Relapse Prevention Therapy (RPT)

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George A. Parks, Ph.D.
CompassionatePragmatism.com
geoaparks@earthlink.net

25th Annual Research Conference

Trainer and Participant Introductions

Name
Credentials and Discipline
Current Job Title
Organization & Service Delivery Setting
Throughout his life, Alan brought empathy and evidence to the addiction field by developing innovative evidenced-based prevention and treatment programs.

His vision, passion, inspiration, collaboration, and hard work created a new paradigm in the Addictive Behaviors field based on “Compassionate Pragmatism,” a phrase he coined reflecting his caring and generous nature.
Relapse Prevention Therapy (RPT) Workshop Topics

1. A Cognitive-Behavioral Model of Relapse
2. Relapse Prevention Therapy (RPT)
3. Preventing Relapse On the Road to Recovery
4. RPT with Substance Abusing Offenders
5. RPT with Sex Offenders
6. RPT as a Case Management Tool
7. Therapeutic Jurisprudence

Relapse Prevention Therapy
Topic 1

A Cognitive-Behavioral Model of Relapse
A Cognitive-Behavioral Model of Relapse

Understanding Relapse
Thomas McClellan, Ph.D.
&
Michael L. Dennis, Ph.D.

Relapse Rates Are Similar for Drug Addiction & Other Chronic Illnesses

McLellan et al., JAMA, 2000.
Understanding and Managing Addiction as a Chronic Condition

Michael L. Dennis, Ph.D.
Chestnut Health Systems
Normal, IL

Presentation at the Congressional Addiction, Treatment, and Recovery Caucus Briefing, “Reducing Health Care Costs: Chronic Disease Management for Alcohol & Drug Problems,” June 11, 2009 from 1:00-3:00 p.m., 122 Cannon House Office Building. This presentation was supported by funds from and data from NIDA grants no. R01 DA15523, R37-DA11323, CSAT contract no. 270-07-0191 and several other authors/studies. It is available electronically at www.chestnut.org/li/posters. The opinions are those of the author and do not reflect official positions of the government. I would like to thank Redonna Chandler, Wilson Compton, Mark Godley, Thomas Hilton, Randy Muck, Chris Scott, and Alan Sender, for their assistance in preparing this presentation. Please address comments or questions to the author at mdennis@chestnut.org or 309-451-7801.

After Initial Treatment…

- Relapse is common, particularly for those who:
  - Are Younger
  - Have already been to treatment multiple times
  - Have more mental health issues or pain
- It takes an average of 3 to 4 treatment admissions over 9 years before half reach a year of abstinence
- Yet over two thirds do eventually abstain
- Treatment predicts who starts abstinence
- Self help engagement predicts who stays abstinent

Source: Dennis et al., 2005, Scott et al., 2005.
The Likelihood of Sustaining Abstinence
Another Year Grows Over Time

After 1 year of abstinence, about 36% will make it another year.
After 2 years of abstinence, about 66% will make it another year.
After 4 years of abstinence, about 86% will make it another year.
But even after 7 years of abstinence, about 14% will relapse each year.

The duration of abstinence and the likelihood of sustaining abstinence are positively correlated. As the duration of abstinence increases, the likelihood of sustaining abstinence also increases.

Duration of Abstinence
1-12 Months 1-3 Years 4-7 Years

% Sustaining Abstinence
Another Year

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Source: Dennis, Foss & Scott (2007)

What does Recovery look like on average?

Duration of Abstinence
1-12 Months 1-3 Years 4-7 Years

- More social and spiritual support
- Better mental health
- Housing and living situations continue to improve
- Dramatic rise in employment and income
- Dramatic drop in people living below the poverty line

- More clean and sober friends
- Less illegal activity and incarceration
- Less homelessness, violence and victimization
- Less use by others at home, work, and by social peers
- Virtual elimination of illegal activity and illegal income
- Better housing and living situations
- Increasing employment and income

Source: Dennis, Foss & Scott (2007)
A Cognitive-Behavioral Model of Relapse

“Nothing is as Practical as a Good Theory”
Kurt Lewin
Calvin and Hobbes

It's true, Hobbes, ignorance is bliss!

