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Relapse Prevention: An examination of relapse issues includes consideration of the relevance of this issue, an historical perspective, a survey of existing knowledge on the subject, and ideas counter to disease concept beliefs. [1]

ARTICLE

Sam has quit drinking; it was not easy. He is thirty-eight years old and has been working full time since graduating from high school. He was fifteen when he first tried alcohol. It worked; he felt great. However, his years of drinking finally caught up with him when he got his second DUI (driving under the influence). He "sort of ignored" the first one. But now, with the second DUI, he is scared of more legal trouble. Since the second DUI, Sam has worked hard to abstain, suffering three relapses in the process. He has now attained seven months of sobriety and is working daily to stay clean and sober. He is attending a twelve-step meeting, has a sponsor for support, and has successfully kept his job. More troublesome for Sam is his desire for his old drinking buddies even though he knows they mean danger to him. Making new friends is hard. Thus describes the composite client who completed the survey for this work.

Like Sam, we humans have been drinking and doing drugs in one form or another for eons. Alcohol predates humans who discovered it as a naturally occurring product, as do many now-illicit drugs (Kinney, 2003). Relapse issues would not exist were it not for the damaging effects of alcohol and other drugs. These damaging effects, including relapses, have been noted and documented for hundreds of years while proactive relapse prevention issues have only been formally addressed for about twenty years, according to Daley in his 1987 article for the publication *Social Work.* In another work a few years later, Daley notes the "…vast amounts of examples of what does not work," regarding relapse prevention while there is not very much about what does work (Daley, 1991).

Exploring relapse issues for this work includes consideration of the relevance of this issue, an historical perspective, a survey of existing knowledge on the subject, and ideas counter to disease concept beliefs. Additionally, inquiry into why relapse happens and what can be done to prevent relapses will include results from the survey (see Appendix) completed assessing attitudes about what helps people remain abstinent.

Terence T. Gorski, acknowledged as the father-of or guru-for relapse prevention, believes, "Relapse is a complex process." He further asserts addiction is a bio-psycho-social disease and, therefore, relapse prevention must address each of these areas: biological, psychological, and relationships (Gorski, 1986). Addiction and relapse issues affect millions of Americans daily. "Nearly one half of the patients who visit a family practice doctor have an alcohol or drug disorder," states author Miller in 1998. That percentage has most likely risen in the subsequent years.

Complicating relapse issues is our country's growing managed health care system which focuses more on managing costs than on the patients' needs. Given the reality of this focus, anyone needing recurring care is under greater scrutiny. The addict faces more roadblocks and is routinely castigated due to common attitudes blaming the addict for their addiction. This is not true of the heart or diabetic patient. "What everyone must recognize is that relapse is part of treatment. The field is just now coming to grips with that," notes Darcy (Experts, 1996). More in line with the managed care industry's approach is Wanigarante's view that addictive behavior can be overcome by a person's own individual efforts, unlike other diseases (1990). Echoing Wanigarante's views, Trimpey in his *The Small Book* challenges the disease concept of alcoholism claiming that over the long haul, over the centuries, "…far more people have probably helped themselves independently than through recovery programs." (1992).

As early as the 1840's a focus on helping people leaving institutions to integrate back into society was evident. Even though primitive by current standards, this aftercare included, "…placing the patient with sober friends and encouraging the patient's affiliation with a church or fraternal temperance society." (White, 1998). Durfee's 'Practicing Farm' was well known in the early 1900's for their treatment with alcoholics. These efforts at early relapse prevention included Durfee helping his clients define 'zero hour', those times and situations most likely to elicit cravings and lead to drinking. He then helped each person to develop alternative activities to get beyond the crisis or critical time. By the mid 1900's medications were in use, notably Disulfiram (Antabuse) to help gain abstinence. Later, in 1992, Naltrexone (ReVia) studies showed this drug could help reduce alcohol relapse rates by reducing cravings, among other effects (White, 1998). Acamprosate (Campral), approved in 2004, assists in balancing brain chemistry to help the addict maintain abstinence after detoxification is complete.

The term, relapse prevention, was "…coined by Professor G. Alan Marlatt who described it as a collection of cognitive-behavioral strategies and lifestyle change procedures aimed at preventing relapse in addictive behaviours." (Wanigarante, 1990). *The New Lexicon Webster's Dictionary of the English Language* defines relapse as "to fall back into ill health" and prevention as "the act of preventing, to cause not to do something, to cause not to happen." Thus relapse prevention can be defined as to cause one to not fall back into ill health, i.e., alcoholism or drug addiction (1987). Interestingly the *Oxford Dictionary of Psychology* has no listing for either 'relapse' or 'prevention' (Coleman, 2003). More to the point is the absence of either word in the DSM-IV (Diagnostic & Statistical Manual). Various kinds of remission are mentioned when the patient does not meet criteria for substance dependence or substance abuse. Only an implied reference to relapse prevention can be inferred from the qualifier on agonist therapy as the use of an agonist/antagonist agent is one way to help prevent relapses (American, 2000).

"Relapse, by definition, involves a failure to maintain behavior change, rather than a failure to initiate change," notes Annis (1994). Daley calls relapse "…a process of building up that, if not responded to, is very likely to lead back to addictive use of alcohol, drugs…". He further notes relapse is an event of returning to the addictive behavior or as a process where

warning signs occur cautioning one that they are likely to return to the substance or behavior unless positive steps are taken. One can be in the relapse process before engaging in the behavior, as thinking one can handle purchasing the substance or avoiding healthy peers. The addict has not indulged at this point but will relapse unless he is able to stop himself. "Relapse should be seen as a complex process culminating in a predictable outcome rather than as a discrete event. Relapse results from an interaction of affective, behavioral, cognitive, environmental, physiological, psychological, spiritual, interpersonal, and treatment factors." (Daley, 1987; Daley, 1991). Wanigarante offers her pithy comment, "Relapse is an anathema for those who work in the field, for it is generally considered to be the most common outcome of treatment." (1990).

Relapse rates are fairly consistent over time and completed studies. Daley notes the, "…majority of people with an addictive disorder experience at least one relapse." Most studies show the majority of relapses happen within the first three months. Gorski reported over sixty percent of alcoholics treated in private sector programs relapsed. Miller and Hester reviewed 7,500 alcohol treatment outcomes with the conclusion that over seventy-four percent relapsed within the first year (Daley, 1987; Daley, 1991; Gorski, 1982; Ringwald, 2002; Thomas, 1994). In considering psycho-social treatment to prevent relapse, Miller notes Alcoholics Anonymous (A.A.) shows an eighty to ninety percent abstinence success rate in the first year when the addicts received weekly continuing care after discharge (Miller, 1998).

The Rand Corporation's 1976 study *Alcoholism and Treatment* found a fifty percent rate of remission for both groups: those who had a single contact with a center and received no treatment, and those who were treated. This suggests treatment may play only an incremental role in recovery. "The crucial factor for success may indeed be the client's decision to contact a treatment center for help in the first place and to remain in treatment, rather than something that occurs during the process of formal treatment itself." (Ringwald, 2002). Conversely, Kelley notes most studies show longer lengths of stay in residential treatment centers are more effective in promoting abstinence. He believes this is related to, "…the natural healing of these symptoms that occurs over time when the patient is confined in a protective environment." (1994). Breining brings both thoughts together noting, "the greater the motivation to avoid problems by changing, the higher the incident of uninterrupted recovery." (2000).

