Co-Occurring Collaborative of Southern Maine

Dual Diagnosis
Relapse Prevention Monograph

A Report on the Training Initiative 1997-1998

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Introduction

This monograph represents further progress in the effort toward integration of treatment approaches for clients with dual disorders in the State of Maine. It is a product of concerted grass-roots efforts by service providers, consumers, families and other interested community members over a period of years to identify and provide the staff training and services needed for clients with dual (mental/emotional and substance use) disorders. This human service community has united around problems and potential solutions for a population that is repeatedly identified as poorly served. At this point the knowledge, goals and aspirations of the Cumberland County Dual Diagnosis Collaborative (CCDDC) and its members far exceed the available funding and administrative support for needed services. In this familiar gap between what is understood and envisioned and what is possible and available, individual service providers may find this monograph a valuable guide to helping people with dual mental/emotional and substance use disorders to stay on a path of growth and change.

Why Study Relapse?

With the changing picture in health care today, behavioral health specialists are under increasing pressure to show lasting, positive outcomes to treatment and services. Insurance companies are making it more difficult for providers to get reimbursed for inpatient care while shortening the number of outpatient visits they will reimburse. There is increased emphasis upon showing behavioral outcomes to the services being provided. The "revolving door" client has become a symbol of the past failures of the behavioral health system. The system is now being challenged to find better treatment options for individuals with dual disorders.

Given the focus on positive, lasting behavioral outcomes to treatment, there is an urgent need for behavioral health specialists to better understand the phenomenon of relapse, and its effect upon successful recovery from mental illness and substance abuse. There is a need to further explore differences between treatment that is designed to stabilize the symptoms and problems associated with mental health and substance use disorders, and those interventions that lead to long-term maintenance of a healthy life style.

Treatment that is effective in the short term but fails to aid in long-term maintenance of gains, in fact, may lead individuals to utilize services at a higher rate than would otherwise be indicated. Continued or recurrent problems of living associated with mental illness and substance abuse have a negative effect upon stability of employment and maintenance of healthy interpersonal relationships and may increase antisocial behaviors and overuse of social services. The continuance of these problems in living reduces a person's quality of life and places limitations on the successful pursuit of personal goals.

In the study of relapse, therefore, the practitioner and researcher must ask the question: Are the factors that promote relapse similar to or identical to those that initiate the disorder? (Wilson, 1992). Certain biopsychosocial processes may cause the disorder to

first occur, but other processes may induce relapse. Thus, relapse prevention approaches may target dynamics that are different from those addressed by traditional symptom-focused treatment.

This paper is intended to serve as a practical guide to understanding issues specific to relapse prevention in individuals with mental health and substance use disorders. It will explore the theories and dynamics associated with relapse and summarize current relapse prevention models. It also will summarize a major relapse prevention training initiative sponsored by the CCDDC in Maine in 1997-1998.

The Cumberland County Dual Diagnosis Collaborative

The Cumberland County Dual Diagnosis Collaborative is an organization made up of over 30 agencies, private practitioners, consumers, family members and community members. It has been in existence since 1992, formed as an initiative of the Maine State Office of Substance Abuse. The CCDDC's mission is to reduce barriers and create effective community-based services for individuals with mental health and substance use disorders. Its goals include the following:

- To provide training and education on dual disorders.
- To support creative interagency problem-solving regarding the enhancement and development of the dual disorders service system.
- To pilot creative solutions to service system issues.
- To support community resource development of services to individuals with dual disorders.
- To enhance communication, coordination, collaboration and the exchange of ideas among mental health service providers, substance abuse service providers, consumers and family members.
- To provide advocacy on dual disorders.
- To create opportunities for interagency resource sharing and development.