Once you know things, you start seeing problems everywhere...

And once you see problems, you feel like you ought to try to fix them...

And fixing problems always seems to require personal change...

And change means doing things that aren't fun! I say phooey to that!
BUT IF YOU'RE WILFULLY STUPID, YOU DON'T KNOW ANY BETTER, SO YOU CAN KEEP DOING WHATEVER YOU LIKE!

THE SECRET TO HAPPINESS IS SHORT-TERM, STUPID SELF-INTEREST!
WE'RE HEADNG
FOR THAT CLIFF!

I DON'T WANT
TO KNOW
ABOUT IT.

WAAUUU...GHNNH!
I'M NOT SURE I CAN STAND SO MUCH BLISS.

CAREFUL! WE DON'T WANT TO LEARN ANYTHING FROM THIS.

CRISS AS OPPORTUNITY

(weí jī)

The Chinese word for "crisis" is made up of two parts: "danger" and "opportunity".

“Danger”, originally pictured as a man on the edge of a precipice

“Opportunity”—a reminder of the seemingly small but important opportunity that can come out of danger.
What is Relapse?

RELAPSE (Webster’s English Dictionary, 9th Edition)

1. An act or instance of backsliding, worsening, or subsiding;

2. Recurrence of the symptoms of a disease after a period of improvement;

3. To slip or fall backwards into a former worse state.

Specific to Substance Use – “Resuming the use of a drug after a period of abstinence”
The “Black and White” Model of Relapse

Abstinence

Relapse

Thin Line
Relapse Terms and Definitions

1. LAPSE (SLIP)
   A “Single Instance or Episode” of Addictive Behavior

2. RELAPSE
   “Falling Back” to .......?

3. PROLAPSE
   “Falling Forward”- Lessons Learned from a Lapse

4. COLLAPSE
   “Hitting Bottom” - Hopeless, Resigned, Death

Map of Lapse, Relapse, Prolapse and Collapse Lands
Let's Take a 15 Minute Break

Relapse Prevention Therapy (RPT)

Topic 1
A Cognitive-Behavioral Model of Relapse
Immediate Determinants of Relapse
Immediate Determinants of Relapse

High-Risk Scenario

Effective Coping Response → Increased Self-Efficacy → Decreased Probability of Relapse

High-Risk Scenario

Ineffective Coping Response → Decreased Self-Efficacy + Positive Outcome Expectancies (for initial effects of the substance) → LAPSE (Initial Use of Substance) → Abstinence Violation Effect + Perceived Effects of Substance → Increased Probability of Relapse

High-Risk Scenarios for Relapse

<table>
<thead>
<tr>
<th>RELAPSE SITUATION (Risk Factor)</th>
<th>Alcoholics (N=70)</th>
<th>Smokers (N=64)</th>
<th>Heroin Addicts (N=129)</th>
<th>Gamblers (N=29)</th>
<th>Overeaters (N=29)</th>
<th>TOTAL Sample (N=311)</th>
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<tr>
<td>Negative Emotional States</td>
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<td>37%</td>
<td>19%</td>
<td>47%</td>
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<td>2%</td>
<td>9%</td>
<td>-</td>
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<td>3%</td>
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<tr>
<td>Positive Emotional States</td>
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<td>10%</td>
<td>-</td>
<td>5%</td>
<td>4%</td>
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<tr>
<td>Testing Personal Control</td>
<td>9%</td>
<td>-</td>
<td>2%</td>
<td>16%</td>
<td>-</td>
<td>5%</td>
</tr>
<tr>
<td>Urges and Temptations</td>
<td>11%</td>
<td>5%</td>
<td>5%</td>
<td>16%</td>
<td>10%</td>
<td>9%</td>
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<tr>
<td>TOTAL</td>
<td>61%</td>
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<td>45%</td>
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<td>48%</td>
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<tr>
<td><strong>INTERPERSONAL DETERMINANTS</strong></td>
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<td>18%</td>
<td>15%</td>
<td>14%</td>
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<td>Social Pressure</td>
<td>18%</td>
<td>32%</td>
<td>36%</td>
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<tr>
<td>Positive Emotional States</td>
<td>3%</td>
<td>3%</td>
<td>5%</td>
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<td>39%</td>
<td>50%</td>
<td>55%</td>
<td>21%</td>
<td>52%</td>
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Relapse Prevention Therapy