Vaillant's fifty year study of 660 men reported more subjects who recovered from alcohol dependence began abstinence at A. A. than in treatment. This study concluded, "…changing an addiction required four elements: a substance dependency; ritual reminders that one drink could cause relapse; repair of social and medical damage; and self esteem." (Vaillant, 1995). Father Martin states, "The disease of alcoholism is the most terminal of all terminal illnesses. I also believe that alcoholism is the most prevalent disease in the United States today." He estimates there are at least twenty million alcoholics (Martin, 1982). That number has certainly risen in the ensuing twenty years. A final sobering note is Ringwald's observation, "on any given day, about one million Americans are being treated for substance abuse." (2002). Yet the vast majority of alcoholics and drug addicts are not receiving treatment and continue to relapse.

Gorski was asked, 'What might I do that would cause a relapse'? His response: "You don't have to do anything. Stop using alcohol and other drugs, but continue to live your life the way you always have. Your disease will do the rest. It will trigger a series of automatic and habitual reactions to life's problems that will create so much pain and discomfort that a return to chemical use will seem like a positive option." (1989). A few years earlier he had noted, "The

relapse process does not only involve the act of taking a drink or using drugs. It is a progression that creates the overwhelming need for alcohol or drugs." (1986). Gorski developed his Relapse Syndrome and Relapse Progression lists itemizing the steps a person goes through to get to the actual relapse. These involved detailing an individual's internal dysfunction, external dysfunction and loss of control. Later he simplified the process of relapsing to six progressive items: high-risk factors, trigger events, internal dysfunction, external dysfunction, loss of control, and finally, the lapse or relapse (Gorski, 1989). He has also listed the phases and warning signs of relapse as well as written volumes of other work; understandable given his long and intense involvement with relapse prevention treatment issues.

Dr. G. Alan Marlatt, another major contributor to relapse prevention thinking, believes there are two main factors contributing to relapse: immediate determinants and covert antecedents. The immediate determinants include high- risk situations, coping skills, outcome expectancies, and the abstinence violation effect. His covert antecedents include lifestyle factors, urges, and cravings. These ideas form the central aspect of his cognitive-behavior model of relapse prevention (Larimer, 1999). Marlatt speaks of his 'relapse chain' noting, "Each relapse warning sign or clue can be seen as one link in this relapse chain. Each link represents an event or situation in which we make a decision that in one way or another affects relapse or recovery." Marlatt further asserts we make decisions seemingly unrelated to a potential relapse, but in reality have a great deal to do with a relapse. One example is the gambling addict who just happens to choose a restaurant knowing it has a casino in that restaurant. Marlatt called these "apparently irrelevant decisions" that are not irrelevant at all (Daley, 1991).

"An inability to deal effectively with high-risk situations involving negative emotional states also has been found to be predictive of relapse," notes Annis (1994). On first reading this seems obvious and it is. Yet these seemingly obvious observations of reality need to be said and dealt with for the benefit of the person trying to stay clean and sober. Most of the knowledgeable people in the relapse field speak to the importance of identifying and learning to deal with high-risk situations (Daley, 1991; Gorski, 2000; Larimer, 1999). To one trying to maintain change and not relapse, challenges and high-risk situations are inevitable. Some can be avoided, i.e., staying out of bars, but most cannot. "Hence whether or not the person has the ability to cope with high-risk situations becomes a crucial factor in preventing relapse." (Wanigarante, 1990). She goes on to list common categories of high-risk situations including negative emotional states, positive emotional states, interpersonal conflict and social pressure. Note her inclusion of both negative and positive emotional states as each can be included in her definition of high-risk situations: any situation or condition that poses a risk or threat to the individual's sense of control and increases the risk of relapse. Larimer adds "…although the relapse prevention model considers the high-risk situation the immediate relapse trigger, it is actually the person's response to the situation that determines whether he or she will experience a lapse. A person's coping behavior in high-risk situations is a particularly critical determinant of the likely outcome." (1999). Or, in other words, the greater the coping strategies the less likely one is to relapse.

Marlatt & Gordon's Relapse Prevention Model analysis concludes that two situations served as triggers for over half of all relapses. They are negative emotional states and situations involving another or group of people, especially interpersonal conflict. Even something seemingly beneficial as a recreational activity can be a high-risk situation. "High-risk leisure situations include leisure-based situations that pose a threat to an individual's sense of

control in maintaining sobriety." Deiser gives the example of an alcoholic going bowling where alcohol is served. In this case the facility and activity could be considered a high-risk leisure situation (Deiser, 1998).

Warning signs for the majority of people show up gradually as the process of relapse slowly evolves. These warning signs are usually a combination of internal (thoughts, feelings, attitudes) and external (behaviors and actions). Most people have warning signs that are unique to that person and situation (Daley, 1991). An internal warning sign could be your not caring anymore or believing you are cured. Failing to notice these warning signs at the earliest possible time could well lead one to relapse. "The most frequently cited (external) behaviors related to the relapse process include returning to places or contacting people associated with the addict's habit." (Daley, 1991). Other examples of external warning signs include cutting or eliminating participation in recovery groups and showing increasing stress symptoms, such as, anxiety, trouble sleeping, or eating too much or too little. Claudia Black notes, "…for the addict, triggers bring them closer to relapse. One particularly strong trigger is euphoric recall. This is when we romanticize using behaviors and forget about the negative consequences." (2000). Her advice is to immediately disengage from the fantasy and/or leave the situation. Too many addicts find this impossible to do. Along these lines, Bill W. wrote, "Resentment is the Number One offender. It destroys more alcoholics than anything else." We must let go or release our resentments. Otherwise, "if we maintain our resentments, we find that we want support in our misery and seek out people who will provide that." At which point, we are one step closer to relapse (Black, 2000).

Marlatt & Gordon's work, (1985), noted the covert antecedent most strongly related to relapse risk, "…involves the degree of balance in the person's life between perceived external demands (i.e., "shoulds") and internally fulfilling or enjoyable activities (i.e., "wants")." Someone with a life full of 'shoulds', i.e., constant stress and high-risk situations, is most vulnerable. This enhances their desire for pleasure and the rationalization that indulgence is justified. ("I owe myself that drink or hit."). If no other pleasurable activity is available, the drinking/drugging can be viewed as the only pleasurable option. These covert antecedents, because they are concealed, are less obvious yet powerful in influencing the rate of vulnerability to relapse. Lifestyle factors (overall stress levels) and cognitive factors (denial, rationalization, and desire for immediate gratification, as urges and cravings) play a major role in determining if one relapses or not (Marlatt, 1985).

