Relapse Prevention: Implications for Health Promotion Professionals

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Abstract:

Health promotion and education efforts often are designed to promote behavior changes among clients, students, or participants. The primary emphasis of health promotion has been the initial behavior change process, with little attention directed to follow-up or aftercare. The relapse prevention model (RP) presents a strategy to enhance the likelihood of maintaining a behavior change using methods clearly rooted in social learning theory. This article provides an overview of the RP model and examples of the implication of RP for health promotion and education programs.

Health education has been defined as any combination of learning experiences designed to facilitate voluntary adaptations of behavior.[1] Thus, the primary emphasis has been on prevention or early intervention to help people to maintain healthy lifestyles or to change behaviors to reduce risk prior to a diseased state. Theoretical underpinnings of health education have focused on how learning takes place and how learning leads to influencing behavior.[2] Health education efforts have not been directly involved in the treatment or the rehabilitation of individuals with regard to maladaptive behavior, however, the two fields draw from the same theories to explain, prevent, and/or remediate behaviors related to health.

This article addresses the relapse prevention model (RP), including the basic tenets of the model, as it relates to treatment of maladaptive behaviors. Finally, additional skills proposed by the RP model that may be utilized in health education programs are suggested.

Treatment of Maladaptive Behaviors

Clinicians, practitioners, and theorists who study addiction long have wrestled with how to treat individuals addicted to substances such as alcohol, drugs, food, and to other maladaptive behaviors such as gambling. Historically, two explanations of addictive behaviors have attained popularity. The moral model perceives the addicted individual as lacking willpower or moral fiber. In this model the individual is responsible for both his or her addiction and its solution or treatment. The *disease* or *medical model* attributes addiction to the substance and its pharmacological effects. The individual is not responsible for the disease, and the treatment is based largely on the notion that the individual must give control to a higher power or to an organization of recovering individuals.[3]

An alternative model of addiction based on social learning theory and cognitive-behavioral psychology has been proposed. As outlined in Marlatt, addictive behaviors represent over-learned bad habits. The *relapse prevention model*, therefore, involves the study of the determinants and consequences of addictive habits. It applies to consumptive habits and nonconsumptive habits such as compulsive gambling and maladaptive work habits. Treatment within the parameters of the model requires individuals to actively participate and assume responsibility for their recovery. Through the development of new skills and cognitive strategies, individuals transform maladaptive habits into adaptive behaviors, controlled by positive mental processes and responsive decision-making. Thus, individuals become "change agents," and the model can be classified as one of self-control by empowering individuals to become involved in their recovery and to view recovery as a learning task.[4] To clarify the RP model, social learning theory and cognitive behavioral psychology will be outlined.

Social Learning Theory and Cognitive Behavioral Psychology

Social learning theory incorporates behavioral, social, cognitive, and affective factors and provides a framework for the self-regulation of behavior, a common goal of health education, as well as behavior change treatment modalities, and relapse prevention.[5,6] Bandura stated that social learning theory relies on four processes of learning a behavior: attention, retention, motor reproduction, and motivation. Simply, attention is the observation of the behavior, enhanced by the attractiveness of the model and the needs of the learner. Retention is the ability to retain or remember the behavior. Motor reproduction refers to the learner's ability to reproduce the behavior, and motivation refers to reinforcement as both a determinant and a reinforcer of behavior (reciprocal determinism). In addition to the reinforcement of behavior by the environment, social learning theory proposes that reinforcement can also be accomplished through self- and vicarious reinforcement. Self-reinforcement is a reward given by individuals to themselves. Vicarious reinforcement is the satisfaction of seeing others rewarded for the behavior. Another construct of social learning theory is the notion of self-efficacy. Self-efficacy refers to an individual's expectation of his or her ability to cope successfully with a situation. Closely related to self-efficacy is the notion of behavioral capability, or the individual's opinion of his or her ability to perform a given behavior. In summary, social learning theory proposes that behavior will be learned if it is attended to through observation, retained, and is able to be reproduced by the learner. Learning is further reinforced if the individual believes he or she can cope successfully with the situation, has the skill necessary to perform the behavior, and expects positive outcomes as a result of engaging in the behavior.[6]