Topic 1

A Cognitive-Behavioral Model of Relapse

Distal Determinants of Relapse
The Abstinence Violation Effect (AVE)

NERVOUS BREAKDOWN LANE

Destination
Seattle
Homefree

Reno
Relapse

Placerville
Safe city

San Francisco
Abstinence

City bypass route
Last chance junction
Highway signs (gambling billboards)

Alternate route junction
Rest stop and U-Turn route

Border crossing

Start of trip

Highway paved with good intentions

A gambler's cognitive road map.
Distal Determinants of Relapse

Lifestyle Imbalance

Desire for Indulgence + Immediate Gratification (I owe myself...)

Urges or Craving mediated by expectancies for immediate effects of the substance

Rationalization, Denial, and AIDs (Apparently Irrelevant Decisions)

High-Risk Scenario

A Cognitive-Behavioral Model of Relapse

Lifestyle Imbalance -> Desire for Indulgence -> Urges and Craving -> Rationlizing, Denial, and AIDs -> High-Risk Scenario -> Decreased self-efficacy & Positive outcome expectancies -> Initial Alcohol or Drug Use (LAPSE) -> Abstinence Violation Effect and Perceived effects

Distal
Immediate
Relapse Prevention Therapy
Topic 2

Relapse Prevention Therapy (RPT)

"Imagination Without Practice Knowledge,
Is Like a Bird with Wings and No Feet"
Relapse Prevention Therapy (RPT) Goals

*Relapse Management* helping clients recover from a ‘lapse’ before it becomes a relapse

*Relapse Prevention* teaching clients to maintain abstinence by anticipating and preventing the occurrence of an initial ‘lapse’

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Key Lessons in Relapse Prevention Therapy

1. Creating a “Recovery Roadmap” providing a big picture of the habit change showing dangerous areas (High-Risk Scenarios) and alternative routes when setbacks happen

2. Developing Coping Strategies for High-Risk Scenarios, Urges and Craving and other challenges to abstinence

3. Recognizing and overcoming “Stinking Thinking”, “Tricks of the Mind” or “Cognitive Distortion” such as denial, minimization, rationalization, displacement, etc. that may lead to AIDs (Apparently Irrelevant Decisions)

4. Anticipating setbacks and breakdowns along the Road to Recovery, managing lapses and turning them into opportunities to learn (Prolapse)

5. Making global lifestyle changes to replace the gratification of addictive behaviors (crime) with healthier alternatives
12 Themes of Relapse Prevention Therapy

1. Learning Principles
2. Craving, Urges, Triggers
3. Warning Signs
4. High-Risk Scenarios
5. Coping Strategies
6. Lapse vs. Relapse
7. Abstinence Violation Effect
8. U-turns/Damage Control
9. Relapse Setups
10. Cognitive Distortions
11. Healthy Habits
12. Lifestyle Balance

*Living A Good Life*

Adapted from SAMM - Substance Abuse Management Module in *Overcoming Addictions* by Roberts, Shaner & Eckman

RPT Therapist Guides & Treatment Manuals

4. Overcoming Your Alcohol or Drug Problem by Daley & Marlatt (2006)
Relapse Prevention Therapy (RPT)

Let’s Have Some Lunch

Relapse Prevention Therapy
Topic 3

Preventing Relapse
On the Road to Recovery
Preventing Relapse On the Road to Recovery
MET-CBT “Phased” Intervention Design

Precontemplation ➔ Contemplation ➔ Preparation ➔ Action ➔ Maintenance ➔ Relapse

3 MET Sessions

9 Coping Skills Sessions using CBT
Preventing Relapse On the Road to Recovery
Program Overview

1. Preventing Relapse On the Road to Recovery is a RPT Program composed of an integrated sequence of MET and CBT modules (METCBT).