Coping skills are identified as critical to one's ability to stay clean and sober. Jack Trimpey created his acronym, BEAST, to help the addict remember these enemies of relapse. He teaches that focusing on these thoughts allows one to avoid relapse. BEAST stands for: Boozing opportunity where one considers doing; Enemy voice recognition of any positive idea about alcohol and drugs; Accuse the voice of malice as a distancing technique; Self-control and self-worth reminders as rational antidotes to poor impulse control; and Treasure your sobriety by reaffirming the intrinsic value of sobriety (Trimpey, 1992).

The importance of coping skills as major determinants of relapse is recognized by many in the field. The lack of coping responses almost guarantees relapse. Thus teaching coping skills is critical. One's self efficacy is also critical to maintaining sobriety and is "…associated with positive treatment outcome(s)." (Annis, 1994). This sense of self efficacy is built on coping skills and responses the client has or learns. These include environmental support, behavioral coping, cognitive coping, and affect coping. Annis cautions these coping skills must be learned from the easy to the more difficult as perceived by the client. This affords the client early

success which must happen for the client to be willing to risk at the next more difficult level. Early success is also needed so the client does not just give up after an initial failure. These efforts are designed to help clients feel better about themselves and to minimize their tendency to blame others which is all too common with those having a lower sense of self-efficacy (Annis, 1991; Annis, 1994; Daley, 1987; Wanigarante, 1990).

Jack Trimpey's counterclaim to the disease concept of alcoholism, as spelled out in his book, *The Small Book,* (1992), argues, "Sobriety is not a miracle: it is a decision. If you want to stop drinking, you can quit right now and you know it….Accept that you are in control of your own drinking and drugging and that you have been in control all along." Trimpey charges that relapse is a failure to have a big plan for life coupled with the failure to follow that plan. In his view relapse is a violation of that plan which is a, "…covenant with yourself that is next to sacred." He continues, "Faith and reason are diametrically opposed to each other, and each forms the philosophical basis for AA and RR (Rational Recovery), respectively." This reasoning asserts that if one accepts that he is in charge of his emotions then he can control his thinking and in that way can avoid relapse. "Relapses don't just happen. There is always a conscious element. Even when alcohol is accidentally ingested, such as at a party where the punch has been spiked, a relapse is a full-fledged conscious decision. Everytime. A lapse, where a drink has been accidentally or impulsively taken, is not a relapse, but a *lapse of judgment."* (Trimpey, 1992).

Other writers and researchers have weighed in about relapse ramifications. Maultsby states, "…within a year of treatment most cured (dry) alcoholics take a running jump off the wagon. That's right. Alcoholics don't fall off the wagon; they take a running jump." He notes two reasons: confusion about what the main problem is and the treatment has not taught them how to live happily without alcohol. Maultsby's summation is, "The main problem is not alcohol. Their main problem is habitual alcohol abuse…that is, drinking to solve personal problems. For such alcoholics to stay cured, they must learn how to solve their personal problems without alcohol." (Maultsby, 1978). Taking a more measured view, Mackay and Marlatt advise, "Rather than seeing a lapse as a return to the diseased state, relapse can be viewed as a single step backward that does not predict what direction the next step will be. Continued worsening is not inevitable." (1994).

While obviously divergent views regarding all aspects of relapse exist, a commonality is the agreement that the alcoholic or drug addict must be willing and able to cooperate with treatment. Without this ability to follow the treatment, no approach has relevancy. Gorski's comments seem especially astute when he states, "Recovery is like walking up a down escalator. It is impossible to stand still." He continues, "When you stop moving forward, you find yourself moving backwards. You do not have to do anything in particular to develop symptoms that lead to relapse. All you need to do is fail to take appropriate recovery steps. The symptoms develop spontaneously in the absence of a strong recovery program." (Gorski, 1986).

"Abstinence from alcohol and other drugs is only the beginning of sobriety. It's the ticket to get into the theater, not the movie we are going to see." Gorski continues by explaining his six relapse prevention stages, which are: 1) transition or giving up the need to control alcohol and other drug use; 2) stabilization as recuperating from the damage caused by the addictive use; 3) early recovery noted by internal change, i.e., change of thinking, feeling and acting regarding alcohol and drug use; 4) middle recovery shown by external change, i.e., repairing lifestyle damage caused by addictive use and developing a balanced lifestyle; 5) late recovery

of growing beyond childhood limitations; and lastly, 6) maintenance where one lives a balanced life and continues growth and development (Gorski, 1989). Later, Gorski listed his relapse plan recovery activities as seeking professional counseling, self-help programs, a proper diet, an exercise program, stress management, a spiritual development program, and morning and evening inventories. He believes each of these needs to be addressed and incorporated into any successful recovery plan (2000). Gorski with others believe a good relapse prevention plan must include an assessment of lifestyle factors related to relapse, a list of personal warning signs showing the person the steps leading from stable recovery to relapse, warning sign management strategies and a revised program with on-going identification and management of relapse warning signs (Experts, 1996).

"Recovery begins when addicts accept the possibility that they can live happily and usefully, without drugs." Ringwald, (2002), continues noting many addicts use the acronym H-O-W to remind themselves of the required virtues of being honest, open and willing. Breining, (2000), lists factors he believes are necessary for a recovering person to live happily without drugs. These keys to a sober recovery are: getting to a painful stopping off place; intense early involvement in treatment; appreciation and gratitude for a changed lifestyle; acceptance of one's powerlessness over drugs and a willingness to follow another's advice; a willingness to embark on a program that "defies scientific inquiry and intellectual grandiosity"; surrender the need for instant gratification and self-centeredness; and finally, acknowledging one's own limitations and acceptance of the need for a mentor.

As early as 1983, Prochaska and Di Clementi proposed a series of discrete stages one goes through regarding any behavior change, including achieving and maintaining abstinence. These take us from pre-contemplation, prior to seeing any need for change, through contemplation, making a decision, actively changing, to the inevitable relapse, and ultimately, maintenance. One is advised this path is circular, not linear. In this circular model, one can enter and leave at any point; one is not required to go through the stages in specific order (Wanigarante, 1990).

Traditional alcohol treatment took the dichotomous view of treatment outcome: they were either abstinent or relapsed. In contrast, several models based on social, cognitive or behavioral theories, such as Annis, Litman, Marlatt, and Gordon, see relapse "…as a transitional process, a series of events that unfold over time." (Larimer, 1999). This transitional process view provides a broader conceptual framework for intervening in the relapse process to prevent or reduce relapse episodes, and thus improve treatment outcomes. Wanigarante, (1990), further elaborates, "…the practice of relapse prevention is focused on the client's ongoing *process* of change, as opposed to a fixed treatment *goal* such as permanent abstinence. I often describe relapse prevention as a *maintenance strategy*, a method to work with the ongoing process (including lapses, relapses, and prolapses) that people experience as they change their behavior."

