Relapse Prevention Manual: Educating Individuals
With Substance Abuse Disorders

By

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Abstract

The importance of relapse prevention for individuals with substance abuse disorders is discussed in detail. The manual discusses substance dependence from the perspective of the disease model and cognitive behavioural model. Included are four best practices for maintaining abstinence along with exercises readers can use to establish basic coping skills. The four best practices for relapse prevention identified by current literature include: mutual help groups, pharmacotherapy, mindfulness based relapse prevention, and addiction counselling. A few other resources were also listed for readers to use such as: help lines, treatment centres, and links to Alcoholics Anonymous. Results yielded a six chapter manual designed to educate individuals with substance abuse disorders on relapse prevention. It is encouraged that readers use the manual as a basic guide to further their knowledge and develop their own recovery process.
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Chapter I: Introduction

According to Witkiewitz, Marlatt, and Walker (2005) chronic use of substances, including alcohol, represents a worldwide health problem. It is also very concerning that the estimated relapse rates for substance abuse is over 60% (Bowen et al., 2009). It is imperative that individuals with substance dependence are taught relapse prevention to help them remain abstinent and in control for longer periods of time. Relapse is defined as "the return of an illness after a period of improvement" or "the act or instance of backsliding, worsening or subsiding" (Brownell, Marlatt, Lichtenstein, & Wilson, 1986, p. 766). Relapse prevention was designed to teach individuals the appropriate coping skills and behaviours necessary to remain abstinent or use substances in moderation. Current treatments for addictive behaviours often focus on the initial cessation of the addiction; however, the threat of relapse continues over the course of the individuals' lifetime (Farabee et al., 2013). Farabee et al., (2013) suggest that there should be a stronger focus on relapse prevention as opposed to initial cessation. It is important for individuals who abuse substances and helping professionals to understand different types of relapse prevention strategies in order to provide the best opportunity for abstinence and maintenance.

It is hypothesized that developing a manual focused on relapse prevention would better educate individuals with addictive disorders and facilitate longer durations of abstinence and improved coping skills. Individuals would have access to this manual within the detoxification centre before attending treatment or going back to their daily lives. The manual would serve as a resource to help teach individuals about the relapse process, various relapse prevention strategies, and improve the chance that they will make proactive decisions when dealing with their addiction. Lastly, the manual would include several relapse prevention exercises and information on self-help groups. In turn, this would help individuals with substance abuse disorders, develop numerous coping strategies and encourage individuals to build a positive social circle.

Manual Description

The most efficient way to present information on relapse prevention to individuals with substance abuse disorders was through the development of a manual. The information presented in the manual will be organized into six chapters. Chapter one, 'Relapse Prevention: An Overview' will provide readers with information on the cognitive behavioural model and the disease model of addiction and relapse. Chapter one will also give details about common causes for relapse and definitions pertaining to relapse (e.g., lapse and relapse). The next four chapters will describe best practices for relapse prevention and they will be organized as followed: Self-help Groups, Mindfulness Based Relapse Prevention, Pharmacotherapy, and Counselling. In addition, exercises will be included at the end of each chapter (e.g., meditation, writing a journal, and readings). The final chapter, 'Personal Stories' will give readers insight into anecdotal evidence about relapse prevention. The purpose for including anecdotal evidence from individuals with substance abuse disorders is to help the reader relate to the material and offer a wide range of relapse prevention techniques. This section of the manual will include tips for readers to help them find what works for them and will include ideas such as: modifying relationships, building a routine, daily exercise, or attending meetings.

Once readers have gone through the manual and tried some of the exercises or tips they can provide feedback to the author. There will be a feedback questionnaire presented at the end
of the manual which will have a list of questions that are rated on a 5-point Likert scale (1-strongly disagree and 5-strongly agree). Also there will be two comment questions to provide more detailed responses. It is essential to collect feedback about the manual to help assess its effectiveness and usefulness, as well as adapt and modifying the manual accordingly.
Chapter II: Literature Review

Leshner (1999) characterizes addiction as a continual condition where relapse is very common (as cited in Witkiewitz & Bowen, 2010). Witkiewitz and Bowen (2010) emphasize incorporating relapse prevention into the treatment of substance abuse disorders. Educating professionals and individuals who abuse substances on the relapse process and the significance of maintenance could increase the likelihood that individuals would be able to maintain their sobriety for longer periods of time (Witkiewitz & Marlatt, 2004). In addition, providing such individuals with proactive coping strategies that promote self-control may better prepare an individual when they come into contact with a high-risk situation (Marlatt & George, 1984). It is important to note that relapse most often occurs when an individual encounters a high-risk situation (e.g., entering a bar) (Marlatt & George, 1984). Marlatt and George (1984) found that the three most common high risk situations include negative emotional states (35%), social pressure (20%), and interpersonal conflict (16%). Therefore, individual treatment may be beneficial for dealing with individual needs (e.g., counselling) and group treatment may create social support and practice opportunities (e.g., self-help groups) (Irvin, Bowers, Dunn, Morgan, & Wang, 1999). As a result, a manual illustrating several different strategies may be beneficial for clients to build a repertoire of skills and encourage the broadening of their support networks.