2. Three Motivational Enhancement (MET) sessions begin the program to increase client engagement, self-awareness, and motivation.


Preventing Relapse On the Road to Recovery

1. Understanding Relapse
2. Motivation and Readiness to Change
3. Self-Awareness and Change Planning
4. Creating a Social Support System
5. Breaking the Addictive Behavior Habit
6. Coping with Urges and Craving
7. Identifying High-Risk Scenarios
8. Coping with High-Risk Scenarios
9. Alcohol and Drug Refusal Skills
10. Coping with a Lapse
11. Working Skillfully with Thoughts and Feelings
12. Creating a Good Life
Topic 4

Relapse Prevention Therapy with Substance Abusing Offenders

Offenders Substance Abuse Programs using RPT

1. Criminal Conduct and Substance Abuse Treatment (Strategies for Self-Improvement and Change) – Wanberg & Milkman
2. Maine - Differential Substance Abuse Treatment (DSAT)
3. US BOP - Residential Substance Abuse Treatment (RSAT)
4. CSC - Offender Substance Abuse Programs (OSAPP, CHOICES, HISAP)
The positive results of DAP treatment on post-release recidivism and drug use were statistically significant for men but not for women… where failure was defined as a new arrest or revocation.

The probability of arrest or revocation for men released to supervision who entered and completed treatment was 44.3 percent as compared to a probability of approximately 52.5 percent for untreated subjects. Thus, men who received and completed in-prison treatment were 16 percent less likely to recidivate.
The positive results of DAP treatment on post-release recidivism and drug use were statistically significant for men but not for women... where failure was defined as a new arrest or revocation.

Among women who completed residential drug abuse treatment, 24.5 percent were likely to be arrested for a new offense or have supervision revoked within 3 years after release compared to 29.7 percent among untreated inmates; that is, those women who completed residential drug abuse treatment were 18 percent less likely to recidivate in the first 3 years following release than those who did not receive treatment. (TRIAD Chapter 9. p. 155.)

1. 1991 National Survey of Offender Substance Abuse Programs found current practice was not evidence-based
2. Development of Strategic Plan to implement EBP
3. Creation of OSAPP, ALTO, CHOICES
   - Offender Substance Abuse Pre-Release Program (OSAPP)
   - ALTO - French Language and Culture tailored version of OSAPP
   - Community Correctional Brief Treatment Relapse Prevention and Maintenance Program (CHOICES)
CSC OSAPP Outcome Research

1. OSAPP was more effective for offenders moderate levels of substance misuse intensity, as demonstrated by their 48% reduction of new convictions as compared to a matched comparison sample, high-need offenders (higher risk and more severe AOD problems) = 26% reduction of new convictions
2. OSAPP for all offenders is more effective when followed by CHOICES delivered in the community


High Intensity Substance Abuse Program (HISAP)

1. Techniques and skills taught in OSAPP might also be applicable for HISAP participants.
2. May require more program frequency and intensity to learn and practice the skills required to make and maintain long-term behavior change.
3. HISAP program consists of about 100 two-hour sessions, with about 8 sessions delivered per week, making the program between 4 and 5 months in length.
Topic 5

Relapse Prevention Therapy with Sex Offenders

RPT in Sex Offender Treatment Programs

The majority of Sex Offender Treatment Programs (SOTP) in the United States, Canada, Australia, and the UK use cognitive-behavioral relapse prevention techniques designed to help sex offenders maintain behavioral changes by anticipating and coping with the problem of relapse.
RPT - Sex Offender Treatment Programs

Offense specific treatment modalities include:

1. Group and/or individual therapy focused on victimization awareness and empathy training
2. Cognitive restructuring
3. Learning about the sexual abuse cycle
4. Relapse prevention planning
5. Anger management and assertiveness training
6. Social and interpersonal skills development
7. Changing deviant sexual arousal patterns

Relapse Prevention Therapy (RPT)