All recommendations for relapse prevention can be included in three main categories: cognitive, emotional, and behavioral. Or more simply put: thinking, feeling and doing. These tools include learning coping skills, increasing awareness and changing one's lifestyle. The Alcoholics Anonymous publication, *Living Sober,* (1998), offers many thoughts to assist in living a sober life including getting active, become aware of one's anger and resentments, and steering clear of emotional entanglements. The book offers many more ideas, all of which include healthier thinking, feeling and behaving. Other recommendations for maintaining sobriety include self-monitoring, relaxation training, assertiveness training, detachment,

changing one's thinking, and positive addictions. An emergency recovery card was also mentioned so one would have a list of people to call and reminders of what to do in a high-risk situation. Spirituality was noted frequently with participation in twelve-step meetings highly recommended. Larimer's intervention strategies ask one to identify and cope with high-risk situations, enhance self-efficacy, eliminate myths and any placebo effects, manage any lapses and apply cognitive restructuring. His lifestyle self-control strategies include learning to lead a balanced lifestyle with positive addictions, stimulus-control techniques, and urge-management techniques, in addition to creating a personal relapse prevention road map (Larimer, 1999).

"Recall the past, live in the present," reminds Fletcher, (2001), as she writes of the people who have maintained sobriety which she calls 'the masters'. These people "…over and over told me that they remain motivated by *never allowing themselves to forget the past*." She continues noting how this one thought is the most powerful and consistent theme in all the information she gathered from these masters. Countering negative memories of drinking days with vivid awareness of the many rewards of sobriety allows one to remember the negative old while focusing on the positive new. All believed the efficacy of learning many things to do and say to cope with the usual situations of daily life, i.e., company parties, dinner at friends, travel for work, or attending any social event. "Everything you do to keep yourself sober comprises your recovery program," asserts Fleming, quietly underscoring the importance of each and everything we do (1991). If addiction was the only coping skill, then the person is more likely to be weak or deficient in healthier, more adaptive coping responses. This person would have great difficulty coping with any stressor once they have given up the addiction because the only skill they had was the addiction. Looking for other ways to avoid relapse, researcher Zinberg and others found differences between non-addicted people and those addicted. The non-addicted had activities and people in their lives completely apart from drug usage whereas the addicts did not (Daley, 1991; Peele, 2004; Ringwald, 2002; & Wanigarante, 1990).

Additional challenges to the disease model of addiction include challenging A. A.'s emphasis on past wrongdoings rather than focusing on the future. Another contention asserts that addiction is a challenge to grow rather than a disease to pull one backward. "In a progressive disease model, the afflicted individual is always on the verge of succumbing to the inevitable downward pull of the disease – always 'recovering', never 'recovered'. An alternative relapse prevention slogan is: 'I'm discovering, not recovering'." (Wanigarante, 1990). Peele, (2004), suggests moderation, not abstinence, is the opposite of addiction. He champions moderate use so one does not attempt abstinence and then fail (relapse).

While these views diverge, they do agree on the need for treatment including the need for cognitive, emotional, behavioral and social changes for the addict's best chance at long term sobriety. For what is success but an increasingly long length of time between relapses? No matter what relapse prevention techniques we employ, abstinence is the marker of achievement. Ergo: success is the ever-increasing length of time between relapses, whether that is one day longer than the last time or until the day one dies.

A look at ways to prevent relapse includes considering what medications are available. Many are used to treat the various addictions with three drugs specifically approved for use in the treatment of alcoholism. Antabuse (Disulfiram) has been used for many years as aversion therapy making the drinker very ill if combined with alcohol. Because the symptoms of this effect can be life threatening, it is not used as often now as it was in prior years. The key to successful use is patient motivation for abstinence and the expectation of adverse reactions. ReVia (Naltrexone) has been principally used in the treatment of opiate addiction with more

recent use for alcoholism treatment. Studies show it is effective in reducing the number of days per relapse and reducing cravings for alcohol. It has fewer side effects than Antabuse and has been successful in reducing the desired 'high' effect. Campral (Acamprosate) was approved recently and is now available. It is used for its anti-craving effects. It is thought to stabilize the brain's glutamate system to make it feel normal allowing patients to not feel the strong need to drink. This drug's efficacy is best when combined with counseling or other psycho-social support. Campral is recommended to help maintain abstinence after successful alcohol detoxification. Dolophine, better known as Methadone, has been used for many years as a harm reduction agent to assist in withdrawal of heroin and opiate addiction. It, like all other medications, is more effective in conjunction with other psycho-social treatment and support. Other medications are used for addiction treatment in addition to the illnesses they were first designed to treat. These include Triazolam, Midazolam, Lorazepam, Valium, Clonidine, Wellbutrin, and Librium (Gelowitz, 1996; Inaba, 2000; Lawson, 1988; Miller, 1998).

The opinion survey completed for this work was designed to ascertain what works for people in their efforts to stay clean and sober. Ninety-eight people responded out of a total population of approximately 375 clients of a rural alcohol and drug treatment agency serving the general population as well as court referred people for driving under the influence and drug related convictions. Before describing the results of this survey which took place over a two month period earlier this year, the following quote from a survey participant deserves to be recognized as it relates well to relapse issues. The participant wrote, "Our thoughts are how we feel and act. Learn to control our thoughts, and our behaviors will change. An example: thinking about the past will enable us to stay focused on the present. Thinking about the future will take our focus off the here and now. To avoid relapse is to just not drink or use. No matter what, don't use! Until you are ready to get and stay sober, relapse is just a word used instead of saying, 'I got loaded'."

Of the 98 survey participants, 78 were male and 20 were female, all eighteen years of age or older. The age range is shown on Chart 1 below. More than half the women are between 36 and 45 years old. The men's ages were more spread out with an equal number between 18 and 25 and between 36 and 45. The third highest category is ages 46 to 55. Men definitely become alcohol and drug treatment agency clients at an earlier average age.

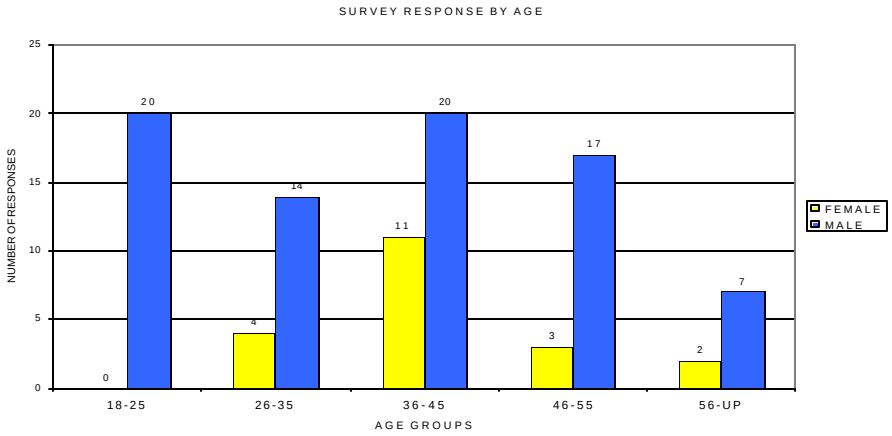


Chart 1 – Age Range of Participants

Education levels vary showing two thirds of the respondents have graduated from high school or earned some college credits. Of the balance, it is equally divided between people who have not completed high school and those who have graduated from college or have done post graduate work. See Chart 2 for details.