Cognitive behavioral theory involves the concepts of thoughts, attitudes, beliefs, attributions, and expectations. The term itself refers to interventions based on the principles and techniques of behavioral therapies used to change an individual's cognitions. A central precept of the theory is that the way individuals view or interpret events influences their behavior.[7] According to Meichenbaum, cognitions are "self-talk," however, whether or not individuals engage in self-talk or are aware of their self-talk is less critical than their willingness to view their behavior as being affected and modifiable by self-statements.[8]

Several cognitive behavioral therapies have been developed to enable individuals to restructure maladaptive cognition. Thought-stopping is used to eliminate unwanted, obsessive thoughts.[9] Rational-emotive therapy is used to ameliorate emotional disorders or negative emotions such as anxiety, depression, anger, and guilt that are caused by faulty or irrational thoughts.[10] Closely related to rational-emotive therapy is cognitive therapy; however, while rational-emotive therapy relies on a common set of irrational beliefs held by all clients, cognitive therapy assumes each client has idiosyncratic thoughts that are distorted interpretations of events. Aimed at restructuring an individual's negative cognitions, the therapy has been used in treating depression, phobias, obsessions, and psychosomatic behavior." Other strategies (eg, relaxation training and self-monitoring) utilized in the management of maladaptive cognitions lie within the parameters of behavioral psychology. [12,13] The relapse prevention model uses the concepts of these two theories of learning and behavior change to explain and study the problem of relapse.

Relapse Prevention

Marlatt and George describe RP as a psycho-educational program that includes behavioral skill training and cognitive techniques to teach individuals how to anticipate and cope with the problem of relapse.[14] Relapse prevention may be used as a specific maintenance program to prevent relapse of a specific maladaptive behavior or as a procedure to elicit and maintain a general lifestyle change. Relapse prevention strategies might equip the individual with behavioral self-management skills necessary to anticipate and cope with problems during post-treatment of maladaptive or addictive behaviors.

Relapse prevention is distinct from treatment; relapse prevention is a systematic means of maintaining the positive outcomes of treatment. Marlatt and George cite areas of distinction. One difference is that treatment is a process administered by a therapist or individual to a client, while maintenance procedures are often self-administered by the clients themselves. The goal of maintenance, therefore, is to teach clients to become their own therapists during post treatment. Instead of relying on willpower to maintain the behavior change, clients are instructed to rely on behavioral self-management skills. Maintenance or relapse prevention is promoted as an adjunct to treatment, to be used in conjunction with a multitude of methods for initial behavioral cessation.[14]

Additionally, according to RP theory, a ne_w definition of relapse needs to be advanced. The traditional definition of relapse is the return to a diseased state, with the cause of relapse usually attributed to internal biological factors associated with a particular disease. This definition gives little or no attention to situational or psychological factors as potential determinants of relapse. Marlatt and George propose that a second definition of relapse be utilized; that of a single act of falling back, a single mistake or error.[14] An overview of the relapse model explains the efficacy of adopting the second definition.

The model begins with the assumption that when an individual maintains abstinence or other established rules with regard to the target behavior (eg, staying on one's diet), a sense of perceived control is enjoyed. The sense of control is maintained until a high-risk situation occurs.[14] A research study (N = 311) designed to describe a high-risk situation reported negative, emotional states such as frustration, anger, anxiety, and depression accounted for 35% of all relapses: Interpersonal conflict defined as conflict in marriages, friendships, family, or work relationships accounted for 16%, and social pressure defined as response to the influence of a person or group of people accounted for 20%.[15] When examining different addictive behaviors, more similarities than differences were noted in the makeup 01 high-risk situations. The same high-risk situations were noted among problem drinkers, smokers, gamblers, heroin users and overeaters.[14,15]