Relapse prevention has been broadly defined as any plan or treatment used to prevent future symptoms associated with relapse and relapse itself (Brown et al., 1986). Relapse prevention procedures can either be something specific such as developing coping strategies or more general practices such as lifestyle changes. Lifestyle changes include: changing geographical location, extracurricular activities, or disconnecting/re-connecting with supportive individuals. The cognitive behavioural model of addiction illustrates that drinking and drug use become maladaptive as a result of learned behaviours (Witkiewitz, Marlatt, & Walker, 2005). In turn, Cognitive Behavioural Therapy (CBT) is used to identify the social, situational, and cognitive precipitants of substance use which then establishes the maladaptive thoughts and behaviours (Witkiewitz et al., 2005). CBT works to help individuals stabilize their mood, manage cravings, adjust faulty beliefs to be less pessimistic and more in line with reality and build self-control. As stated afore, Marlatt and George (1984) found three main predictors of relapse implicated in gambling, smoking, drinking, and drug use; therefore the use of CBT may be beneficial for individuals across different types of substance dependence. Marlatt and George (1984) identified three main categories for relapse prevention: cognitive reframing, skills training, and lifestyle intervention. Cognitive reframing is a self-talk technique in which an individual learns to alter their maladaptive thought process into a more adaptive one. Skill training consists of an assortment of techniques that create positive coping. One important skill is problem solving training which is used to help individuals seek out and create proactive solutions when dealing with stress or high-risk situations (e.g., searching for a new job after being fired instead of going to a liquor store). The example provided is a probable solution for someone with adequate problem-solving skills; however, it takes practice to be able to identify alternative solutions. Problem solving often needs to be broken down into smaller steps such as: identifying the problem, setting a goal, generating alternative solutions, choosing the best solution, implementing the solution, and then evaluating its effectiveness. Breaking down the solution into smaller steps makes it more feasible for individuals to make proactive decisions. Other skills training can include stress management, anger management, and relaxation training (Marlatt & George, 1984). Different techniques can also build on each other to help strengthen
one's ability to remain abstinent. In the example of a person losing their job, one might need to use relaxation training to calm down before they even consider trying to problem-solve. Marlatt and George (1984) also stated that a lifestyle intervention can improve sobriety. A lifestyle intervention consists of several different changes made to one's daily life such as social affiliation and living situation. By changing the relationship with friends, family, and other supports in one's life to consist of abstinent individuals it may increase abstinence as well as decrease isolation. Modifying one's environment to make the access to alcohol or drugs more difficult can also help maintain abstinence. A crucial part of CBT is modeling and role-playing; both give individuals the chance to practice their newly developed skills and strategies, which will better prepare them for real world situations (Marlatt & George, 1984; Witkiewitz, 2005). CBT is an effective form of treatment for individuals with addictions and contains a multitude of strategies that help prevent relapse, however it is usually limited to hypothetical situations (Wanigaratne, Davis, Pryce, & Brotchie, 2005).

The treatment that individuals receive for addiction is only a short term solution to help build healthy coping strategies, support networks, and self-efficacy. Once an individual returns to their real world they face a lifelong challenge of maintaining abstinence and trying to manage their addiction. Miller (1993) identifies alcoholism as an irreversible disease in which the condition can never be cured, only controlled at best. Consequently, there should be an equal focus on the relapse prevention aspect of addiction in comparison to treatment because a person's ability to function within the real world without substance dependence is the main goal. Teaching mindfulness based relapse prevention (Witkiewitz & Bowen, 2010), attending self help groups (Miller, 1993), attending counselling/therapy (Brownell, Marlatt, Lichtenstein, & Wilson, 1986), or using pharmacotherapy (Krupitsky et al., 2013) has been met with reductions in relapse rates amongst addictive disorders. Thus, educating individuals on a range of relapse prevention strategies appear to increase the chance of them developing coping skills that work for them on an individual level and, in turn, help them maintain their abstinence.

**Diagnosing Substance Use Disorders**

According to the *Diagnostic Statistics Manual of Mental Disorders, (5th, ed.)* (DSM-5; American Psychiatric Association [APA], 2013), there are ten classes of drugs associated with substance use disorders. Drugs included are: alcohol, cannabis, hallucinogens (e.g., LSD and psilocybin), opioids (e.g., oxycodone and morphine), and stimulants (e.g., cocaine) amongst a few others. The DSM-5 places individuals on a spectrum of mild to severe substance dependence on the number of symptoms they have according to the list below:

1. Taking the substance in larger amounts or for longer than was meant to
2. Wanting to cut down or stop using the substance but being unsuccessful
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to function at work, home or school, because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational or recreational activities because of substance use
8. Using substances again and again, even when it puts the person in danger
9. Continuing to use, even with the knowledge of having a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the desired effect (tolerance)
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Clinicians are able to categorize an individual with a mild substance use disorder if they have two or three symptoms, a moderate substance disorder is categorized by four or five symptoms, and a severe substance abuse disorder occurs when six or more symptoms are observed.

Pharmacotherapy

There are a variety of pharmacological treatments for alcohol and drug addiction such as: Disulfiram and Naltrexone. Pharmacotherapy has also been used to help prevent relapse for individuals with substance abuse disorders. Disulfiram (Antabuse) has been a long standing medication prescribed to individuals who abuse alcohol to prevent relapse (Galanter, 1993). Disulfiram works by blocking the metabolism of alcohol which produces high levels of acetaldehyde (Galanter, 1993). As a result, individuals who drink alcohol while taking Disulfiram experience great discomfort and have adverse reactions such as: headache, dizziness, nausea, and vomiting (Galanter, 1993). Azrin, Sisson, Meyers, and Godley (1982) found that individuals who took Disulfiram on a daily basis had longer durations of abstinence, were more likely to be employed, and reported fewer absent from home days. Galanter (1993) identifies significant limitations to taking Disulfiram, including that it only works if the individual takes it on a daily basis. Galanter (1993) explained that individuals are more likely to take Disulfiram if they are reminded by a family member (spouse) or close friend which in turn lengthens the number of days sober. A study conducted by Azrin et al. (1982) supports this theory as the single participants in the Disulfiram assurance group had an average of eight days abstinent compared to the 30 days couples experienced.

Naltrexone is an opioid receptor antagonist used to reduce cravings associated with alcohol and for individuals who abuse opiates. Naltrexone works by blocking the pleasurable reactions when drugs like cocaine or heroin are used and it works for those who abuse alcohol by reducing cravings. A study conducted by Krupitsky et al. (2013) found that individuals who took extended release Naltrexone had significantly lower rates of craving compared to the placebo group. Cravings were reduced for individuals who abused alcohol, cocaine, and heroin. Accordingly, Naltrexone is a relapse prevention strategy that can help individuals maintain their abstinence for longer durations of time. It is important to note that Naltrexone does not help cessation of substances as it is only prescribed seven to 10 days after someone has stopped using/drinking.

Methadone is another medication used for pharmacological treatment in individuals with opiate dependence. Methadone works by blocking the effects of other opioid drugs because it binds to equivalent receptors, referred to as cross-tolerance (CAMH, 2009). Methadone is often dissolved into an orange flavoured drink for clients to take orally (CAMH, 2009). Farrell et al., (1994) found that individuals who were taking Methadone regularly in comparison to individuals in the controlled conditions illustrated decreases in opiate use, mortality rates and crime rates. Individuals taking Methadone regularly also had longer durations of abstinence from illegal
opiates, more positive family interactions, and were more often employed (Farrell et al., 1994). It should be noted that Methadone treatment alone can be an effective means of relapse prevention however, when paired with other relapse prevention strategies such as ongoing counselling or mutual help groups' abstinence rates are increased (Farrell et al., 1994).