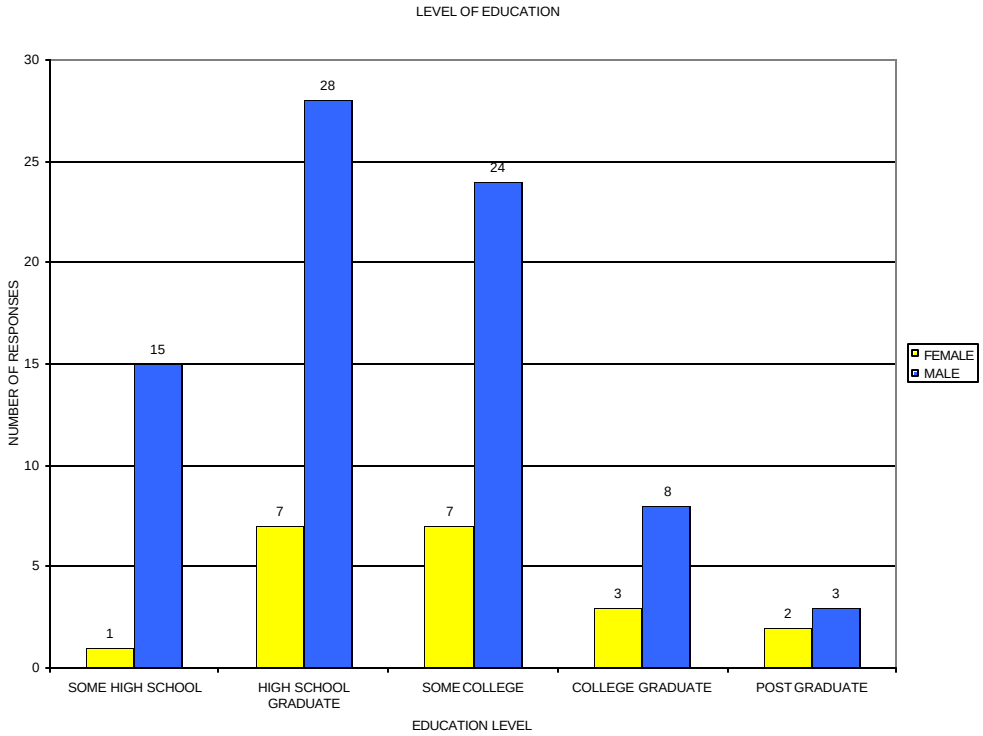


Chart 2 – Educational Level of Participants

An overwhelming seventy percent of the respondents are employed full time. About ten percent stated they are not employed with the balance either working part time, are retired or are currently a student.

Numbers for men and women diverge regarding drug or alcohol related convictions. For the women, almost half have one conviction with another twenty five percent having two convictions. The men's number of convictions is higher with about fifty-seven percent having one or two convictions while over forty percent of the men have three or more convictions. Twenty-two percent of the men stated they have five or more convictions. See Chart 3 for details.

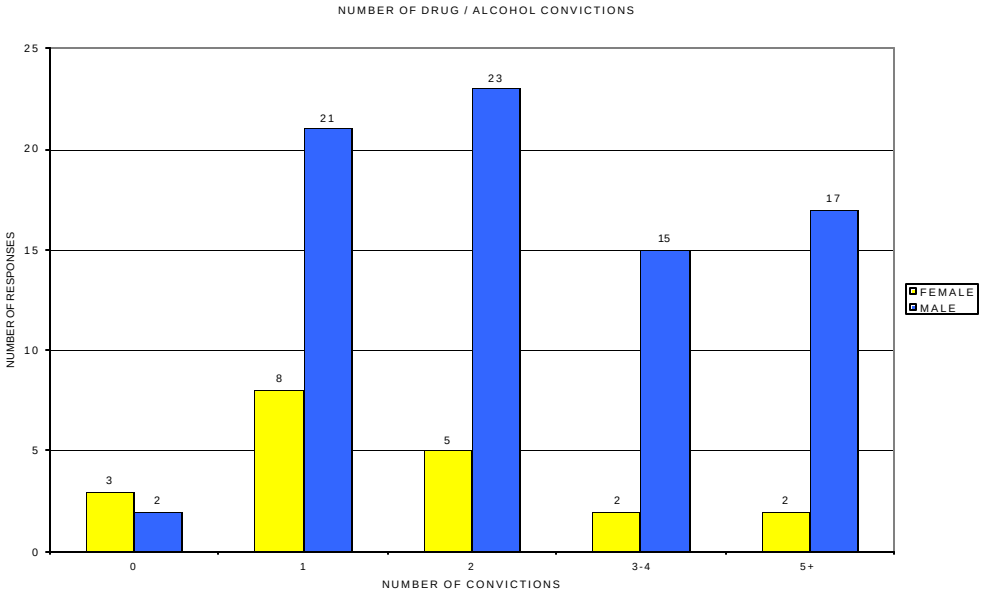


Chart 3 – Number of Convictions

Again, the men and women's experience is different regarding the age of first use. Forty-five percent of the women reported beginning use between the ages of 12 and 17, with an equal number beginning at age 18 or over. For the men, sixty percent stated they began using between 12 and 17 years of age. Only fifteen percent of the men began use at age 18 or over. Perhaps this is an indication of the availability of drugs to the young males. More likely the young men are more willing to test and try what appeals to them coupled with more freedom to experiment. See Chart 4 for details.

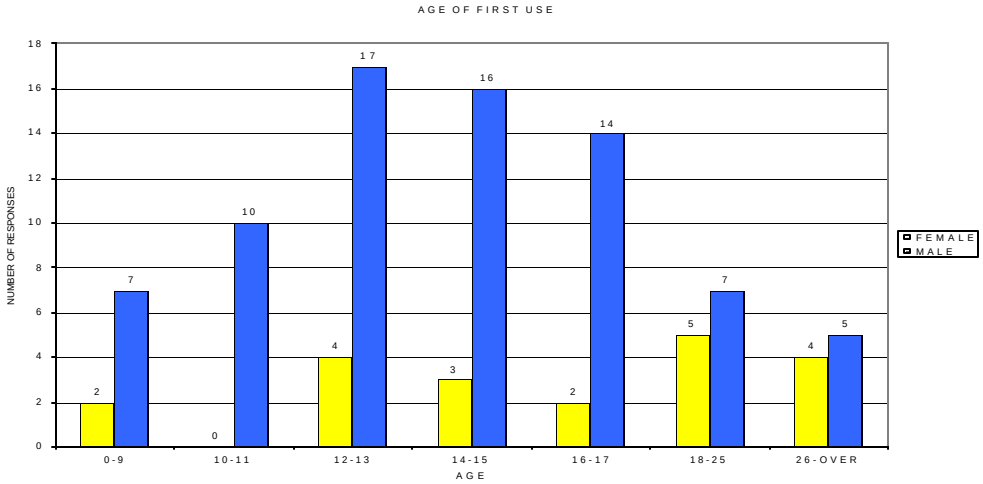


Chart 4 – Age at First Use

Alcohol was listed as drug of choice for half the respondents. Marijuana, methamphetamines, and stimulants were each listed by about fifteen percent with the balance

naming eating disorders, gambling, sedatives, shopping, and tobacco. Seven percent did not state a drug of choice. Approximately forty percent of the respondents stated they are currently using their drug of choice and about sixty percent have stopped using. Of the group who are currently using, thirty-six percent specifically noted they simply do not want to stop. Twenty-three percent stated they see no benefit to quitting with another twenty percent admitting they have tried to quit but returned or they are just not strong enough to quit. Some noted they do desire to quit and others admitted they are not sure how they feel about the issue. See Chart 5 for further details.