Thus according to the RP model, the first step toward relapse is the encounter with a high-risk situation. The encounter itself is not enough to precipitate relapse; other factors are involved such as the lack of ability to utilize a coping response for the high-risk situation. Thus, the individual engages in the forbidden behavior. According to Bandura, the self-efficacy of the individual declines in this situation.[6] When the individual holds positive outcome expectancies for the addictive behavior, such as the use of alcohol as a stress coping mechanism, the behavior is more likely to be manifested. Whether or not the situation proceeds to complete relapse depends on the individual's perception of the cause of the relapse and the reaction associated with the relapse.[4] The reaction to relapse within the RP model is called the abstinence violation effect (AVE). Marlatt proposed that AVE is more intense if the individual attributes the slip to internal, stable, and global factors that he or she perceives to be uncontrollable (eg, lack of willpower, internal guilt conflict, and perceptions of power brought on by the use of the substance).[4] Curry et al designed a study of RP among smokers to test the hypothesis that individuals who relapse after an initial slip will report more intense AVEs than those who remain abstinent. The study employed three dimensions of measurement for the AVE: *locus of causalty*—whether the cause was due to the individuals themselves, to other people, or to circumstances; *specificity*—whether the cause influenced other areas of their lives besides the addictive behavior; and, *stability*—whether the cause of the relapse would be present in similar situations in the future. Findings revealed that the three attribution rates differed significantly in the example. Relapsers gave more internal, stable, and global attributions for having smoked a single cigarette than slippers. Relapsers were defined as subjects who returned to regular smoking while slippers were defined as subjects who regained abstinence after an initial slip The AVE was more strongly correlated with relapsers who reported higher AVEs than slippers.

Three components of the relapse process include covert antecedents, lifestyle imbalances, and relapse set-ups. Covert antecedents involve denial and rationalization to covertly plan a relapse situation. Lifestyle imbalances where individuals struggle with things they "should do" versus things they "want to do" also contribute to relapse. The third component of the model is "seemingly irrelevant decisions" such as choosing a seat in the smoking section of an airplane, a behavior which may figure significantly in creating a relapse situation. All of these issues put an individual at increased risk for relapse by creating a high-risk situation with many external circumstances which may be very difficult to resist.

An important component of the RP model is that clients understand that "what we do" and "who we are" are not necessarily the-same. This frees clients of guilt and defensiveness. The overall goal is to increase client awareness of behavior choices to develop coping skills and self-control capacities, and to generally develop a greater sense of confidence, mastery, or self-efficacy in their lives.[4] One strategy used to assess a high-risk situation is self-monitoring, which provides an individual analysis of what constitutes a high-risk situation for each person.

Additionally, clients may be asked to relate relapse fantasies and to describe past relapses. These activities provide a description of each individual's high-risk situation. In conjunction with this, clients also are asked to rate the degree of temptation they are likely to experience and how confident they feel about their capacity to cope effectively with the situation. Coping strategies are individually planned for each client. Skill training methods derived from Meichenbaum are incorporated and include direct instruction, modeling, behavioral rehearsal and coaching, and feedback.[8] Coping strategies include relaxation training, stress management, and education regarding the immediate and delayed effects of the drug or activity. A decision matrix may be used to deal with clients' perceptions of positive outcomes as a result of the substance or maladaptive behavior. Clients are asked to write positive and negative, immediate and delayed consequences of stopping or remaining abstinent as opposed to continuing or resuming the behavior. Programmed relapses are often used by the therapist to provide clients with an opportunity to practice RP techniques, outside of high stress situations. Cognitive restructuring is used to change cognitions with regard to perceptions of the meaning of relapse.

Additionally, global strategies are designed to increase the ability of each client to deal with stress, to cope with high risk situations, and to exercise self-control. One strategy is balancing daily lifestyle—in terms of balancing "shoulds" and "wants." Another strategy advocates including activities for pleasure such as physical exercise and meditation. Substituting other indulgences (eg, massage, recreational activities) for the addictive behavior and teaching the client to utilize imagery to cope with stimulus control to remove as many stimuli associated with the maladaptive behavior as possible from the environment are also included. Finally, clients are instructed and helped to develop and practice behavioral avoidance strategies specific for high-risk situations.[4]

Implication of RP for Health Promotion Professionals

The basic tenets of RP mandate a reexamination of how health promotion professionals address programs designed to foster behavior change. Many of the traditional community-based health promotion and education programs have been single episode information dissemination and awareness raising activities, which often have little impact on behavior. Such initiatives are conducted under the premise that information gained will result in a behavior change. Even if this were the case, the RP model suggests that more emphasis should be placed on the maintenance of a behavior change. Therefore, the focus of these initiatives may, in many cases, be misdirected. Although numerous educational, social, and environmental strategies may be employed to foster the initial behavior change, RP strategies should be used to help maintain that behavior change.