**Mutual Help Groups**

The most common forms of treatment for substance use disorders are mutual support groups or 12-step programs (Bowen et al., 2009). McCrady, Epstein, and Kahler (2004) conducted a study using three different treatment groups: Alcohol Behavioural Couples Therapy (ABCT), ABCT with Alcoholics Anonymous, and ABCT with relapse prevention (RP). The relapse prevention component of treatment provided participants with cognitive and behavioural skills to use when they come into contact with high-risk situations. Alcoholics Anonymous (AA) was provided to the second treatment group. This treatment condition encouraged building a positive social network and continual treatment through booster sessions (McCrady et al., 2004). Results indicated that participants in the AA/ABCT and RP/ABCT groups remained abstinent for longer periods of time compared to the control group (ABCT)(McCrady et al., 2004). A study conducted by Tonigan and Rice (2010) also concluded that individuals who attended AA regularly had an increase duration of abstinence. Often individuals with addictions are referred to mutual help groups such as AA as an additional relapse prevention method. AA allows for individuals to admit powerlessness over their disease, alter their view of self and others, and build positive social circles (Morgenstern et al., (1997). Conversely, some of these change strategies are sections of behavioural treatments which help illustrate AA's effectiveness as a treatment and relapse prevention, according to Morgenstern et al. (1997). It is important to note that AA alone can be a successful relapse prevention strategy; however evidence shows that additional RP techniques can be used to help individuals remain abstinent. For example, having an AA sponsor can greatly increase abstinence rates (Tonigan & Rice, 2010). A sponsor can aid in an individuals' recovery process for several reasons. First, having a sponsor builds on an individual's support network and allows them to relate to someone going through the same substance abuse issues. Second, a sponsor helps assist and guide an individual to remain abstinent. Another variable in the effectiveness of AA is how often an individual attends meetings. For instance, people who attend meetings on a daily basis or an average of five times per week have higher rates of abstinence when compared to people who attend only one meeting per week (Morgenstern et al., 1997).

Another type of mutual help group is relapse prevention. As there is limited research on the effectiveness of relapse prevention groups it can only be speculated that it shows some positive results as it shares similar qualities with AA. Relapse prevention groups differ from AA in that it only focuses on sober talk. For instance, participants are asked to state what they are doing for today to stay sober (their daily routine) and how they are living in the solution not the problem. RP groups are similar to AA in the sense that people feel part of a community and can discuss ideas to maintain sobriety.

**Mindfulness Based Relapse Prevention**

Witkiewitz and Bowen (2010) describe mindfulness, when referenced to substance dependence, as a meditative skill that allows a person to focus on the cognitive, emotional, or physical states of craving in a non-judgemental manner. Mindfulness can be better described as the association between feelings of craving and analyzing such feelings in a neutral manner (not
good or bad but currently present) (Witkiewitz and Bowen, 2010). Current literature illustrates that groups who receive mindfulness based relapse prevention (MBRP) in comparison to groups receiving treatment as usual for substance use have lower rates of relapse (Bowen et al., 2009). MBRP uses mindfulness meditation to directly target cravings and negative moods associated with relapse (Witkiewitz & Bowen, 2010). Mindfulness meditation sessions last between 30-45 minutes or 10-20 minutes for beginners, during which participants focus on the presence of their drug cravings in a non-judgmental manner (Witkiewitz & Bowen, 2010). In addition, Witkiewitz and Bowen (2010) explain that participants also receive meditative homework in which they practice mindfulness meditation for 30 minutes on their own. With the collaboration of in class teachings and homework, participants are able to become more mindful and control their cravings, thus reducing relapse rates.

**Addiction Counselling**

Addiction counselling can be a fundamental aspect of the recovery process and prevention of relapse in individuals with substance abuse disorders. Najavits and Weiss (1994) found that 97-99% of addiction treatments offered some form of counselling or psychotherapy. Brownell et al. (1986) articulate that positive social supports often lead to increases in an individual's abstinence rates (i.e., individuals remain abstinent for longer periods of time and more frequently). As such, receiving services from an addiction counsellor on an ongoing basis, even after treatment or initial cessation, can improve maintenance and lengthen abstinence periods (Brownell et al., 1986). Addiction counselling can be conducted in an individualized or group manner. Individualized counselling helps the client establish various coping strategies along with other impaired aspects of functioning. The other areas of functioning include but are not limited to: family/social relations, illegal activity, employment status, and overall life management skills. Counsellors also encourage clients’ to attend mutual help groups such as AA or NA at least twice per week. Group counselling is often paired with individual counselling to enhance the therapeutic experience. By attending group counselling clients are able to take advantage of the social reinforcement offered by discussions with peers. According to Najavits and Weiss (1994) counselling aims to increase people's awareness on substance abuse, the risks involved, and how to manage their lives effectively. Incorporating effective counselling into treatment can improve relapse prevention if counselling is consistent (Brownell et al., 1986). Najavits and Weiss (1994) found that the effectiveness of counselling on addiction related disorders was related to a therapists skill rather than the method used (e.g., Dialectical Behaviour Therapy or Cognitive Behaviour Therapy).

One method of counselling for substance dependence is Cognitive Behaviour Therapy (CBT). CBT uses techniques that challenge the cognitions and behaviours associated with addiction (Wanigaratne, Davis, Pryce, & Brotchie, 2005). Skills included are challenging negative thinking, identifying triggers, increasing self-efficacy, and rehearsal (Wanigaratne et al., 2005). Relapse prevention is usually incorporated into the maintenance stage of counselling sessions. Relapse prevention focuses on teaching the client to cope adaptively with lapses, identify triggers, identify high-risk situations, and manage cravings (Wanigaratne et al., 2005). A study conducted by McLellan et al. (1993) found that counselling paired with Methadone had significantly greater decreases in opiate use compared to a Methadone only condition (as cited in Wanigaratne et al., 2005). Farrell et al., (1994) also demonstrated that when individuals received counselling paired with Methadone they had decreases in crime rates, mortalities, and substance use.
Focus of the Manual

Treatment for individuals who abuse substances is only a short-term solution to maintain sobriety. It is important to incorporate a variety of relapse prevention strategies for individuals so that RP can be tailored to individual needs. It is through the use of pharmacotherapy, mutual help groups, and MBRP that people with addictions can find RP solutions that will strengthen their ability to remain abstinent. By developing an RP manual, individuals will have access to such techniques which they can use outside of treatment, thereby empowering them.
Chapter III: Method

Participants
This manual is intended for individuals with substance abuse disorders who currently receive or have received detoxification treatment from Hotel Dieu. The RP manual outlines proactive strategies for dealing with alcoholism and drug addiction. The manual also highlights general information of RP and related definitions. The manual will be made available to adult clients, 16-years or older, at Hotel Dieu Detoxification Center. Individuals will have access to the manual throughout the day except during in house meetings that clients are required to attend.

