

RELAPSE MANAGEMENT

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One of the most powerful components of the learning model of psychotherapy is that the patient begins to incorporate many of the therapeutic techniques of the therapist.

(Beck et al., 1979, p. 4)

Successful CBT makes us redundant: it enables patients to become their own therapist, quite independent of us. Crucially, this means that they have learnt the *life skill* of relapse management. For long-term coping, patients must be able to tackle setbacks productively. Clichéd as it might sound, patients need to be able to experience set-backs as learning opportunities.

You might wonder why this section is called relapse *management* rather than *prevention*. Although some treatment approaches might aim to have no relapses, it can be almost impossible to prevent some degree of relapse in some disorders and with some clients. Patients (and therapists) who anticipate that they can completely prevent relapse are likely to be disappointed. However, it is possible to learn how to *manage* such events, learn from them and regain progress that has been lost.

We recommend that relapse management is introduced early on in therapy so that there is time for it to be developed as a skill which is refined over the course of treatment. Although tomes have been written on the topic – most notably Marlatt and Gordon’s excellent “Relapse Prevention” (1985) - the most basic form of relapse management comprises just three questions to be asked following a setback:

How can I make sense of this?

What have I learnt from it?

With hindsight, what would I do differently?

Following a set-back or lapse or relapse (however it is experienced), patients are often too distressed to engage in a demanding recovery procedure, but these 3 simple questions are “mentally portable” and will give them swift direction for recovery. You can first work through them in session and later prompt your patient to apply them in the field - in this way, your patient develops the habit of analysing and profiting from setbacks. For example:

Karim struggled with over-eating and alcohol misuse. One evening he bought quite large quantities of his favourite foods and wine, went home alone and consumed it, only spitting out chewed mouthfuls when he became over-full, but unable to stop eating. During this time he also drank several glasses of wine. Such an evening would usually have marked the beginning of a significant decline. He would have woken the next day feeling physically unwell and uncomfortable, would have concluded that he was a hopeless failure and his mood would certainly have been depressed. As a ‘hopeless failure’ he would have felt powerless to resist the urge to have a “numbing” glass of wine and /or comfort-eat. However, on this occasion, he asked himself:

How can I make sense of this lapse? Karim realised that he had been feeling stressed at work for several days but had kept pushing on in order not to think about his troubled relationship. In addition, he had begun to resume an old habit of starving throughout the day in an attempt to lose weight. Once he had reflected on the situation, he was able to say: ‘It’s no wonder that I fell off the wagon. Not only was I stressed to breaking point but I set myself up for a binge by not eating during the day.’

What have I learnt from it? I realise that, for me, it is dangerous to starve as a means of weight control or to try to take control of my emotions— it backfires. Also, I need to keep a check on my stress level: when it gets too high I am vulnerable to buying that bottle of wine and comfort-eating.’

With hindsight, what would I do differently? Hard as it is, I would try to eat “sensibly” during the day and avoid starving. Looking back, I made a mistake in trying to pretend that I did not have problems in my relationship and instead throwing myself into my work as a distraction. If I had that time over again I would acknowledge my problems, maybe even talk to someone about them rather than ignoring them. I could probably have talked with my brother – he always says that I should. Next time I will.’

Not only does this give Karim a plan for coping in the future, but he has learnt more about his particular needs and vulnerabilities. With each setback he will be able to continue to ‘fine-tune’ his understanding of difficulties and develop a wider and more individually tailored repertoire of coping responses.

Relapse work pioneers, Marlatt and Gordon (1985), developed their model and strategies in the treatment of addictive behaviours. However, this understanding of relapse risk and management has proven to be relevant across a wide range of psychological disorders (Witkiewitz & Marlatt, 2007). Marlatt and Gordon identified several vulnerability factors for relapse and a particularly potent one was a dichotomous, or ‘all or nothing’, interpretation of a setback. They observed that those who perceived themselves as *either* being in control *or* having failed tended to relapse at the first sign of difficulty: these patients flipped from feeling in control to feeling as though they had failed completely. Once in the ‘failure’ mind-set, they tended to be dominated by a sense of hopelessness which drove unhelpful behaviours such as continuing to drink for comfort. Marlatt and Gordon promoted a continuous notion of being in control and slipping out of control, which could accommodate minor and even significant setbacks without the client automatically assuming failure (see Karim’s continuum below).



Holding onto this perspective (of a *spectrum* of experiences ranging from “Control” to “Relapse”) increases the likelihood that a slip or a setback is perceived as a temporary aberration – one which could be corrected. To further encourage resilience, patients are urged to consider the different stages along the continuum and to ask:

When will I be at risk of this happening?

What are the signs?

What could I do to avoid losing control?

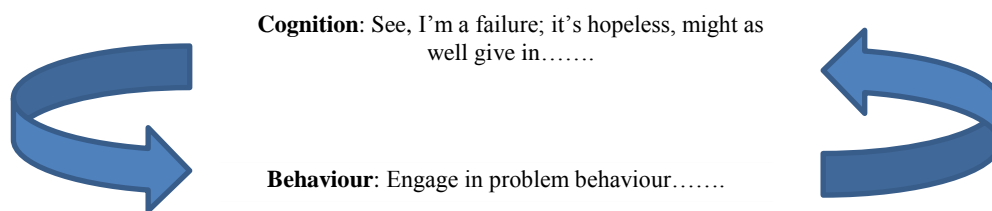
What could I do if I did lose control (damage limitation)?

