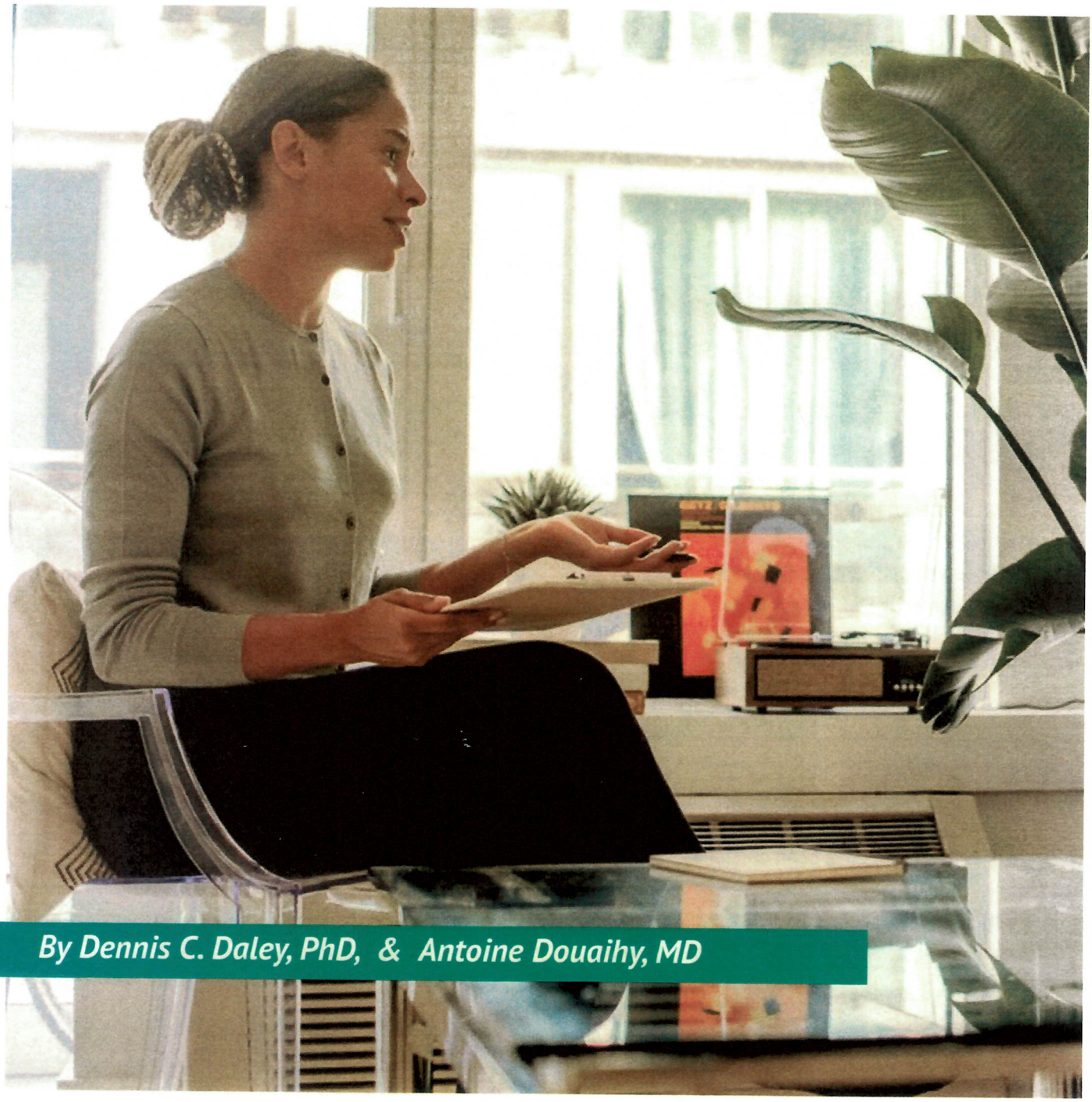