Design
The format of the RP manual is a six-chapter manual that outlines best practices techniques for preventing relapse along with anecdotal evidence. The information provided in the manual is based on RP literature and empirical studies.

Chapter one provides readers with an overall description of RP including the Cognitive Behavioural model compared to the Disease model. In addition, chapter one provides insight about common causes of relapse and the definition of lapse and relapse. Also included is an outline of the process of getting an addictions counsellor, getting an assessment, and getting admitted into a treatment center.

The next four chapters explain the best practices used for RP and will be formatted as followed: Self Help Groups, Mindfulness Based Relapse Prevention, Pharmacotherapy, and Counselling. Each of the four chapters describes the technique in detail and provides the reader with an exercise or suggestive approach. An exercise example would be writing in a journal, meditation, or readings. The usefulness of including exercises along with literature in the RP manual is to help the reader not to just understand the material but to apply it as well. For example, an individual with a substance abuse disorder may understand the concept of MBRP but without implementing it (i.e., actually meditating), the technique will not be effective.

Chapter six describes anecdotal evidence/personal stories. The stories entail the daily routines of several recovering alcoholics and the different RP strategies they use (e.g., contacting a sponsor or hobbies). Although some strategies are not empirically supported, they have been effective in the lives of such individuals. The inclusion of anecdotal evidence is to help readers learn a variety of relapse prevention techniques and help readers relate.

Format
As previously stated the format of the RP manual is a six-chapter manual that explains RP from the Disease model perspective versus the Cognitive Behavioural model, as well as, best practices. The rationale for developing an RP manual is to provide individuals with substance abuse disorders a variety of RP techniques and to educate them about substance use disorders. The manual may also be effective for increasing the duration of abstinence for residents of the detoxification center because many will not receive follow-up treatment immediately after being discharged. The coping strategies and psychoeducation gained from reading the manual may also increase the chance of making a proactive decision when faced with a high-risk situation.

Evaluation Measure
The RP manual will be evaluated using a questionnaire that readers can fill out at the end of the manual. The questionnaire will be available at the end of the manual and will require the reader to complete questions rated on a 5-point Likert scale (1-strongly disagree and 5-strongly agree).
agree). There will be two comment questions to provide a greater critique. The feedback provided will help the author update the manual to make it more effective and user friendly. It will also establish which RP strategies and exercises users find most effective and which ones can be improved.
Chapter IV: Results

The relapse prevention manual (Appendix A) provides an outline of varying relapse prevention strategies as well as local resources for readers to access. A few techniques mentioned in the manual are: MBRP, Pharmacotherapy, Counselling, and Mutual help groups. In addition to the techniques described chapter 6 lists exercises for the reader to do which promote abstinence. Some feedback received by the author was to include more information on community supports that the readers could access. Chapter 6 of the manual also required more information and guidance on the meditative process as readers were not able to follow along. Other recommendations included providing more information on addiction counselling and on the treatment process. The compilation of the manual was designed to educate individuals with substance abuse disorders about relapse prevention and to help establish adaptive coping strategies and supports.
Chapter V: Discussion

Summary
The rate of relapse for individuals with substance abuse disorders is upwards of 60% as asserted by Bowen et al. (2009). Although addiction treatment centres focus on the initial cessation of substance use and incorporate maintenance strategies, the rate of relapse is still high. Therefore, more emphasis on the maintenance procedures could be more beneficial for the substance dependence population.

As a result, the relapse prevention manual was designed to educate individuals with substance disorders to hopefully increase the rate of abstinence. The relapse prevention manual is a six chapter manual that discusses the Disease model and the Cognitive Behavioural model of substance abuse along with best practices. The best practices included in the manual are: MBRP, pharmacotherapy, counselling, and mutual help groups. Each best practice was then divided into its own chapter. Each chapter provides a brief overview of a best practice and then goes into more specific details on how the method can be applied. By incorporating multiple relapse prevention strategies, the reader can build their own relapse prevention plan and choose the methods that are most suitable for them. The last chapter provides the reader with different exercises that promote relapse prevention by identifying high-risk situations, building coping strategies, and increases motivation.

Strengths
The development of a relapse prevention manual for individuals with substance abuse disorders has several strengths. First, outlining four different relapse prevention strategies allows the reader to build a broader understanding of relapse prevention. It also provides the ability to develop an individualized recovery plan. Second, the manual includes various exercises that may help the reader, including identifying triggers, identifying high-risk situations, and developing adaptive coping strategies. Third, the manual offers additional resources for the reader to utilize such as: help lines, addiction agencies, and treatment centres.

Limitations
There are a few limitations that can be identified in the development of the manual. First, the manual may become outdated easily because the organizations included could change their contact information. Second, readers of the manual might not understand a concept or an exercise and might not be able to ask for more information to understand the concept. Third, some readers of the manual may be from a different area and therefore the community resources in Kingston would not be available to them. Lastly, the manual was not evaluated by individuals with substance dependence. Therefore, some of the techniques included may not be explained well enough for readers to fully comprehend.

Multilevel Challenges
There are a few challenges with the development of a relapse prevention manual on the client level. For instance, if an individual is unable to read or write they would have difficulty understanding the manuals content and would not be able to engage in the exercises. Some of the best practices might not be applicable for all individuals such as pharmacotherapy. Pharmacotherapy could be difficult for some individuals because they might not have the funds needed to afford the medications involved and to ability to take the medication on a regular
basis. Another challenge to note is that the reader must be willing to read the manual as it is not a requirement.

On the program level the manual might not provide enough information for the reader to gain full understanding of the relapse prevention technique described. Also, some individuals may miss the opportunity to read the manual if it is a structured day in which they have limited spare time. If only one manual is provided, then only one resident would be able to read the manual at a given time.