Let’s Take a 15 Minute Break
Topic 6

Relapse Prevention Therapy as an Offender Case Management Tool

Towards a Cognitive-Behavioral Model of Recidivism
Retrospective Research on the Reoffense Process
*The Criminal Recidivism Process* (Zamble & Quinsey, 1997)

Recidivists compared to those who desisted:

- Unsettled lives
- Frequent moves
- Frequent unemployment
- Unstable relationships
- Psychological distress
- Substance abuse problems
Static Risk Characteristics

1. Younger
2. Earlier age at first trouble with law
3. Scored higher on the LSI

Recidivist Static Risk Characteristics

Less:
1. Job tenure
2. Time current residence
3. Stable relationships
4. Schooling

Greater:
1. Substance abuse
2. Consideration of suicide
3. Prior convictions
4. Problems mentioned
Coping Skills and Recidivism

1. Emotions and habits play critical roles in the chain of events leading to reoffense

2. The offense process works like a ballistic missile once dynamic factors have reached high intensity, crimes can occur within hours or days at most

   (Cusp-Catastrophe Theory – Calvin & Hobbs)

3. Behavioral/emotional triggers for reoffense may be predictable and preventable

A Model of Coping Skills and Recidivism
(Zamble and Quinsey, 1997)

1. Coping skills of recidivists not adequate to solve life problems
2. Recidivists turned ordinary hassles and stress into more serious problems
3. Recidivists were incapable of fulfilling their basic needs in prosocial way
4. Lack of need fulfillment led to recidivist frustration, anger and depression
5. Emotional distress often dealt with by alcohol and other drug use
6. Coping ability was as accurate in predicting reoffense as the LSI score
7. Offenders with higher coping ability had less extensive criminal records
8. Reoffense is similar to a relapse when a user returns to alcohol or drugs
9. Ultimate breakdown in self-control mechanisms maintaining lawful behavior
10. Reoffense predictable by risk factors similar to AOD relapse such as negative emotional states, interpersonal conflict, and social pressure

(See ACI, Antecedents of Crime Inventory - Ralph Serin, CSC)
Towards a Cognitive-Behavioral Model of Recidivism

1. Static Risk: Dispositional factors and the crime behavior profile detailing high-risk scenarios & crime cycles
2. Dynamic Risk: Intensity of criminogenic needs
3. Offense chains creating pathways to a high-risk scenario
4. Acute Dynamic Risk: Elements of a high-risk scenario
5. Greater probability of reoffense, if coping skills have not been learned or are not used

Temporal Dimension of Recidivism Risk

1. **Static Risk**: Predisposition to commit criminal acts within a given behavioral repertoire (crime cycles)
2. **Dynamic Risk**: Criminogenic needs that perpetuate offending such as anti-social attitudes, anti-social associates, substance abuse, etc.
3. **Acute Dynamic Risk**: Imminent factors at the end of a specific offense chain creating pathways to exposure to a high-risk scenario typical of a particular crime cycle
Creating a Criminal Behavior Profile

Detailed behavioral information is required for each offense or class of offenses

1. What (offense type)
2. Who [victim(s)]
3. With whom (accomplices)
4. When (timing)
5. Where (place)
6. How (means)
7. Harm (damage done)
8. Why (purpose/goal)

Offense Chains

1. Thoughts, feelings and behaviors that form links of both internal and external events to the eventual occurrence of criminal conduct.

2. Provides a pathway of exposure to high-risk crime scenarios where reoffense is likely to occur.
Creating Offense Chains

1. Identify observable event in the offense chain
2. “What” happened (versus “why”)
3. At least seven events preceding the crime
4. Construct associated interpretations, thoughts, self talk for each observable event
5. Identify places to intervene with cognitive-behavioral coping skills

Acute Dynamic Risk
The Imminent Precursors of Recidivism

Anders et al. (1998) state a criminal act occurs when the following factors are present for an individual at a particular time and place:

- The person is motivated to acquire the perceived rewards of a crime
- Internal inhibitions and objections have been neutralized
- Intention to commit an offense is formed
- The person self-efficacy suggests “I am able to do it” and “This crime will pay off”
- Personal belief that it is “okay” to commit the crime
- External controls are absent
- The scenario is perceived by the person as one in which it is “okay” and “safe” to commit the crime
- Balance of rewards/costs shifts in favor of crime
- A personal choice is made to engage in criminal conduct
- A crime is committed
Elements of High-Risk Crime Scenarios

1. **What** type of offense is committed
2. **Who** was the **victim(s)**
3. **With whom** (accomplices)
4. **When** the offense occurs
5. **Where** it occurs
6. **How** the offense was committed
7. What level of **harm** was done
8. **Why** was offense committed.

Crime Cycles

The repetition of a sequence of offense chains leading to similar high-risk crime scenarios and offense types is a crime cycle
Preventing Recidivism with RPT

1. Identify and monitor dynamic risk and acute dynamic risk factors specific to an offender’s criminal behavior profile
2. Increase offender awareness of dynamic risk factors, offense chains, high-risk scenarios and cognitive-behavioral coping skills
3. Increase probation or parole officer’s understanding of offender risk factors allowing actions to interrupt the process of reoffense
4. Create an educated network of offender collaterals to assist the offender and correctional officer in monitoring offender behavior that increases reoffense risk and take appropriate action
5. Correctional officer intervenes with coaching and catching strategies
6. Offer offender access to community-based resources to foster relapse prevention and support offender efforts toward creating a good life

Preventing Recidivism with RPT

Develop effective coping skills such as

“PACE Your Recovery”

Plan ahead to anticipate exposure to high-risk crime scenarios
Avoid high-risk crime scenarios whenever possible
Cope with urges to commit crime while exposed to high-risk scenarios. Make a U-turn and exercise damage control. If a lapse of criminal conduct does occur
Escape from high-risk crime scenarios at the earliest opportunity
Components of RPT Case Management Tool

1. Didactics to increase offender, correctional officer and collateral understanding of the recidivism process
2. Identifies crime cycles, high-risk scenarios, offense chains
3. Monitor changes in dynamic and acute dynamic risk by routine contact with the offender and collaterals
4. Assess offender at every contact for increases in risk
5. Assess offender coping capacity
6. Promote coping skills and offender community integration
7. Evaluate results frequently

Topic 7

Therapeutic Jurisprudence
Therapeutic Jurisprudence

Therapeutic Jurisprudence is the study of the effects of law and the legal system on the behavior, emotions, and mental health of people.

It is a multidisciplinary examination of how law and mental health interact.

Focuses on how the processes used by courts, judicial officers, lawyers, and other justice system personnel can impede, promote or be neutral in relation to outcomes connected with participant well-being such as respect for the justice system and the law, offender rehabilitation and addressing issues underlying legal disputes.

“Therapeutic Jurisprudence concentrates on the law’s impact on emotional life and psychological well-being.

It is a perspective that regards the law (rules of law, legal procedures, and roles of legal actors) itself as a social force that often produces therapeutic or anti-therapeutic consequences.

It does not suggest that therapeutic concerns are more important than other consequences or factors, but it does suggest that the law’s role as a potential therapeutic agent should be recognized and systematically studied.”

David Wexler, Distinguished Research Professor Emeritus of Law, University of Arizona and Professor of Law and Director, International Network on Therapeutic Jurisprudence, University of Puerto Rico.
**Works on Therapeutic Jurisprudence** by David B. Wexler


5. *Therapeutic Jurisprudence: The Law as a Therapeutic Agent* (Carolina Academic Press 1990),


**Therapeutic Jurisprudence: Two Key Books**


2. Shad Maruna. *Making Good: How Ex-Convicts Reform and Rebuild Their Lives*, American Psychological Association (APA), 2001 provides a fascinating narrative analysis of the lives of repeat offenders who, by all statistical measures, should have continued on the criminal path but instead have created lives of productivity and purpose. This examination of the phenomenology of "making good" includes an encyclopedic review of the literature on personal reform as well as a practical guide to the use of narratives in offender counseling and rehabilitation.