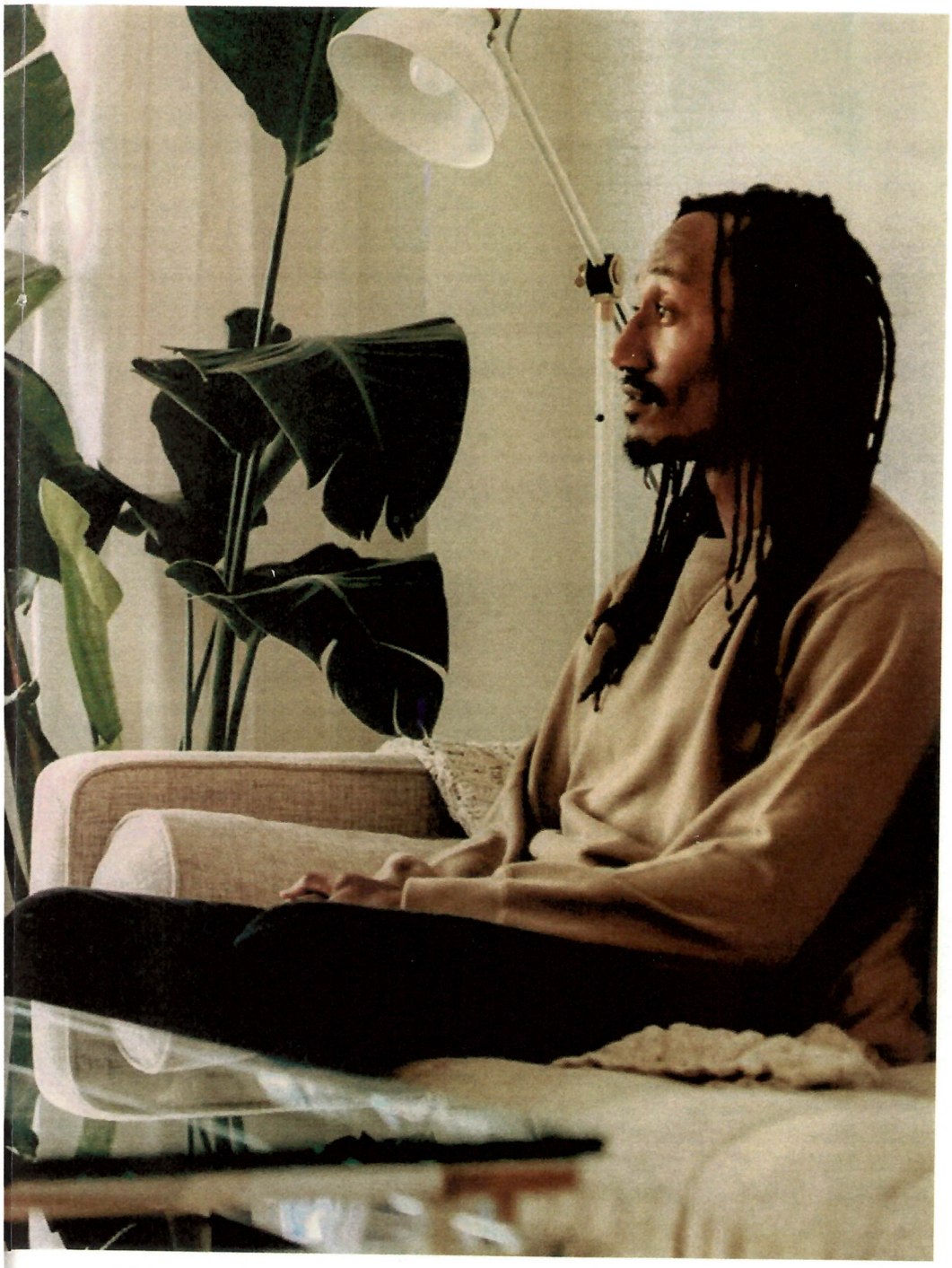