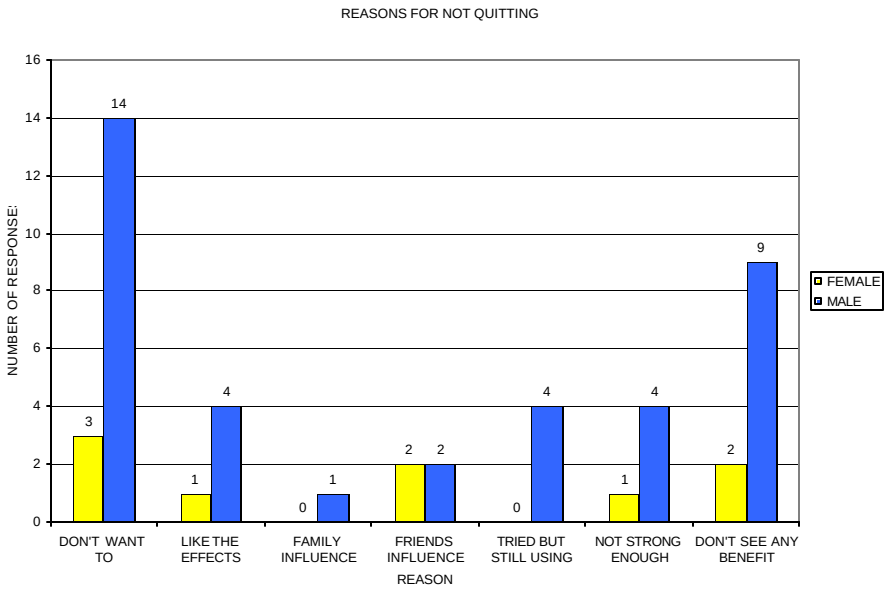


Chart 5 – Reasons for Continued Use

The length of time being clean and sober is quite varied for the group of people who have quit. Seventeen percent have less than 30 day's sobriety. About twenty percent have been sober 31 to 60 days, seventeen percent stating three to six months' sobriety, and an additional twenty-three percent have earned seven to twelve months' sobriety. Thus almost eighty percent have been sober less than one year. The balance of about twenty percent have one or more year's sobriety with five percent of this group sober for more than ten years. See Chart 6 for further details.

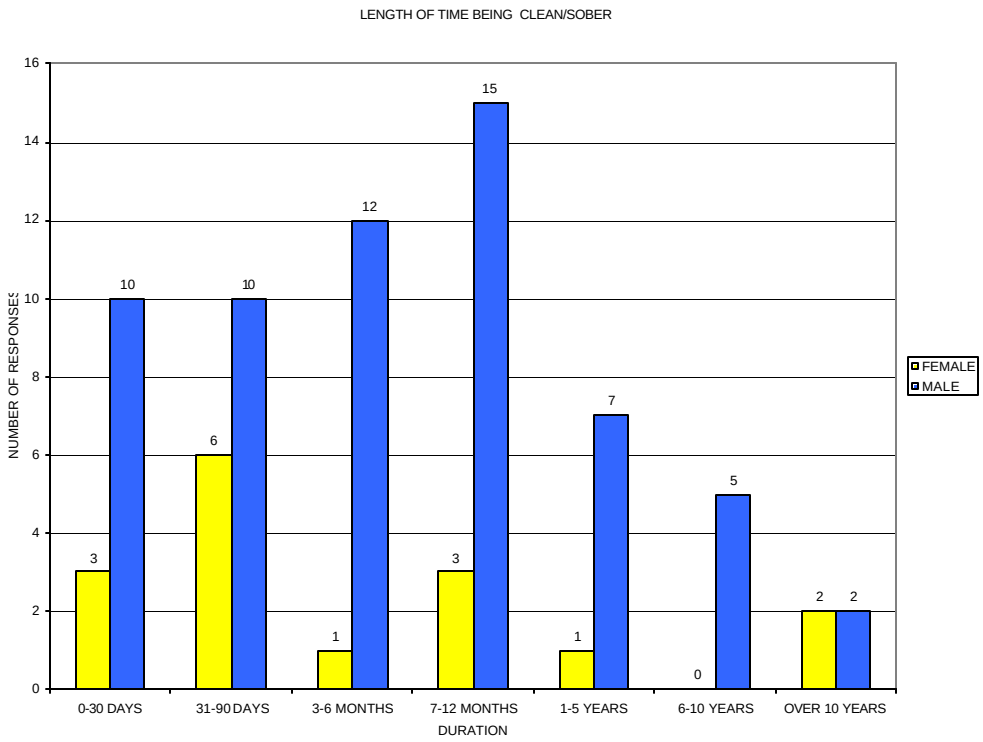


Chart 6 – Length of Clean and/or Sober Time Achieved

The age of the respondent at the time of first quitting is shown on Chart 7 below. Sixty percent of the respondents noted they first tried to stop between the ages of 26 and 45. Another thirty-six percent tried to stop at age 25 or before, while the remainder of the people were 46 or over before they attempted to quit drinking or using. To take one example, those men who started at age 12 or 13 used their drug of choice on average fifteen to twenty years before trying to stop. Perhaps at around age 30 to 35, people have gained a measure of maturity and realize the damage drugs are doing to them. Thus begins the long road to abstinence.

