with the client's treatment goal. For those who desire moderate drinking strategies may include them sniffing, tasting, then decreasing sizes of sips and lengthening intervals between them. Others where the goal of abstinence may involve the client acting out the stages of drinking (picking up, looking at, smelling the drink) without actually consuming any. By so

doing treatment providers are able to tailor the skills training to the client's specific needs by identifying his/her triggers (Longabaugh & Morgenstern, 1999). Despite the limited amounts of controlled studies that have been conducted on CET, these authors suggest that evidence is promising an endorsement of it given its ability to reduce the severity of alcohol consumption and the more frequent use of urge-specific coping skills independently.

### **Criticisms of Relapse Prevention**

No therapeutic approach is without critique and several concerns have been raised in the literature regarding RP techniques. Marlatt's theory has been criticized for its hierarchical classification of factors that influence relapse (Witkiewitz & Marlatt, 2004). In terms of the specific methods described earlier, it is difficult to expose participants in research studies and CET programs to all the potential real-life situations that they will encounter. At worst, it would be a grave ethical breach to explore the gamut of alcohol consumption with persons already having challenges in this area. In such cases imagery exposure or vicarious learning is used (Monti & Rohsenow, 1999).

Constrained by ethical considerations regarding experimental design studies with human subjects, in many of the theories and models of RP cannot be fully tested to their empirical fullness. One potential remedy with hope of redressing this lies in the use of computing techniques that allow simulation studies to index the trajectory, severity and variability of symptoms during the course of treatment (Witkiewitz & Marlatt, 2004).

Ethical concerns may also arise from the use of Urge-specific CST/CET techniques as the client is (actually) given alcohol as a primer for subsequent situations that call for his/her resistance. Given the addictive quality of alcohol and other substances with which this technique has been used and the fact that the participant's are often in non-resident facilities their cognitive, physical and emotional well-being becomes a concern. Programs that employ these methods claim to provide adequate supervision, therapist care and terminal observations at the end of the session for residual effects (Monti & Rohsenow, 1999).

Regrettably, the veracity of CBST's effectiveness has not been conclusively proven for several reasons. Firstly, one must consider that CBST calls for mastery and the application of coping skills to real life situations before the therapist can actually attest to the client's acquisition of it. Research needed to fully determine this would have to be longitudinal and is therefore cost prohibitive. Also because of the cut backs to therapy by managed care, clients are often not provided with the timeframe needed to accomplish this (Longabaugh & Morgenstern, 1999). Despite the existence of Alcoholics Anonymous (AA) and other group self help programs from the 1940s there has been renewed interest in these 12 step facilitation programs (TSF). This is due in great measure to the managed care has reduced the amount of time and intensity of professional addiction (Humphreys, 1999).

### Concluding Remarks

In conclusion, the future of RP is promising and it remains a therapeutic approach to addiction that is in high demand. The goal of the article is to examine the utility of the Cognitive–Behavioral model for circumventing relapse in the treatment of alcoholism. Plans for RP include broadening its focus to include components of other therapies. These would include motivational interviewing to increase a client’s desire for change; the inclusion of a referral module to one of the successful addiction/behavior change groups such as AA; the inclusion of the client’s significant other(s) in the treatment process; the use classical conditioning to extinguish responses; and the use of psychosocial techniques and pharmacological therapy in combating addiction to alcohol (Longabaugh & Morgenstern, 1999).

### References

- Humphreys, K. (1999). Professional interventions that facilitate 12-step self help group involvement. *Alcohol Research and Health, 23*(2), 93-98.
- Larimer, M. E., Palmer, R. S. & Marlatt, G. A. (1999). Relapse prevention: An overview of Marlatt’s cognitive-behavioral model. *Alcohol Research and Health, 23*(2), 151-160.
- Longabaugh, R. & Morgenstern, J. (1999). Cognitive-behavioral coping-skills therapy for alcohol dependence. *Alcohol Research and Health, 23*(2), 78-85.
- Monti, P. M. & Rohsenow, D. J. (1999). Coping –skills training and cue-exposure therapy in the treatment of alcoholism. *Alcohol Research and Health, 23*(2), 107-115.
- Simonelli, M. C. (2005). Relapse: A concept analysis. *Nursing Forum, 40*(1), 3-10.
- Webster. (1996). *Encyclopedic unabridged dictionary of the English language*. New York, NY: Gramercy Books.
- Witkiewitz, K. & Marlatt, G. A. (2004). Relapse prevention for alcohol and drug problems. *American Psychologist, 59*(4), 224-235.