The CCDDC members' resources include:

- Consumers
- Family members
- Four inpatient programs
- Residential programs
- Outpatient programs
- Case management services
- Shelters
- Vocational services
- Family advocacy groups
- Consumer advocacy groups
- Social Services
- Correctional Services
- Social clubs

In September 1997 the CCDDC sponsored a three-day Relapse Prevention Counseling program taught by Terence T. Gorski, M.A., with assistance from Arthur B.Trundy, M.Ed., CADC and regional relapse prevention specialists. This training was followed by two days of consultation with Arthur Trundy and Hilary Ryglewicz, ACSW on client services and organizational support for the implementation and adaptation of the Gorski/CENAPS model to individuals with dual disorders in the Greater Portland area of Maine.

This training provided a detailed presentation of the Gorski/CENAPS model of relapse prevention, which was then placed in the framework of a developmental model of a total dual-diagnosis treatment continuum. This framework reflects training initiatives in dual disorder presented in prior years by Bert Pepper, M.D. and Hilary Ryglewicz, ACSW with special attention to skill training in psychoeducational treatment. The present monograph also includes adaptations of the Gorski/CENAPS model suggested by CCDDC participants, supplementary strategies for clients with dual-disorders highlighted in the training and an expanded discussion of terms commonly used in relapse prevention when applied to treatment issues for individuals with mental/emotional disorders (Ryglewicz, 1998).

Summary of Relapse Prevention Theory and Principles in Substance Abuse Treatment

It is common knowledge that disorders that are addictive and chronic in nature are characterized by high rates of relapse. Recent psychiatric inpatient recidivism data suggest that the incidence of relapse among individuals with mental illness and substance use disorders is as high as 60% and that 80% of the readmissions to a psychiatric facility are a direct result of relapse to use of drugs or alcohol. Yet it was not until the 1980's that counselors directly addressed problems associated with maintaining treatment outcomes.

Few treatment outcome studies prior to the early 1980's compared relapse prevention strategies to other interventions that focused primarily on the reduction of symptoms related to the primary disorder. With emerging empirical support for approaches that are specifically designed to help individuals recovering from their disorders to avoid a recurrence of primary symptoms, models that focused on the prevention of relapse emerged. Most outcome studies were conducted in the field of alcohol addiction (Litman, 1980). In the field of mental health, two early studies on relapse prevention and improving long-term treatment outcomes are the works of Belsher & Costello (1988) and Wilson (1989). Both of these approaches emphasized behavioral and cognitive interventions for the prevention of relapse in certain types of depression.

The model that sparked the most study, and had the greatest influence upon the field of addictions treatment, was the work of G. Alan Marlatt and Judith Gordon. In their influential book *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors* (1985), they present a conceptual framework for addressing the prevention of relapse to alcohol, smoking and food addictions that today has formed the

basis for studying relapse in virtually any problem area. Earlier approaches to relapse prevention tended to involve increasing the number of primary treatment components, in the belief that, sooner or later, one of the treatments will have some lasting effect. In contrast, Marlatt and Gordon suggested that the maintenance or recovery stage ought to be considered a period in which there is "the opportunity for new learning to occur" (p. 25), and proposed a cognitive-behavioral model of relapse prevention focused on skill acquisition rather than on reducing symptoms of the disorder.

Their model combines *primary treatment* and *relapse prevention* strategies to overcome addictive disorders and maintain treatment outcomes. The approach was controversial at first because it challenged the disease model of addiction, suggesting that some individuals do not need to practice total abstinence in order to lead functional, productive lives. However, since this model provided a more flexible alternative for treating addiction, it has been widely studied and endorsed by some relapse prevention specialists.

Marlatt and Gordon believe that relapse may occur as a result of social, interpersonal or situational stresses at any one of a number of points in the chain of events from initial treatment to maintenance; and that individuals can learn to cope with these threats through the learning of new skills and responses to these situations. Key to their model is the assumption that *threats to most recoveries are common and predictable*.

In a study of 311 initial relapse episodes obtained from individuals with a variety of problem addictions (alcohol and heroin use, smoking, compulsive gambling and over-eating), Cummings, Gordon and Marlatt (1980) identified three primary high-risk situations associated with 75% of all relapses reported:

(1) *Negative emotional states* (35% of all relapses): moods or feelings, such asfrustration, anger, anxiety, depression or boredom, prior to or at the time ofa relapse episode.
(2) *Social Pressure* (20% of all relapses): response to the influence of another person or group exerting pressure to engage in taboo behavior.
(3) *Interpersonal conflict* (16% of all relapses): conflicts in marriage, friendship, family members or employer-employee relations.