Many of the worksite health promotion initiatives offered over the past ten years have placed a heavy emphasis on the initial behavior change process. Metcalfe states that the goal of the Turnaround Health and Fitness Program at the Campbell Soup Company is to help employees "turnaround" unhealthy lifestyle behaviors to achieve a higher lever of personal well-being.[17] To this end, employees are offered a myriad of opportunities, mainly related to physical fitness with lesser emphasis placed on nutrition education and other lifestyle issues such as stress management and smoking cessation. Generally, these programs focus on initial behavior change. The labor intensive processes of follow-up and maintenance receive lesser emphasis. For example, Campbell's smoking cessation program is a behavior modification approach where participants meet for one hour a week during the behavior change portion of the program and for one session per month during the maintenance component. Although the three months of follow-up represent a significant effort when compared to other smoking cessation programs, the RP model would prescribe a more extensive follow-up program to foster the maintenance of any behavior.

Clearly, the RP model mandates that health professionals re-think how they provide programs to clients, students, and employees. A greater emphasis must be placed on helping those who have adopted healthy lifestyles to maintain them throughout their lifetimes. Too often programming efforts are aimed at those who have developed inappropriate behavior and do not relate to the large percentage of the population who engage in healthy behaviors, but may be influenced to adopt unhealthy behaviors. Programs designed to assist people in the maintenance of healthy behaviors should be provided to people across the lifespan, not just to those currently at risk or engaging in potentially risky behaviors. Using smoking as an example, cessation programs often are provided for current smokers. These programs have varying success rates, but a 25% success rate is

average. Along with providing aftercare for program participants, the RP model can provide current non-smokers with the skills to continue that non-smoking behavior across the life course if they so choose.

Such a perspective on health and health promotion would require a change in public perception of risk factors and the etiology of disease. To say that alcoholism is a disease implies that the behavior is not under the control of the individual and, therefore, can only be treated through medical intervention. The outcome of successful treatment for alcoholism is abstinence. Because alcoholism is viewed as a disease, any relapse into drinking is seen as a return to the diseased state, requiring further treatment. The RP model requires that these behaviors be seen as learned behaviors which can be unlearned. Public awareness and social marketing efforts should help promote this concept. Accordingly, when relapse occurs it will not be seen as a return to a diseased state, but rather as an indication that the person at risk needs to learn how to cope more effectively with problem drinking. The drinker who returns to risky drinking behavior would not be viewed as a treatment failure, but rather as someone who needs to further practice responsible drinking skills.

A common criticism of many health promotion programs is their tendency to blame the victim for the problem. O'Donnell believes health promotion professionals need to embrace an integrated approach to health promotion. He states, "As a profession, we must make a commitment to change social and economic inequities that discourage healthful life practices…We must also address individual lifestyle choices."[18] The RP model does not blame the victim for the problem, but it does encourage the participant to be responsible for learning how to cope with the problem or to unlearn the inappropriate behavior, In essence, the participant is not responsible for the development of problem drinking or for smoking, but he or she is held accountable for the solution to the problem.

Closely aligned to this notion of victim blaming is the need for appropriate environmental support activities to help encourage behavior change and its maintenance. In a worksite setting it is not enough to offer stress management session to employees (a form of victim blaming) without also examining ways to reduce the causes of stress at the worksite and to provide employees with moderately stress-free work environments. Environmental and social support activities send a clear message that numerous factors are likely to influence a health behavior. Therefore, it is important to approach problems related to health and health behavior from multiple dimensions. The client, the employee, or student who believes that numerous factors contribute to a drinking problem is more likely not to totally self-blame when relapse occurs and not to embrace the notion that a relapse is a return to a diseased state.

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