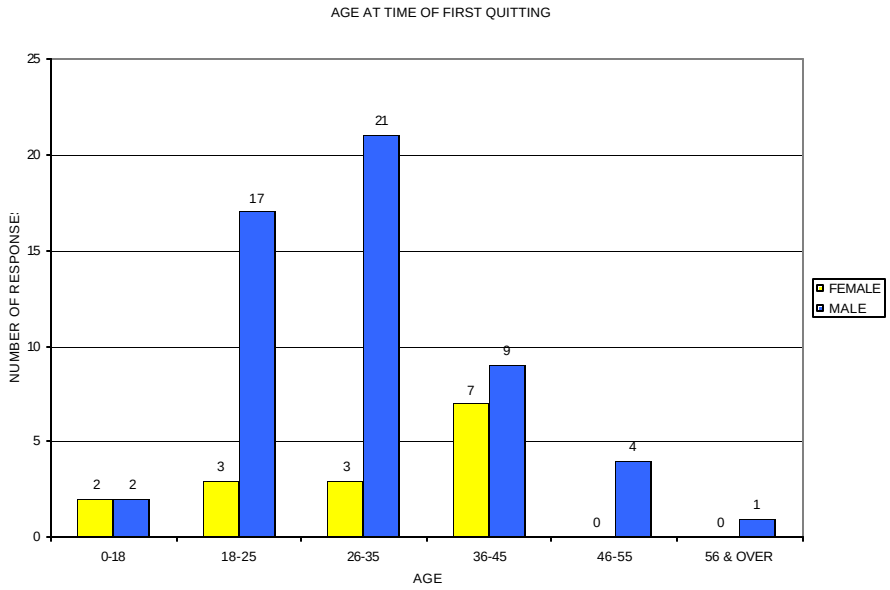
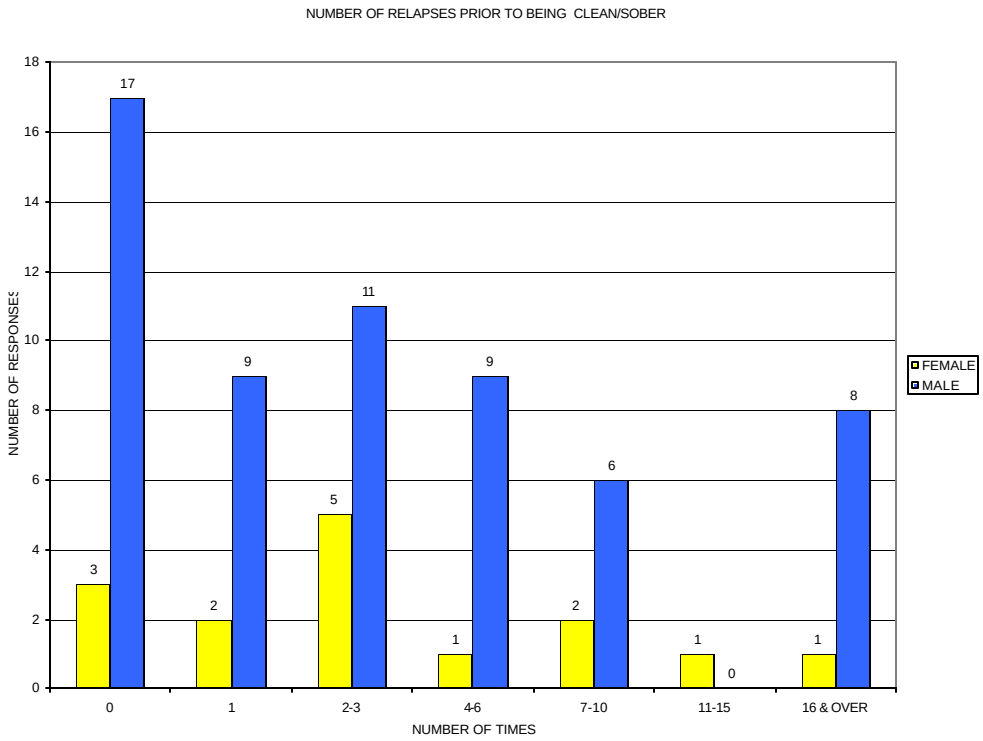


Chart 7 – Age at Time of First Quitting

Given eighty percent of the respondents noted they had been clean and sober for less than one year, it is understandable that thirty-six percent of that group reported being sober less than thirty days with a total of almost half stating being sober for ninety days or fewer. This is consistent with other studies noting most relapse at least once in the first ninety days and seventy-four percent relapse within the first year. If the quest for abstinence is achieved, it seems to be quite successful as twenty percent of the respondents stated they have been sober over one year, with about twelve percent noting over six years of sobriety.

The struggle for successful abstinence is a rough road indeed as shown in Chart 8 below. At one extreme are the twelve percent of people noting they have relapsed more than fifteen times in their quest. Another twenty-five percent state they endured from four to ten relapses. More tolerable for the respondents are the thirty-six percent who had one to three relapses. A full twenty-six percent have not had any relapses. It is reasonable to assume these people with fewer relapses are in the group who has been sober under one year; however,



exceptions do exist.

Chart 8 – Number of Relapses Suffered

Most experts in the field have published lists, procedures, concepts and philosophies for relapse prevention treatment. Often lacking were specific things a person might do to stay abstinent. The survey lists seventy-five items which have been known to assist. Respondents to the survey were asked to note which of the items were helpful to one degree or another. These items were later consolidated into six categories: the cognitive, emotional and behavioral elements of both social-external oriented actions and of personal-internal oriented actions. An example of the social-external-behavior action would be to join a club while talking yourself out of using is a personal-internal-cognitive action. Only twenty-one to thirty-one percent of the men rated any of these items very helpful. In contrast, forty-two to fifty-seven percent of the women rated items very helpful. Perhaps the men are more accustomed to independent action and the women more open to accepting help. Clearly no one thing works for everyone. See Chart 9 below for details. The margin of error for all charts is +/- 8.52.

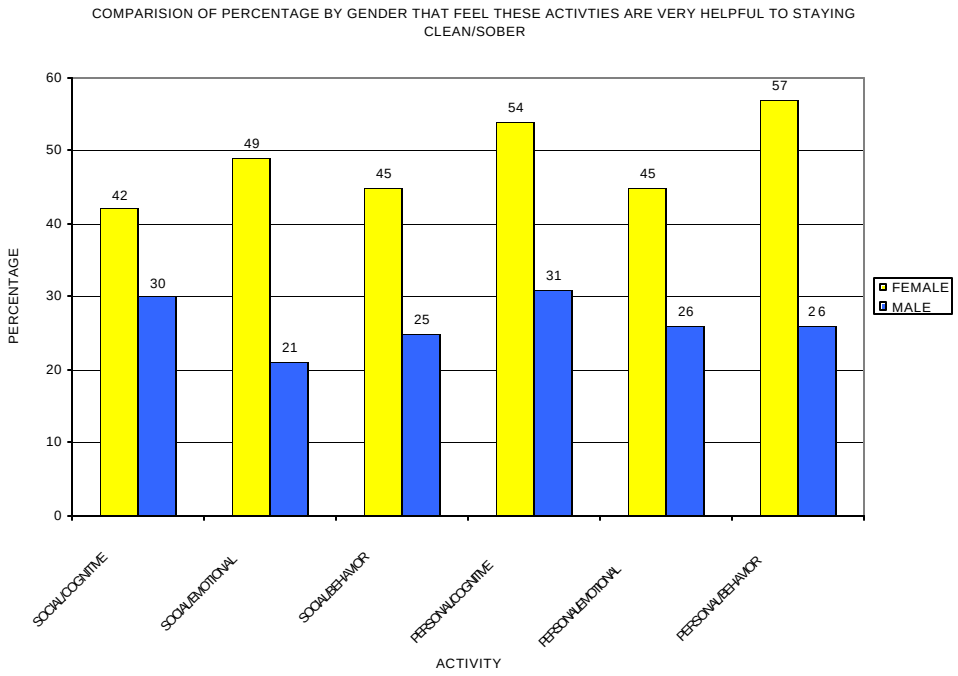


Chart 9 – Very Helpful Activities Rated by Gender

Specifically, of the seventy-five activities listed in the survey, the sixteen most helpful ones for women were, in descending order: making time for self, learn a new skill, don't let others pressure you to drink, stay away from drinking/drugging friends, get more sleep/rest, take a hot bath, work to change negative thinking, talk yourself out of using, learn to speak your truth clearly, find own spiritual strengths, increase awareness of emotions, spend more time with family, take medications only as directed, recognize your cravings and wait, distract self with other activity, and increase patience with self and others.