These findings suggested to Marlatt and Gordon that there were common mechanisms underlying the relapse process across different addictive behaviors. Thus, they developed and researched a model of the relapse process that focused on the events surrounding the initial return to the addictive behaviors after a period of abstinence.

In Marlatt and Gordon's model, addictions are explained as acquired *habit patterns* that are on a continuum from normal to excessive. These behavioral patterns are influenced by similar cognitive and perceptual processes in which prior events, beliefs, expectations and behavioral consequences play important roles in the continued use of drugs or alcohol. The major focus of treatment is to enhance the individual's perception of control over important events that are likely to result in a return to problem substance use. This

perception of control over events in one's life is termed *self-efficacy*. A high self-efficacy concept is related to the conviction that one can execute a behavior that will result in a desired outcome. It is a person's belief about his/her ability to act out a specific behavior at a particular time and place. Self-efficacy is correlated with the individual's potential to relapse in that it influences whether one will be able to initiate and maintain successful coping behaviors. The important role of self-efficacy as a predictor of successful long-term recovery from chronic and addictive disorders has become the subject of many studies (Sitharthan & Kavanagh, 1990).

Another major component of Marlatt and Gordon's (1985) relapse prevention model is the identification of high-risk situations. Through self-report, self-efficacy ratings and detailed analysis of previous relapse episodes, an individual is helped to become more aware of the influence of *environmental cues*, *cognitive factors and negative emotional states* upon problematic alcohol and drug use. Individuals are encouraged to view the recovery period as an opportunity for new learning to occur so that they can develop new strategies for coping with high-risk situations. *A high-risk situation* is defined broadly as "any situation that poses a threat to the individual's sense of control and increases the risk of potential relapse" (p. 37).

Another important concept thought to increase the risk of a full relapse is the *"abstinence violation "effect."* This refers to the thoughts that are frequently associated with unsuccessful attempts to control drug or alcohol use. Knowing that one has used a substance is in direct contradiction to one's self-image as a recovering person who is committed to abstinence. This contradiction produces negative feelings, such as guilt and shame. These feelings, in turn, increase a person's urge to use in order to obtain relief from the pain associated with the feelings. In this situation, an initial lapse becomes the precipitant of a full relapse. It is for this reason that Marlatt and Gordon allow for the individual in treatment to choose a treatment goal other than abstinence, such as controlled drinking.

These concepts help Marlatt and Gordon explain relapse not as a spontaneous happening but as the last step in a series of events. Thus, relapse is seen not solely as a problem of physical dependence, lack of proper motivation or lack of will power, but as a potential dynamic for individuals in recovery resulting from situational factors (high-risk situations) and negative cognitive and emotional states that result from social pressures. Their relapse prevention model teaches individuals how to make needed life style changes in order to identify and cope with these pressures. It is a set of strategies aimed at empowering individuals:

- to make a commitment to total abstinence;
- to reognize that a lapse may occur;
- to learn how to anticipate, avoid and cope with high-risk situations;
- to alert for cognitive, attitudinal and emotional warning signs;
- to recognize that people can control their behavior and avoid lapses; and
- to learn to recognize and interrupt decision chains that lead to exposure to high-risk situations.