A few challenges to note on the organizational level would be that if the manual is not accepted by staff, it would likely not be encouraged and given to residents to read. If anything happened to the manual itself (i.e. it got damaged or stolen) it would be up to the organization to reprint the manual and provide it to residents which adds additional work. The organization might also have to monitor the whereabouts of the manual and who they would allow to access it if it went missing. If a resident wanted a copy of the manual or specific pages they would have to ask staff for assistance, which could increase their workload.

At the societal level some of the resources included in the manual such as hot lines and treatment centres may not help or be able to help the individual who is seeking support or help. The pharmacological aspect of relapse prevention might be difficult for some clients to receive because they have abused the system in the past, they do not have a doctor, or their doctor assesses them not suitable for that specific pharmacotherapy. Finding an addictions counsellor might also be difficult for some residents because there is an insufficiency in some areas and some require an address in order to be eligible for service.

Implications for the Behavioural Psychology Field

The development of a relapse prevention manual to educate individuals with substance abuse disorders represents a minor contribution to the field of psychology. Each of the relapse prevention strategies included have been empirically validated in the reduction of the rates of relapse in individuals with substance use disorders. Each of these techniques provides an example of adaptive coping, the mastery of which may be a considerable area of growth for the reader of the manual. However, most of the current literature only examines one or two techniques together whereas the manual gives insight into various techniques so that the reader can make informed decisions on their recovery process. The importance of the manual is that it draws on multi facets of relapse prevention and combines the strategies in one place for the reader to get an overview of relapse prevention. The manual also provides the reader with community resources and activities that further promote abstinent behaviours.

Recommendations for Future Research

For future research the manual could include more information on pharmacological treatments, more mindfulness exercises, and be empirically evaluated. The results of the evaluation may better inform what information should be described in more detail, what exercises the reader found most helpful, and which of the best practices worked most effectively. In addition, the manuals effectiveness could be compared to different classes of substances (i.e., is it more effective for individuals with alcohol dependence versus opioid dependence). The effectiveness of the manual could also be compared across gender and age.
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Relapse Prevention: Educating Individuals with Substance Abuse Disorders

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(2015)
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Introduction

This manual is intended to educate individuals with substance abuse disorders on different relapse prevention strategies. It focuses on several aspects of addiction and varying strategies to maintain abstinence. Strategies highlighted in the manual will be: mutual-help groups, pharmacotherapy, mindfulness based relapse prevention, and counselling. This manual provides a brief description of each relapse prevention strategy and incorporates several exercises to support learning.

Incorporating a range of relapse prevention strategies allow individuals to draw from different techniques when beginning their recovery process. Addiction is considered by some to be a lifelong struggle and therefore more than the initial stoppage of abusing substances is important.

Reading this manual may help build a better understanding of addiction and relapse prevention strategies. It is intended for you to gain insight into your own addiction as well as to develop effective coping strategies to manage your addiction.

You may not find every chapter applicable or useful as it is okay to skip chapters and move onto sections that capture your interest. Remember that the exercises provided are there to help you; you don't have to do all of them just pick a few that you are interested in. Try modifying the exercises to better suit your needs as they don’t have to be done exactly as the manual describes. If you feel comfortable try talking to peers who have also read the manual as they may have different ways of doing the exercises.
Chapter I: Relapse Prevention Overview

Relapse prevention is an approach used to increase the healthy coping strategies used by individuals with substance dependence. Relapse prevention also gives individuals the ability to recognize early warning signs of relapse while in recovery. The goal of relapse prevention is to help individuals maintain their abstinence and stay sober for longer periods of time.

There are a variety of models that help explain addiction; however this manual will only focus on the Disease model and the Cognitive Behavioural model. The new *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) identifies individuals with substance abuse disorders on a spectrum of mild, moderate, and severe. An individual is identified as having a mild substance use disorder if they have two or three symptoms, a moderate substance disorder is four or five symptoms, and a severe substance abuse disorder is six or more symptoms based on a list of 11-12 criterions. Some criteria for substance use disorder include: experiencing cravings, experiencing tolerance (requiring more and more of a substance to become high), using larger amounts than intended for a long period of time, inability to cut down or control use, or experiencing withdrawals (American Psychiatric Association, 2013).

**Disease model**

The Disease model of addiction considers addiction to be a brain disease in which any use of substances causes an individual to become addicted and once exposure has occurred addiction is irreversible. Therefore, a substance use disorder is considered to be a lifelong disease. According to the Disease model, when an individual uses a drink or a drug after a period of abstinence it is considered a relapse. The only way to manage the disease is total abstinence. Once the disease regresses, it remains hidden but symptoms can always return throughout one's life. Alcoholics Anonymous uses the disease model to define addiction and acknowledges that the only way to prevent relapse is complete abstinence. This means that an addicted person cannot use a drink or a drug, even in moderation, without relapsing. The Disease model also outlines four assumptions of substance dependence. These are as followed: (1) you either have an addiction or you do not; (2) addiction is caused by genetic factors and physical abnormalities; (3) you are unable to control substance use; and (4) addiction is not reversible, meaning it can only be stopped, not cured.

**Cognitive -Behavioural Model**

The Cognitive Behavioural (CB) model of addiction describes addiction as a result of maladaptive thought processes and learned behaviours. In other words the CB model states that addiction is a result of poor coping skills and negative thought processes. The CB model of addiction defines relapse differently than the disease model. For instance the CB model focuses on a harm reduction approach to addiction. A harm reduction approach is characterized by using substances as safely as possible and any decrease in substance use is viewed as a positive outcome. The CB model also breaks down the use of substances after a period of abstinence as a lapse which can turn into a relapse. This is different than the disease model because the disease model describes any substance use after a period of abstinence as a relapse. A lapse is defined as a single event or a slip back to previous habits. A lapse may or may not lead to a relapse, it depends if corrective action is taken. A corrective action would be stopping substance use immediately after the lapse. A relapse is defined as falling back to pre-treatment levels of use after a lapse has occurred.
CB model also identifies six stages of change to explain the recovery process. The six stages help explain the recovery process that every individual with substance dependence must go through. The stages are as followed: pre-contemplation, contemplation, preparation, action, maintenance, and relapse.

**Stages of Change**

1. **Pre-contemplation**: Not yet acknowledging there is a problem
2. **Contemplation**: Acknowledging there is a problem but unsure how to handle it
3. **Preparation**: Getting prepared to change
4. **Action**: Actively involved in changing problem behaviour
5. **Maintenance**: Maintaining changed behaviour (relapse prevention)
6. **Relapse**: Returning to pre-treatment levels of use

It is important to note that the relapse stage can happen during any of the other five stages; it can and often does happen more than once on the path to recovery. Relapsing can be very disappointing but is also a normal part of the recovery process. Relapsing is a learning opportunity and a chance to become stronger and to better understand why you have chosen to use substances at different times in your life. Analyzing the relapse and coping differently in the future will help an individual through the stages of change.