The men's most helpful list reads: stay away from drinking/drugging friends followed by: exercise more, make new clean and/or sober friends, stay out of bars, don't let others pressure you to drink, reduce frustration levels, pay attention to how you feel, distract self with other activity, work to change negative thinking, spend more time with family, learn to speak your truth clearly, find own spiritual strengths, take up new hobby, express emotions appropriately, sports participation, and eat more nutritious/healthy foods.

While these lists for men and women differ, there are seven activities noted by both men and women. They are: stay away from drinking/drugging friends, don't let others pressure you to drink, distract yourself with other activities, spend more time with family, learn to speak your truth clearly, work to change negative thinking, and find own spiritual strength. Interestingly, five of these involve self-management and self-awareness while the other two involve action and other people. Crucial to abstinence, then, is choosing one's companions and consistent, long-term learning and growing in self-awareness and maturity. This is challenging work; no wonder abstinence is such an illusive goal for millions.

Conclusion

Ultimately, then, what does work for relapse prevention? In short, anything and nothing. Anything one does can work; conversely nothing anyone does will help. It all depends on the person. The crux of the matter lies in the motivation of the individual. Will she accept help? Does he want to stop? What about the person who didn't call his sponsor when he recognized he was heading for a relapse? His answer, "I didn't want to be stopped." He recognized he wanted to get drunk at a funeral because, "That's what everyone I know does at funerals." Does she recognize her addiction causes her difficulties? Or does she assign blame to anyone and everyone else? What about the woman who repeatedly laments that her children "drive her to drink"? Is she willing to accept she is addicted and get the help she must have? Or will she continue on her course of destruction? For the person who is both able and willing to seek and accept help, everything is helpful. For the person who is not able or willing to be helped, nothing works. Perhaps this is the essence of the issue of addiction. Getting the person to that place where they are able to accept help is critical and a monumental achievement.

******* APPENDIX *******

Thank you for taking time to answer this questionnaire. Your answers will help me with the research I need for a college paper about relapse issues. I very much appreciate your assistance.

No names please. This is completely anonymous.

This first page asks for basic demographic information.

The next page asks about your drug or activity of choice.
If you have more than one, please use one that you have quit using, rather than one you currently use.

The last two pages ask you to tell what activities work for you to remain clean and/or sober.

Please ask any questions you may have. Thank you.

Demographic Information					
Gender	Male	Female			
Age	18 - 25	26 – 35	36 – 45	46 – 55	56 & over
Education	Less than High School	High School Graduate	Some College	College Graduate	Post Graduate Work
Employment/Work	Not employed	Part time employment	Full time employment	Retired	Student
Number of drug or alcohol related convictions?	0	1	2	3 – 4	5 or more

Please write name of your drug or activity of choice_____

Just in case, here is a list of common drugs and activities: Alcohol, Amphetamines, Anti-depressants, Barbiturates, Caffeine, Cocaine, Darvon, Eating disorders, Gambling, Hallucinogens, Heroin, Inhalants, Internet, LSD/acid, Marijuana/Cannabis, MDMA, Morphine, Nicotine/Tobacco, Over-the-counter drugs, PCP, Prescription Drugs/Rx, Ritalin, Sex/Love, Spending/Shopping, Steroids, Tranquilizers.

Now CIRCLE your answer to each question about your named drug or activity of choice

Regarding your named drug or activity:							
Your age at first use?	Under 9	10-11	12-13	14-15	16-18	18-25	Over 25
Are you currently using/doing?		Yes	No				
If NO (you have quit the activity) how long have you been clean and/or sober?	0 – 30 days	31 – 90 days	3 – 6 months	7 – 12 months	1 – 5 years	6 – 10 years	Over 10 years
Prior to becoming clean and/or sober, how many relapses did you endure?	None	One	2 – 3	4 - 6	7 – 10	11 – 15	16 & over
How long ago was the last relapse?	0 – 30 days	31 – 60 days	61 – 90 days	3 – 6 months	7 – 12 months	1 – 5 years	6 – 10 years
Your age when you first quit?	Under 18	18 – 25	26 – 35	36 – 45	46 - 55	56 & over	
If YES (you currently use) do you want to quit?		Yes	No	Not sure			
What keeps you from quitting?	Don't want to quit	Like the effects	Family influence	Friends influence	Tried, but go back to using	Don't feel strong enough	Don't see any benefit

Please rank how useful each of these items, activities or qualities is to helping you stay clean and/or sober. Please mark appropriate box.	Not at all or Does not apply	A bit helpful Or use seldom	Somewhat helpful or use once or twice a month	Mostly helpful or use at least weekly	Very helpful or use almost daily
Stay out of bars					
Sports participation					
Take up new hobby					
Work more hours					
Work fewer hours					
Get new job					
Quit stressful job					
Exercise more					
Meditate					
Write in journal or diary					
More leisure/fun time					
Less leisure/fun time					
Join a club					
Join support group (AA/NA/church)					
Make new clean and/or sober friends					
Stay away from drinking/drugging friends					
Enroll in educational classes					
Join a health/sports club					
Spend more time with children					
Spend less time with children					
Spend more time with family					
Spend less time with family					
Eat more nutritious/healthier foods					
Make time for self					
Don’t let others pressure you to drink/use					
Pay attention to how you feel					
Reduce frustration levels					
Call someone/sponsor when tempted					
Call someone when upset/frustrated					
“Talk” yourself out of using					
Distract self with other activity					
Take a hot bath					
Take a long walk					
Work with your dreams					
Learn new coping skills					
Manage or control pain					
Increase awareness of emotions					
Increase awareness of rising tensions					
Get hugs from safe people					

Please rank how useful each of these items, activities or qualities is to helping you stay clean and/or sober. Please mark appropriate box.	Not at all or Does not apply	A bit helpful Or use seldom	Somewhat helpful or use once or twice a month	Mostly helpful or use at least weekly	Very helpful or use almost daily
Learn new ways to deal with anger					
Learn a new skill					
Teach someone a skill you know					
Increase patience with self					
Increase patience with others					
Spend more time with animals					
Obtain individual counseling					
Obtain group counseling					
Learning to be less impulsive					
Tolerate delays and frustration					
Recognize your cravings and wait					
Learn how long your cravings last					
Remind self of what worked before					
Learn and use deep breathing to calm					
Write your goals/desires					
Write your progress toward your goals					
Work to change negative thinking					
Ask for help when needed					
Get finances in order/reduce debts					
Volunteering/helping others					
Finding own spiritual strengths					
Learn better communications skills					
Express emotions appropriately					
Learn to speak your truth clearly					
Get more sleep/rest					
Remain aware of tendency to deny truth					
Take a vacation					
Write poetry					
Write letters to others					
Spend time with the elderly					
Spend time with the very young					
Learn a new language					
Get medical help for any illness/disability					
Take medications only as directed					
Lose excess weight					
Gain pounds if underweight					
Other:					
Other:					

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ACKNOWLEDGEMENTS AND NOTICES

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