The concepts in Marlatt and Gordon's relapse prevention model have led to other approaches that have incorporated similar principles to aid in the recovery process. One such approach has been developed by the National Institute of Drug Abuse (1994) entitled *A Relapse Prevention Technology Transfer Package*. This training package consists of empirically tested materials for use in relapse prevention. It relies heavily upon the principles underlying Marlatt and Gordon's model and stresses a combination of approaches to relapse prevention that include social support, lifestyle changes and cognitive-behavioral therapy. The relapse prevention training consists of two modules:

RecoveryTraining and Self-help

This training consists of a cognitive-behavioral social support approach designed to address the threats to recovery after detoxification and the completion of primary treatment. Key theoretical principles underlying this approach are that: *threats to most recoveries are common and predictable; effective coping strategies for dealing with high- risk situations can be identified and implemented for each individual; and individuals in recovery can learn to help each other implement these coping strategies.*

Recovery training and self help involve the use of as many as four *group* interventions: *recovery training group sessions* to provide peer support and review for anticipating and avoiding or handling high-risk situations; a *weekly fellowship group* to provide a format for individuals to help each other learn coping techniques and provide encouragement to face challenges; *group social recreation* for clients, friends, family members and staff to participate in social activities; and *the network of senior recovering addicts* to give guidance, help with social activities and act as role models.

Cue Extinction

This training helps weaken, and in some cases eliminate, the craving for substances that individuals may experience when faced with high-risk situations. The principle underlying this training is that cravings can be ‘de-conditioned’ by repeatedly exposing individuals, in a controlled setting, to cues that trigger a return to the addiction. Exercises used in the controlled situation include: *deep relaxation* - stress-reduction tapes, meditation, etc.; *delay plus behavioral alternatives* - delaying use of substances after an early warning sign by focusing on doing something else like exercise; *negative/positive consequences* - helping individuals learn to identify the most important positive and negative consequences of acting or not acting upon the urges; *mastery imagery* - picturing oneself as a very powerful person capable of defeating the craving; and *cognitive interventions* - helping individuals think rationally about using addictive substances and recognizing flawed thought processes.

In summary, the above relapse prevention models, which have been developed since the 1980's, emphasize cognitive-behavioral and social support intervention techniques to address common early warning signs of relapse for individuals in recovery. Common theoretical assumptions underlying these techniques are:

(1) There are common dynamics associated with the relapse process across different addictions and chronic problem behaviors or disorders.
(2) Interventions that target symptom reduction are not necessarily effective in addressing and reducing threats to recovery.
(3) Individuals in recovery can learn to interrupt decision chains and identify and manage high-risk situations that lead to relapse, thereby developing self-efficacy.
(4) Cognitive-behavioral interventions, coupled with social supports, are the most effective ways of helping individuals recognize the influence of environmental factors, cognitive processes and emotional states upon recovery.

The Developmental Model of Recovery from Mental Illness and Chemical Dependency

Most behavioral health specialists working with individuals recovering from and mental/emotional and substance use disorders subscribe to a **developmental model of recovery** (Anthony, 1991; Drake, 1991; Gorski, 1990, Minkoff, 1989; Osher & Kofoed, 1989; Ryglewicz & Pepper, 1996). Briefly stated, *recovery from a long-term, disabling illness or disorder(s) is influenced by environmental, social, interpersonal and familial factors in complex ways, as well as by the nature of the illness or disorder itself, and by any neurobiological aspects that it involves; and 'recovery' follows a winding course through a series of predictable stages.*

It is common for developmental models of recovery to describe a continuum of successive stages. In the beginning stage, individuals first experience problems related to alcohol or drug use and/or to symptoms of mental/emotional disorder. In the ending stage, individuals have progressed to full recovery, which is characterized by the absence (or effective management) of symptoms and negative behaviors associated with the disorders and the achievement of a functional, high-quality lifestyle.

This model of 'dual recovery' reflects a useful effort to incorporate the needs of individuals with dual disorders into the substance abuse recovery framework. However, to describe the recovery process in this way oversimplifies the problem of 'recovery' for individuals with dual disorders. For one thing, mental/emotional and substance use disorders are *separate*, yet *co-existing and interacting* problems or *vulnerabilities*. This means that:

(1) *'recovery'*, even though it may follow a course through identifiable stages, *is not necessarily at the same stage for each disorder*; and that
(2) during the recovery process(es), each disorder represents a *vulnerability to relapse* in the other.