The CB model also explains self-efficacy as an important role in the stages of change process. Self-efficacy refers to an individual's confidence in one's self. When an individual has a lapse their self-efficacy decreases which often leads to a relapse. However, when an individual has effective coping responses and avoids a relapse their self-efficacy increases. Having high-self efficacy is only a small step in working through the stages of change.
Chapter II: Mutual Help Groups

What are mutual help groups?

Mutual help groups are nonprofessional meetings hosted by members of the community who share the same problem as you. These groups do not provide treatment but provide social and emotional support as well as information about the recovery process. The most common and widely available group is Alcoholics Anonymous, also known as AA. There are several other mutual help groups for individuals with substance abuse disorders such as: Narcotics Anonymous (NA) and Relapse Prevention. Each of the groups will be described in detail below. Note, not everyone will find each group helpful, you have to find the one that works for you.

What is AA/NA?

AA is a 12-step recovery program focused on sobriety and as long as you have a desire to stop drinking, you are invited to attend. During meetings you can choose to listen or speak when it's your turn. During meetings, members share personal experiences related to their alcoholism along with how they are dealing with their disease. Also members discuss the book of AA, referred to by many as the Big Book in which members seek advice and consultation. AA helps individuals build a sense of community because it brings together a group of people battling the same disease. Also, belonging to a community or social network that is abstinence based can build on ones support network. There are a lot of other things that can be learned from AA such as: understanding that recovery is possible, understanding other people's recovery methods, and understanding a range of consequences as a result of drinking. Lastly, AA can often be a safe place to go if nothing else.

AA members work through the following 12-steps:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to other alcoholics, and to practice these principles in all our affairs.

NA follows the same guidelines as AA and uses the same 12-steps. The only difference is that the discussion at NA meetings are more drug focused. It is important to note that individuals with alcohol dependence are more than welcome to attend NA meetings as the focus of AA/NA is on sobriety.
In both AA and NA there is a possibility of getting a sponsor. A sponsor is an individual who has been working the program for a period of time and has reached a stage where he/she wants to give back by helping new members stay on track. Each sponsor is different but has the same goal in mind, abstinence. A sponsor becomes a positive support that can be contacted for advice and guidance. A sponsor is a person you can talk to about your addiction and who may help you to develop coping strategies. A sponsor helps motivate you to attend meetings and remain abstinent by typically asking new members to contact them if they feel the urge to drink or use drugs.

For more information on Alcoholics Anonymous visit [www.aa.org](http://www.aa.org) or Narcotics Anonymous visit [www.na.org](http://www.na.org). Here you can find more information about AA/NA, meeting lists, and links to local offices.

**Relapse Prevention**

Relapse Prevention group (RPG) is a good beginner group to attend as the focus is on preventing relapse through the techniques used by members. Attending RPG groups can be very beneficial. The way RPG works is: members take turns discussing their daily schedule and the daily plans/actions in which they engage in, in order to prevent relapse. Making RPG work for you is about taking little pieces of everyone's daily routine and creating one for yourself. RPG groups can be facilitated by a professional or a member of the community.

**Finding the right group**

Each mutual help group will differ slightly on how it works but the basis remains the same; abstinence. Each group has a different mix of people with unique personalities so it is important to find a group that you feel comfortable in. One suggested way to find the right group is to first attend a meeting. At most meetings you can pick-up a free booklet that lists all of the AA or NA meetings in the area; pick up a meeting list as you may find it very useful. After the meeting, you might consider asking individuals that you felt comfortable with what meetings they like to attend (it is a common question and members won't take offence to it). Now try attending one of the meetings suggested and repeat the process until you find a meeting that suits your needs.

The number of AA/NA sessions that run daily depend on the city you are located in. There are also fewer NA meetings per week than AA meetings. Kingston AA meetings are run daily often with a morning meeting and several evening meetings. Meetings usually last around an hour but can sometimes be two. However, it is not unusual to leave a meeting early if needed, there is no excuse necessary.

AA/NA meeting lists also categorize meetings as being open or closed. An open meeting is for anyone interested in AA/NA including professionals, students, and non-members interested in learning more about the recovery process. A closed meeting is limited to members and potential future members. Opened and closed meetings focus on the same message, recovery, the only difference is the audience or participants who can attend.
Chapter III: Mindfulness Based Relapse Prevention

Mindfulness Based Relapse Prevention

Mindfulness based relapse prevention (MBRP) is a meditative technique aimed at focusing the mind on the present moment in a non judgmental manner. In other words you concentrate and are aware of your current thoughts, feelings, and sensations. You examine your thoughts and feelings as being present but you don’t give them a label of being good or bad. The main goal of MBRP is to develop awareness of personal triggers and create a pause between your current thoughts (cravings) and the action of using. Meditation sessions usually last 30-45 minutes, however 10-20 minutes can be beneficial as well. MBRP can help build an awareness of triggers and more importantly disrupt previous automatic behaviours. Mindfulness supports the acceptance of present/past experiences whereas substance use avoids it.

Here is an example of when MBRP can be useful: you're planning on attending a family event or wedding that is coming up. You know there is going to be alcohol present and almost everyone there will be drinking. As a result, a range of thoughts have crossed your mind. For instance, if you attend the event you might feel obligated to have a drink or that it will lead to a relapse. You also know you cannot just stop at one drink so you know you are going to make a fool of yourself and upset your family because they have already given you plenty of chances. So attending the event will result in a relapse and damaged relationships. This is when MBRP is effective, by pausing and acknowledging that relapsing at this event is just a story the mind started telling; you can realize it is just that: a story. Having this pause and observing your thoughts can create an understanding that the story your mind created does not have to occur, you have the choice to not drink. Therefore, you can attend the event without the fear of relapsing.

Mindfulness Meditation Exercise
Step 1: Find a comfortable place to meditate. Try a location with little to no background noise and as few distractions as possible.
Step 2: Posture: Sit in a chair or cross legged on the floor or you can lie down on your bed.