In this way, ‘early warning signs’ can be detected and patients can try to avert a lapse, whilst still having a well-considered back-up plan. Thus, a lapse can be construed as an anticipated event for which there is a solution. This is similar to the notion of the “blue-print”.

What factors besides dichotomous thinking predispose a person to relapse? Marlatt and Gordon (1985) identified a sequence of events that systematically increased the likelihood of relapse. These were:

- **Being in a high-risk situation:** for example, a depressed person being socially isolated, someone with an eating disorder not having eaten for too long, the woman with a gambling problem travelling through Las Vegas.
- **Having poor or no coping strategies:** for example, poor mood management skills or no helpful ideas for dealing with hunger pangs in a controlled way or poor impulse control.
- **The sense of loss of self-efficacy:** for example, thinking ‘I’m hopeless. It’s my fault that I’m depressed,’ or ‘There’s no point in trying to resist. I just can’t.’ Such thoughts give a person ‘permission’ to let go or give in. This step can be exacerbated by substance misuse.
- **Engaging in unhelpful behaviours:** for example, withdrawing further or binge-eating or abandoning oneself to the casino.

In Marlatt and Gordon’s view, the worst was still to come: they recognised that many patients who were striving to remain abstinent from problem behaviours became caught up in a powerful cycle of unhelpful thoughts and behaviours once they ceased to be abstinent. They called this the ‘Abstinence Violation Effect’ (AVE) and saw this as marking true relapse – a state of not being able to break away from the problem behaviours because of compelling cycle of negative thoughts and problem behaviour (see below).



An advantage of identifying the steps *en route* to the AVE is that they offer clear points for interventions that can interrupt progress towards relapse. As memory and performance are often impaired in distress, it is a good idea to encourage your patients to write down their personal plan for minimising relapse and to make sure that they have easy access to it, of course. Below are some strategies for managing each of the steps towards relapse:

Being in a high-risk situation: The key is to identify (through monitoring), predict and, where possible, avoid high-risk situations. For example, if a depressed person learns he is at risk of becoming miserable when socially isolated, he needs to strive to maintain social contacts; if a man with an eating disorder is at risk of binge-eating when over-stressed or hungry, he needs to avoid getting into those situations; if a woman can't resist her gambling urges when there are opportunities, she needs to plan to avoid temptation until she has reliable impulse control. However, difficult circumstances are sometimes unavoidable, so the vulnerable may find themselves in a high-risk situation. A relapse is not yet inevitable, although it is more likely if the person has poor coping strategies or has grown increasingly ambivalent about change (in which case it may be helpful to try to re-motivate patients by using a motivational interviewing approach: see Miller & Rollnick (1991); or Rollnick, Miller, & Butler (2008).

Having poor or no coping strategies: Patients can be encouraged to develop appropriate cognitive and behavioural coping strategies and then to plan how they would put them into action. Someone prone to depression might list all the social activities and contacts he could try if he felt vulnerable; a person at risk of binge-eating or gambling might keep a reminder of activities that curb urges. Although this is a routine part of their CBT, it is helpful if patients keep reminders of what works for them, reminders that they can access at times of need when their memory might be impaired by their emotional state. Smart phones are useful places to keep this information.

The sense of loss of self-efficacy: This is a very cognitive element in the course of relapse, and therefore CBT is well placed to help people develop realistically hopeful and empowered self-statements. For example:

It is my way of thinking that is bringing me down, but tough as it is I can “coach” myself out of it again. And, there are a lot of friends out there who want to support me.’

I can resist. I have resisted in the past. I am not saying that it is easy but I know that it’s possible for me.’

I matter, I’ve learnt that much. I’m going to push myself and I am going to do this for me.’

Again, patients need to anticipate when they are likely to use such statements, and it can be helpful to rehearse using them either in role play or in imagination. This also affords the therapist an opportunity to check that the self-statements are not unhelpfully bullying or critical.

Engaging in the unhelpful behaviour: for example, withdrawing further from social activity, or binge-eating, or gambling. As you saw above, people can get locked in a powerful and unhelpful cognitive-behavioural cycle. You can help your patient to use techniques of cognitive restructuring to break the pattern and to support behavioural change. This will in turn provide support for further cognitive reappraisal.

To err is human and I’m human. A lapse is only that – it’s not the end of hope for me; I’m going to look back over today and try to see why I blew it, and then I’m going to make a plan.’

I feel wretched now. I’ll try to sleep it off, but as soon as I’m sober I’m going to go over to Gerry’s to “debrief” what I’ve just been through. He helps me get a perspective and get back on my feet.’

“That was a bad move and now I’m broke, but if resist borrowing I can break out of this trap. I must walk through the door and ring home. Dad will be mad but he’ll come and collect me.’

Clearly the more ambivalent your patient, the more difficult it might be to generate helpful statements and plans. It is worth noting that ambivalence concerning change can render a person even more vulnerable to lapses and relapse, and you need to keep track of your client’s motivation to change. Patients are also more at risk when they have to cope with life events and stresses; so again, you need to check in on this regularly.

In summary, managing relapse means helping your patient:

1. Learn to learn from set backs
2. Appreciate the spectrum that spans “Control” to “Relapse”
3. Recognise risk and to have comprehensive coping plans

Additional reading:

Marlatt, G.A and Donovan, D.M (2005) Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours (2nd edition). Guilford Press