Psychiatric, or mental/emotional, disorders themselves are of various kinds, with different implications for the recovery process and for the tasks of relapse prevention. Ryglewicz and Pepper, in their book *Lives at Risk* (1996), describe symptoms and dynamics of major mental illness, emotional disorders and personality disorders that may

increase the person's vulnerability to relapse in substance abuse and/or the difficulty of developing motivation for trying abstinence. Some of these mental, emotional and personality disorder symptoms and characteristics include:

- Symptoms of schizophrenia, including hallucinations, delusions, disturbance of thought processes, and/or paranoia, as well as deficits in information processing, stimulation and stress management and social skills.
- Symptoms of bipolar disorder, including pressured speech, wild elation, euphoria, grandiose or paranoid ideas, profound depression, agitation and suicidal and/or homicidal thoughts.
- Symptoms of personality disorders, including suicidal thoughts, gestures and attempts, intense anxiety, extreme anger and impatience, impulsive behaviors, sexual promiscuity and aggression.
- The tendency for most individuals with dual disorders to use alcohol or drugs in an effort to try to control symptoms of anxiety, depression, anger and confusion.
- Psychiatric symptoms that present problems in group treatment, including preoccupation with inner thoughts, anxiety over speaking or being confronted and being overstimulated or 'flooded' by stories about childhood traumas, physical or sexual abuse histories.

The ability of the individual with dual disorders to take the first step onto the path toward abstinence is strongly affected by: (1) the nature and intensity of these symptoms; (2) the degree to which the person has been able to manage them with medication and other treatments; and (3) the person's level of awareness of problematic substance use and motivation for change. The authors summarize some of the obstacles along the recovery path for these individuals with dual mental/emotional and substance use disorders as follows:

> The more a mental illness, a major personality disorder, or a disabling level of anxiety and depression interferes with a person's thought process and/or stability of mood, the more difficult it is to gain a commitment to a major change in habits and attempted coping. A person whose thinking is confused finds it difficult or impossible to hold onto goals or thoughts about goals. A person whose mood is deeply depressed or whose feelings are chaotic and painful feels an intense need for relief, and often any excitation is translated into a craving for a drug, be it alcohol or cocaine, marijuana or heroin, caffeine or nicotine. The more severe and pervasive the disturbance in thinking, or the more overwhelmingly painful the feelings, the more difficult it is for the person to gather the strength and clarity that are needed to undertake abstinence. (p. 85)

Of course, these factors continue to affect the person throughout the process of substance abuse recovery, with a degree of strength that varies with the intensity of the symptoms as well as the stage of recovery achieved for each disorder.

By the same token, alcohol and other drug use, reflecting an early or premotivational stage of recovery in substance abuse, is a major risk factor for the destabilization of

someone with a mental/emotional disorder, whether it takes the form of triggering an acute episode of major mental illness (sometimes in part by diminishing the effect of prescribed medication) or, for another individual with dual disorders, both reflecting and leading to a loss of emotional and behavioral control.

Stages of Substance Abuse Recovery

Considering first the developmental recovery model in the framework of substance abuse treatment, causes of relapse to alcohol or drug use - and a return of active symptoms of mental illness or emotional/personality disorders - vary according to the person's stage of recovery. In the *transition* or *pre-treatment* stage, the major cause of the inability to abstain from using alcohol or drugs and to remain free from psychiatric crises precipitated by substance use is the individual's belief that abstinence is unnecessary and that one can engage in 'moderate' or 'controlled' drinking or drug use. This stage ends when the individual recognizes that 'controlled' use of substances is not working because there is a continuation of situations involving difficulties at work, home or community, perhaps including return of acute symptoms of mental illness and/or intense negative feelings such as anxiety and depression, with resulting emotional and interpersonal crises.