By Dennis C. Daley, PhD, & Antoine Douaihy, MD

Strategies to Enhance Recovery and Reduce Relapse Risk with Substance Use Disorders

Part 2: Goals and Clinical Issues



Relapse prevention therapy and counseling approaches for substance use disorders (SUDs) prioritize the development of cognitive and behavioral coping strategies to manage challenges that may arise during recovery. The goals of this approach include: 1) identifying and managing high-risk relapse factors; 2) identifying and managing early signs of potential relapse; 3) making lifestyle changes to decrease the need for substances and increase healthy activities and pleasures; and 4) preparing to intervene early in a lapse or relapse (Center for Substance Abuse Treatment [CSAT], 2007; Daley & Douaihy, 2015; Marlatt & Donovan, 2004; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008).

Various evidenced-based treatments (EBTs) for SUDs, such as individual, group, couples, and family-related therapies, aim to help clients sustain their recovery and decrease the risk of relapse. Treatment manuals and protocols describing EBTs have been developed by the National Institute on Drug Abuse (NIDA, n.d.), the National Institute on Alcohol Abuse and Alcoholism (NIAAA, n.d.), and SAMHSA (n.d.). These manuals were utilized in multi-site clinical trials, resulting in demonstrated efficacy of these treatments.

Following are strategies to enhance your client's recovery and reduce their risk of relapse. These can also be used with other addictions or co-occurring psychiatric disorders.

Address Decrease in Motivation to Change

Motivation fluctuates in early recovery and impacts on the desire to attend treatment and mutual aid programs. This often leads to clients' missing treatment sessions, mutual aid meetings, or early drop out. Motivational Interviewing (Miller & Rollnick, 2012) can help clients focus on ambivalence to change and ways to increase motivation. Ask the client to rate motivation on a daily basis in so that action can be taken when motivation decreases. Address current motivational struggles and help the client

learn from past experiences when poor motivation led to substance use or dropping out of treatment or mutual aid programs.

Facilitate treatment adherence.

Clients who adhere to their treatment and recovery plan are likely to do better than those who are poorly adherent or do not adhere at all (miss sessions, mutual aid meetings, fail to take medications, fail to "work" their specific recovery program). Help your clients learn from past experiences with poor adherence (why, when, results). Transitioning between levels of care is a potentially high-risk time for some clients to not attend sessions.

We increased rates of transition from a psychiatric inpatient co-occurring disorders program to ambulatory care over 50% by using a single MI session prior to hospital discharge (Daley & Zuckoff, 1999). We increased attendance at an intensive outpatient program by nearly 60% by using Motivational Incentives in which clients earned rewards for daily program attendance (Kelly, Daley & Douaihy, 2014). You can also outreach to new clients or those who miss treatment sessions to re-engage them in care.

Offer options for recovery pathways

There is no single approach that works for all clients. Offer the client options for recovery that may include professional treatment programs; individual, group and family counseling; medication-assisted-therapy; mutual aid programs; recovery services for families; or self-recovery (Daley, 2019; Daley & Douaihy 2019a). If needed, link clients to "peer support" to paid professionals (recovery specialists, patient navigators, peer specialists, etc.) or volunteers in community mutual aid programs. Some client move between levels of care due to the severity and/or complexity of their conditions. It may take several episodes of treatment before they sustain long-term recovery. Clients with milder forms of SUDs may benefit from self-recovery (Kelly et al, 2017).

Provide or facilitate integrated treatment for clients with co-occurring psychiatric disorders (CODs) that focuses on substance use and psychiatric issues (Daley & Douaihy, 2022; Mueser et al, 2004). More severe types of psychiatric disorders (psychotic disorders, bipolar illness, recurrent major depression, borderline personality disorder) are usually best treated in a mental health system that offers enhanced services for CODs.

Offer medication-assisted-treatment (MAT) for addiction to opioids, alcohol or nicotine

MAT is the gold standard for treatment of opioid addiction and can be used with most addicted clients. Medications for alcohol addiction improve sobriety rates and decrease the length and severity of relapses and can be used with clients who have difficulty staying sober from alcohol. Unfortunately, these are underutilized even in specialized substance use disorder programs.

Identify and manage high-risk relapse factors.

The most common potential high-risk factors include negative emotions or mood states, social pressures to engage in substance use, social networks comprised mainly of others who have substance problems, unresolved conflict with a family member or other person, physical pain, strong cravings to use substances, or negative attitudes and distorted beliefs about lapse and relapse. Help your client prioritize high-risk factors, and then develop and use cognitive and behavioral coping strategies to manage the most critical ones.

Identify and manage early warning signs

Obvious and subtle relapse warning signs often precede a client's lapse or relapse and may show in changes in attitudes, thinking, behaviors or emotions. This does not imply all changes indicate a relapse process is in motion. It implies that clients need to be aware of indicators that a relapse process may be in motion before substances are used. Common signs include cutting down or stopping counseling sessions, medications, mutual aid program attendance, or other active elements of a recovery plan (e.g., not taking a daily inventory, not talking regularly with peers in recovery). Seemingly-irrelevant-decisions (SIDs) are situations that at first may appear unconnected to relapse, but upon an in-depth review of a client's relapse process are connected to the relapse. Examples of SIDs include: calling a drug-using friend from the past with no intention of using drugs that leads to getting high again; or going to a local bar to hang out with friends and play pool with the intention of not drinking that leads to drinking a few beers.