- Hands should be rested on your thighs, knees, or folded on your lap
- Chest should be upright and open
- Head should be tilted upwards slightly to open airways
- Have your eyes closed or focus on a spot in front of you
- Feel free to loosen tight or restricting clothing (take off your belt or shoes)

Step 3: Begin your meditation by focusing on your breathing. Take a deep breath in through your nose, hold it for a few seconds, and then slowly release it through your mouth (focus on your breathing for about a minute).

Step 4: Next, think about feelings of discomfort, cravings, or any thoughts to do with addiction. Focus on each thought individually as being present but do not give those thoughts labels of being good or bad.

In the example above one might start their meditation with thoughts about the upcoming wedding that will have alcohol available. Try to focus on the wedding and imagine yourself being there. While imaging being there one might think about the alcohol that is present. Just remember alcohol being present at the wedding is not good or bad it is just a thought that you
should recognize and be aware of. Thinking about the alcohol or even thinking about "what if I drink it" is just different thoughts.

This activity is just a basic guideline for MBRP. Use this exercise daily and try to reach 30-45 minute sessions. Remember, pay attention in the present moment in a nonjudgmental manner and if your attention wanders try to bring it back. Focus on anything to do with your addiction as it can be beneficial and all of this is a learning experience.
Chapter IV: Pharmacotherapy

What is Pharmacotherapy?
Pharmacotherapy is the use of legally prescribed medications, by a doctor, such as Suboxone, Methadone, Naltrexone, or Disulfiram (Antabuse) which is substituted for a person's drug of choice. One advantage of using pharmacotherapy is that it can help stabilize one's condition and allow for more time for an individual to manage their life and rebuild relationships. Once stabilized, clients tend to taper off of their dosage and strive for a drug-free lifestyle. However, pharmacotherapy can have several disadvantages such as: becoming dependent on the drug, withdrawal effects for missed doses, and finally pharmacotherapy will not work if a client is not taking it regularly and as prescribed. 

Always consult your doctor before taking any of the medications described as each drug has varying side effects, may interact with other medications being taken, and can have other health concerns. It is important to note that Pharmacotherapy is not for everyone and other treatments/relapse prevention strategies may be more effective. Listed below are four medications prescribed for pharmacological treatments.

Naltrexone
Naltrexone comes in a tablet form or a monthly injection. Naltrexone is used to reduce cravings associated with alcohol and for individuals who abuse opiates. Naltrexone works by blocking the pleasurable reactions when drugs like cocaine or heroin are used and reduces cravings for those who abuse alcohol. This means, if you are taking Naltrexone on a regular basis and decide to use heroin you will not feel any of the pleasurable effects because the Naltrexone has already bonded with your body's opioid receptors (i.e., the Naltrexone fills up your receptors and the heroin cannot attach itself because there is no space left to bind). Naltrexone is taken daily by individuals who want total abstinence or on pre-determined drinking days for individuals attempting moderation.

Suboxone
Suboxone is a combination pill of Naloxone and Buprenorphine which is dissolved under the tongue. Suboxone is used to prevent Withdrawal symptoms (listed below) from occurring when an individual stops taking opioid drugs. The buprenorphine is responsible for binding to your opioid receptors, causing no withdrawal symptoms and negating the effects of using other opioid drugs. This means instead of going into withdrawal after a period of time without ingesting opioids the Suboxone acts as a replacement but without the pleasurable effects (high). The reason for combining the two drugs is to prevent users from injecting the tablets as the naloxone if it enters the bloodstream will cause powerful withdrawal symptoms such as: vomiting, nausea, diarrhea, and muscle cramps. However, when taking naloxone orally there are no withdrawal symptoms.

Methadone
Methadone reduces withdrawal symptoms in people addicted to other opioid drugs such as morphine or heroin. Methadone will help control drug cravings and block the pleasurable effects (high) of other drugs. Methadone comes in a pill form but is generally dissolved into water or orange juice for clients to drink. Methadone is only available at specific pharmacies and individuals have to be supervised taking their dose for the first two months. Methadone can be used for short term detoxification or maintenance treatment. Starting doses of Methadone vary between 20-40mg/day and then are increased gradually until a maintenance level is reached.
(between 60-120mg/day-varies per person). For short term detoxification individuals receive a total daily dose of 40mg and then are gradually decreased after a few days.

For more information about methadone consult your doctor or try these resources below:
Centre for Addiction and Mental Health: 1-800-463-6273
Street Health Centre (Kingston): 613-549-1440

**Disulfiram (Antabuse)**

Disulfiram is given to individuals who abuse alcohol to prevent relapse. It works by blocking the metabolism of alcohol which produces high levels of acetaldehyde. A high level of acetaldehyde in the body causes great discomfort, dizziness, headaches, nausea, and vomiting. Disulfiram comes in a tablet form and is taken once a day. Disulfiram is not a cure for alcoholism but can act as a deterrent for drinking. Accordingly, a disadvantage to using Disulfiram is that it is only effective if taken as prescribed. If an individual misses several doses they may be able to ingest alcohol without the negative effects. An individual has to be motivated to take Disulfiram regularly or should have a daily reminder (e.g., friend or spouse). It is important to avoid any foods, beverages, and oral hygiene products containing alcohol when prescribed Disulfiram.
Chapter V: Counselling and Treatment

Counselling

Addiction counsellors attempt to explore a variety of problem situations by using a supportive therapeutic relationship. This means the counsellor works alongside the client by understanding that everyone is a unique individual with different circumstances surrounding their addiction. The goal of therapy is to help the client understand the importance of making decisions for themselves and to take responsibility for his or her actions. The counsellor will use a variety of skills to build a positive rapport with the client. The counsellor's role is not to "fix" the client's addiction but to help in the recovery process by providing support and encouraging self direction. The counsellor uses a variety of techniques to encourage increased self-efficacy as well as building positive coping strategies.

Treatment process

There are a variety of treatment centers across Ontario, each with slightly different services. Each treatment center has a different length of stay with short term programs lasting 21 days and long term programs lasting upwards of 6-12-months. Most treatment centers require a referral process from an addiction counsellor before being eligible for acceptance. There are government funded treatment centers that individuals can attend after getting connected with an addictions counsellor and completing an Admission and Discharge Criteria Assessment Tool (ADAT). The ADAT is conducted with a trained counsellor and based on the results the counsellor in collaboration with the client chooses appropriate treatment options. If a treatment program is required the counsellor then sends the assessment to that specific government funded treatment center. Government funded treatment centers run at no cost to the client; however, there is often a waiting period of 1-2-months before space becomes available.