During the *stabilization* or *active treatment period*, the major cause of relapse is the lack of skills necessary to self-manage the symptoms of both disorders. When the person is not actively engaged in formal treatment or counseling programs, his or her ability to cope with the stress and pressure of both mental/emotional and substance use disorders, each having biological, psychological and social aspects is weak. As a result, she/he may try to manage symptoms and relieve distress through self-medication. In *early recovery*, the stress associated with trying to establish a chemical-free lifestyle with a new peer group and to build a drug-free support system is a common cause of relapse. During *middle recovery*, the individual is beginning to make internal changes in ways of thinking, feeling and perception of past and present life experiences that are a major source of discomfort, leading to the urge to use substances or self-medicate. In *late recovery*, major causes of relapse can be attributed to unresolved intrapsychic issues and failure to fully develop a functional lifestyle. Finally, during the *maintenance* stage, major causes of relapse include the failure to continue a recovery program and the advent of a major lifestyle transition or crisis (Gorski, 1993).

Each of these stages in the recovery process has specific meanings and problems for the individual with dual disorders, depending upon the nature of the mental/emotional disorder.

Concepts of Relapse and Recovery in Mental Health vs. Substance Abuse Treatment

The term *recovery* can be used for individuals with dual disorder with the same meaning it has for any person recovering from substance abuse or addiction -- that the person has undertaken a process of change with the goal of abstinence from substance use. But,

more commonly, we speak in terms of *dual recovery* - that is, 'recovery' also from whatever mental status, emotional state(s) and/or personality dynamics tend to reinforce substance use and abuse and therefore are relevant to the substance abuse (SA) recovery process. And the mental health (MH) 'recovery' process differs from SA recovery, certainly not in all respects, but in at least some of the meanings, expectations, choices and responsibilities involved.

What, for instance, does relapse mean when applied to various disorders?

In substance abuse:

An action or series of actions:
Return to a pattern of substance use, abuse, dependence or addiction by a person who has committed to a recovery process.

In other compulsive behaviors:

A return to the behavior, or an intensification in its frequency and severity, by a person committed to recovery or change

In major mental illness:

A change in mental status:
An acute psychotic episode requiring hospitalization and/or more intensive services.

In anxiety / depression:

A new episode or an intensification of anxiety and/or depression, usually requiring more intensive services.

In post-traumatic stress disorder:

An inner experience:
Relapse is not generally used in this context. It could mean a return of more intense symptoms after a period of relief.

In personality disorder:

A change of circumstances and/or behavior:
Relapse is not generally used in this context. But, it could mean a situational crisis resulting from problematic or 'dysfunctional' patterns in self-management and interactions with others. Or it could mean a return to previous problematic behavior in these areas.

What is a slip or lapse*?*

In substance abuse: An action:

A single incident or very brief interval of substance use by someone who has committed to abstinence, which does not necessarily develop into a full-blown relapse.

In other compulsive behaviors:

Similar meaning.

In major mental illness, PTSD, anxiety and depression:

The words *slip* and *lapse* have no meaning in this context.

In personality disorder:

These terms are not generally used in this context, but could be applied to incidents of problematic thoughts, feelings and/or actions.

What do we mean by recovery?

In *substance abuse:*

A process of learning to abstain from (or, in some models, control) use of a substance.

In other compulsive behaviors:

A process of learning to abstain from *compulsive use* of a substance or behavior.

In major mental illness:

Remission of symptoms experienced during an acute psychotic episode, with some attendant improvement in reality-based functioning; and a lifelong process of managing an illness -- comparable to the lifelong 'recovery' process in alcoholism.

In anxiety/depression:

Relief from symptoms experienced during an episode of anxiety and/or depression.

In post-traumatic stress disorder:

Relief from ongoing and/or intermittent symptoms.

In personality disorders:

Success in changing longstanding problematic patterns of self-management and interactions with others.

What about the meaning of high-risk situations?

In substance abuse:

Situations and stressors that are likely to lead to a lapse or relapse in use of the substance - again, an *action.*

In other compulsive behaviors:

Similar meaning re: compulsive use of a substance or behavior.

In major mental illness, anxiety/depression and PTSD:

Situations/stressors that are likely to lead to a recurrence of acute symptoms - *a change in mental status*.

In personality disorders:

Situations/stressors that are likely to make it more difficult to change or maintain changes in entrenched problematic patterns of self-management and relating.