Manage negative emotions and moods

This is an important issue for clients who report failure to manage anger, anxiety, boredom, emptiness, depression, guilt and shame, or

loneliness can impact on relapse. Negative mood states that are symptoms of a mood, anxiety or other psychiatric disorder may require an evaluation for medications in addition to learning cognitive or behavioral coping strategies. Recurrent or chronic psychiatric conditions, many of which include disturbances in mood, often require medications in addition to psychosocial therapies.

Involve the Family or Significant Other(s)

If appropriate and feasible, involve the family in assessment and treatment, and connect family members to community or on-line resources that aid their own recovery. Many family interventions lead to improvements in the SUD client and family members (Daley & Douaihy, 2019b; Klosterman & O'Farrell, 2013; Mueser et al, 2004; NIDA, 2020). Ask for specific details from your client on the impact of the SUDs on the family. For example, if your client states "my addiction had a terrible impact on my family," elicit examples. This information can be used in the treatment plan and affect the client's decision to include the family in treatment and recovery services.

Resist Social Pressures to Engage in Substance Use

Direct and indirect social pressures contribute to desires to use substances, sometimes unexpectedly. Help your client identify social pressures, how these can impact on thinking (e.g., "I want to fit in, a few drinks can't hurt, it's only weed"), emotions (e.g., anxiety, excitement) and behaviors (use or resist substances). Avoiding high-risk people, places and events can help, but your client can also benefit from practicing ways to refuse offers or minimize interactions where others exert pressure to use.

Use Social Support

Support can come from family, friends, peers in recovery, participation in mutual aid programs, going to recovery clubs, or using other community supports. Clients who have difficulty reaching out and asking for help and support can benefit from practicing ways to talk with others to get their support. It helps to have a list of people, phone numbers and email addresses to stay connected with others.

Other Coping Strategies to Reduce Relapse Risk

These include helping the client: learn to identify external and internal triggers, craving intensity, and ways to manage strong cravings; learn mindfulness skills; identify and refute negative, addictive or "stinking" thinking (e.g., "I need some action; I'll limit how much I use; I had four drinks, I blew my recovery"); and/or use mindfulness (e.g., meditate; or accept cravings, unwanted substance-related thoughts, feelings or sensations, but take positive actions to cope with these or other high-risk situations).

Facilitate Lifestyle Change

This may include helping the client: learn to reduce stress in daily life; improve health care habits related to smoking, eating, exercise, hobbies, creative activities, sleeping, and health promotion such as regular medical, dental and vision check-ups; manage money; address sex and recovery issues; and achieve balance between "wants" and "shoulds."

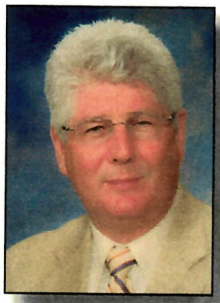
Prepare to Intervene Early to Manage Setbacks (Lapse or Relapse)

An emergency plan can help your client stop an initial lapse from leading to a relapse. Your client also needs a plan to stop an actual relapse to limit the damage and stop it. Help your client learn to engage in self-talk (e.g., "I made a mistake, I'll throw away my weed and call a peer in recovery; I'm not going to let this get out of control"). Suggest he or she carry a reminder card (or info on a smart phone) with names and phone numbers, and a list of these steps: stop, look and listen; keep calm; renew your commitment (to recovery); review the situation leading up to the lapse or relapse; take immediate action; use the help and support of a confidant or peers in recovery (Marlatt & Donovan, 2004; Daley & Douaihy, 2015).

Our next and final article on the topic of relapse prevention will discuss clinical tools to use in treatment sessions.

About the Authors

Dennis C. Daley, PhD, served many roles at the University of Pittsburgh School of Medicine. He is the author of many articles, treatment manuals, books, and guides for families and children affected by addiction.



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"Strong obsessions about substances and beliefs about recovery and one's coping abilities can impact on relapse. If a client believes that they can fight off cravings or manage a high-risk situation and uses active coping strategies to do so, the risk of relapse is reduced"

-Dennis C. Daley, PhD & Antoine Douaihy, MD