There are also private residential treatment programs that do not typically require a referral however clients have to pay out of pocket for their services.

Additional Resources

<table>
<thead>
<tr>
<th>Name of Agency</th>
<th>Number</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Alcohol Helpline</td>
<td>1-800-565-8603</td>
<td>Helpline is for individuals to receive basic information about treatment centers, community supports, and drug/alcohol problems</td>
</tr>
<tr>
<td>Drug Rehab Ontario</td>
<td>1-800-419-7941</td>
<td>Service provides callers with advice on which centers are most applicable in their area</td>
</tr>
<tr>
<td>Frontenac Community Mental Health Services</td>
<td>1-866-616-6005 or 613-544-1356</td>
<td>FCMH provides services such as: addiction counselling, community support, housing support, court support, and crisis services.</td>
</tr>
<tr>
<td>Harbour Light</td>
<td>613-546-2333</td>
<td>90 Day residential program for adult males. The program is abstinence based, has a 12-step treatment philosophy, and is Christian influenced.</td>
</tr>
<tr>
<td>Kairos</td>
<td>613-548-4535 ext 223</td>
<td>Counseling services for young people (ages 12-26) with substance abuse problems.</td>
</tr>
<tr>
<td>Brock Cottage</td>
<td>613-342-6415</td>
<td>3-7 month program for adult males. The program uses a bio-psycho-social model.</td>
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</tbody>
</table>
Chapter VI: Exercises

Positive self talk

Positive self talk is a technique that alters the way an individual views a situation or alters their perspective. For example, if you are currently unemployed and think to yourself "I will never be able to get a job because I'm not good at anything." This is a situation when you may use positive self talk, which can shift your thinking to be more positive such as "I will get a job eventually because I have a lot of great skills." Positive self talk is useful for changing negative thoughts into positive ones. Having positive thinking can be more encouraging and can lead to increases in motivation, confidence, happiness, and self-esteem. An example is given below, try writing this exercise out and coming up with a view examples of your own (AnxietyBC, 2014).

<table>
<thead>
<tr>
<th>Negative Self Talk</th>
<th>Positive Self Talk</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've messed everything up</td>
<td>Things can get better as I am in a safe place</td>
</tr>
<tr>
<td>I'm such an idiot for drinking last night</td>
<td>I made a mistake and things can get better</td>
</tr>
<tr>
<td></td>
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When you find yourself struggling with negative thoughts or bad self talk, try to replace that bad self talk with positive thinking or good self talk. Write down your positive thoughts on paper and keep repeating the good self talk out loud or internally. Consider using this technique whenever you have negative self talk.

Building inconsistency

Make a list of things that would probably occur if you continued using versus if you stopped using. This list can be as short as you want or as long as you want. Highlight the reasons that influence you the most.

<table>
<thead>
<tr>
<th>If I continue using</th>
<th>If I stop using</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will get liver damage</td>
<td>I can spend more time with my kids</td>
</tr>
<tr>
<td>I will lose my family</td>
<td>I will have more money for other activities</td>
</tr>
<tr>
<td>I won't be able to go to school</td>
<td>I could work hard and get promoted</td>
</tr>
<tr>
<td>I will lose my job</td>
<td>I will be healthier</td>
</tr>
</tbody>
</table>

Have a Go to Card

There is a wide range of Go to Cards that could be useful in different situations; the main one is a relapse prevention card. The Go to Card is the size of a business card and is kept in your
wallet. When a situation arises that is too difficult to deal with and you think you may relapse, pull out the card and use it accordingly.

What to include on your card

1. Phone numbers of people you can count on for support and guidance. These numbers could include family members, friends, a sponsor, counsellor, spouse, crisis line, or the detoxification center. The more phone numbers on your card the greater the chance a support will be available when you need it most.

2. Behaviours that you can engage in instead of picking up a drink or a drug. These would be behaviours that you find helpful such as: removing yourself from the high-risk situation, breathing exercises, reading a meaningful book or passage, praying, positive self talk, exercising, or any behaviour that engages your attention elsewhere and you find calming/relaxing.

3. Reasons not to pick up a drink or a drug. These would be personal reasons that would deter you from using/drinking. This would include things such as: health reasons (possible liver damage, brain damage, contracting HIV/AIDS or hepatitis), a child, a spouse, and family, being pregnant, or losing a job. Any reason that makes you re-think guess relapsing would be beneficial to add.

Have a daily plan

A daily plan can help an individual maintain their sobriety and avoid high risk situations. A plan would also help with HALT (hungry, angry, lonely, and tired) an acronym often used by individuals with substance abuse disorders who find they often relapse in a state of HALT. A daily plan is unique and different for each person and it is a daily schedule or guideline of activities/events a person would engage in over the course of a day to prevent relapse. A plan could be established the night before or the morning of, depending on what a person finds more useful. There are a variety of things to include in a plan from basic hygienic needs, to working, to attending mutual help groups. An example of a plan is included below

Plan:

1. Wakeup at 8:00am
2. Shower
3. Brush teeth
4. Eat breakfast
5. Attend MHG meeting (AA/NA)
6. Eat lunch
7. Go Grocery shopping
8. Meet a friend for coffee
9. Read a book or watch TV.
10. Eat dinner
11. Attend another meeting (AA/NA)
12. Call sponsor
13. Get ready for bed
14. Sleep

Make a list of your high-risk situations

Make a list of 5-10 situations in which you are most likely to relapse. The three most common high risk situations include negative emotional states (depressed, angry, lonely), social pressure, and interpersonal conflict which are brought on by varying situations. A situation can be: fighting with your spouse, boredom, feeling lonely or depressed, going to a restaurant that serves alcohol, or anywhere you are more likely to relapse. Now for each situation that you listed
write down a healthy coping strategy that you could use in that situation instead of drinking or using a drug.
Example: If I go over to Jimmy's place I will most likely relapse because of social pressures. This is a high-risk situation because I know that Jimmy will offer me drugs which I have a hard time saying "no" to. Even if Jimmy does not offer me drugs, drugs will be present. One positive coping strategy would be to avoid going over to Jimmy's place at all and instead meet somewhere for coffee or food.

**Changing social circles**

Changing your social circle to consist of individuals who are either in recovery or do not abuse substances can increase your chances of maintaining abstinence. A few ways to do this is by removing individuals from social media and cell phone contacts who fuel your addiction. This idea is used for individuals who are new to the recovery process and have difficulty staying on track and with social pressures.
References