These discrepancies in the meanings of r*elapse*, *slip/lapse*, *recovery*, and *risk*, depending upon the specific category of mental, emotional and/or personality disorder, tell us that a recovery/ relapse prevention model for individuals with dual disorders:

(1) must be multifaceted and flexible in its implementation;
(2) must call upon diverse means of 'symptom' relief and relapse prevention;
(3) must aim toward variable goals and expectations regarding the MH recovery process; and
(4) must recognize the differences in the client's *actions*, as distinguished from symptoms, as points of choice and targets for change.

Client choice and responsibility are important aspects of MH recovery, as they are of SA recovery, but the person cannot choose *not to have symptoms* in the same way that a substance abuse client can choose *not to use*. How we define the area of responsibility, and the factors affecting the person's ability to make constructive choices, is a crucial aspect of a dual-recovery treatment model and will be discussed later in this monograph.

Stages of Substance Abuse Treatment

Much of the growing attention to the needs of individuals with dual disorders has focused on the process of developing motivation for substance abuse treatment or readiness for change in substance-using behavior. Concern with this process is not limited to work with individuals with dual disorders. Rather, it reflects an awareness that a lasting commitment to change, in many or most cases, does not take place in the form of a single leap from substance use/abuse/dependence/addiction to abstinence. As the development of substance abuse and dependence is a process, so, too, is the development of motivation to change. And change, especially change that involves *giving up* a reliable and immediate gratification for the sake of delayed or more global consequences, is never welcome, so that denial of the need to change is stubborn and strong.

If the development of motivation or 'readiness' is problematic for the general population, it is even more so for people whose mental/emotional status makes it difficult to commit fully to a change in substance use behavior. People with mental illness or severe personality disorders and/or overwhelming negative emotional states (anxiety, depression, anger) generally experience greater-than-average stressors in both their inner experiences and their life situations, combined with some deficits or impairments in social resources and coping skills. If this discrepancy between coping ability and what must be coped with is part of a person's baseline functioning in life, and if substance use offers at least a temporary relief from confronting that basic problem - - experienced as confusing events, alarming situations, overwhelming demands, unmanageable feelings, ungratifying or nonexistent relationships - - it is easy to understand the reluctance to change, the doubt that change is possible and the denial that change is necessary.

For these reasons, the *pre-recovery* process has been increasingly recognized by both mental health and substance abuse services. On the mental health or psychiatric side, Osher and Kofoed (1989) identified stages of *engagement* and *persuasion* as precursors to *active treatment* and *relapse prevention* or *maintenance*, and as predictable and sometimes lengthy stages for individuals with dual disorders. Other authors (Ryglewicz & Pepper, 1996; Drake & Minkoff, 1991; Minkoff, 1989) have related these stages of *preparation for treatment* to the client's *level of motivation*: *pre-motivated, pre-abstinent, trying abstinence* and *committed to recovery*, with *psychoeducation* (Ryglewicz & Pepper, 1996) and *motivational interviewing* (Miller & Rottnick, 1991) emerging as interventions of choice for the pre-recovery stages. In the substance abuse treatment field, based not only upon the needs of individuals with dual disorders but also on the high rates of dropout and relapse from traditional substance abuse programs, Prochaska, Norcross, and DiClemente (1995) have identified comparable *stages of change: pre-contemplation, contemplation, preparation, action and maintenance*. These stages parallel the stages of recovery discussed above and can be used to examine the most effective interventions or treatment to match the individual's motivational level for recovery.

During the *pre-contemplation* stage, individuals have not yet acknowledged a problem with drug use and are unaware of the relationship of drug use to problems of living. The focus of interventions at this stage needs to be on beginning to build a therapeutic alliance and on problem recognition. Changing one's habits and lifestyle at this stage would be counter-productive, since there is little or no motivation to change. Psychoeducational approaches are preferred over more confrontational or analytical approaches because the former are less threatening. *Denial* is the major defense operating and avoidance of stress and anxiety is the prime motivation. Unless the counselor can begin to build a trusting relationship, the ability to influence clients to begin examining the relationships among drug use, mental disorders and problems in living will be negligible.

The next stage of treatment is *contemplation*. During this stage, *ambivalence* is the prominent feature. There is greater recognition of the relationship between drug use and problems in living, but the motivation for change is still quite low. Empathic understanding of the intrapsychic struggles and ambivalence the client is experiencing is essential. The timing of interventions aimed at encouraging the individual to seek active treatment is critical. The counselor must be acutely aware of the resistance to change and utilize motivational techniques in an attempt to reframe the individual's negative perceptions of the ability to make positive changes, manage the illnesses and improve one's quality of life. There can be more emphasis at this time on continuing to acknowledge the substance abuse problems and recognition of the need for change.

Once an individual acknowledges the need for treatment and the desire to change, she/he enters the *preparation* stage. During this stage, the focus of interventions is on developing a resource inventory and beginning the biopsychosocial assessment process. Motivation for taking action is higher than in the preceding stages, but the action steps must be small ones, that will result in success. During this stage, more emphasis can be placed on personal responsibility to change. The resource inventory and assessment process should identify potential support systems that will be necessary to assist in encouraging treatment and instilling a message of hope when the individual is discouraged with progress. Once the client has made a commitment to action, and is successfully referred and engaged in formal service, active treatment begins.

Active treatment, or *action*, is characterized by heightened anxiety regarding change. With increased anxiety, there is more of a need for friends, relatives and peers to support the continuation of treatment. Once again, messages of hope and taking control of one's life are essential. Both substance abuse and mental health problems need to be worked on simultaneously. Action must be success-oriented in order to be rewarding. If abstinence is not felt to be a realistic immediate goal, reducing problematic drug or alcohol use may be a more appropriate first step. Particularly for individuals with dual disorders, the leap to total abstinence at the beginning of treatment may be counterproductive. The inability to feel in control of the symptoms associated with both disorders may result in heightened feelings of anxiety and despair, which may lead to the return to drug use or abuse of prescribed medications.

The type and length of appropriate treatment programs depend upon the level of acuity and severity of the disorders, motivational level and availability to the individual. Once the individual has made a commitment to abstinence or reducing drug or alcohol use, relapse prevention strategies need to be implemented as part of active treatment. Now that a therapeutic alliance has been formed, the individual is more motivated to change and there is a reduction in the debilitating effects and symptoms of both disorders, the individual can begin to benefit from cognitive-behavioral approaches to the acquisition of relapse prevention skills.

During the *maintenance* stage, relapse prevention training becomes the focus. With long-term supports in place, a prolonged period of abstinence and the self-management of mental illness symptoms, relapse prevention strategies need to be focused on the

acquisition of the skills necessary for the continuation of a drug-free lifestyle and coping with the residual effects of mental illness. Self-management and self-help principles become major factors in the recovery process.

The Anatomy of a Relapse

In *Cultures of Change* (1993), Janice Gabe presents a description of the dynamics involved in adolescents progressing from a period of stable recovery from alcohol and drug use to a full relapse. Certain features of this progression seem to apply to adults with mental illness and substance abuse as well.

Gabe (1993) first describes *recovery* for individuals with dual disorders of mental illness and substance abuse as an ongoing process of improving one's level of functioning while striving to maintain abstinence from mood-altering drugs. Key phrases in this definition are:

- *improving one's functioning*: not an end result or perfection, but *progress* towards a more productive lifestyle; and
- *striving to maintain abstinence*: as long as individuals are making a sincere effort to be free from the use of mood-altering drugs, they are engaged in the *recovery* process.

Gabe also makes an important distinction between a *lapse* and a *relapse*. She defines a *lapse* as an isolated incident of use in recovery. *Relapse* is defined as a return to prolonged, problematic drug or alcohol use after a period of abstinence. The distinction between these two processes is important from an intervention point of view. *Lapses* need to be addressed as a clinical issue. Gabe feels that the counselor's attitude plays an important role in determining the therapeutic value of a *lapse*. She points out that counselors should not tell individuals with dual disorders that they have chronic illnesses that will include slips and relapses, then respond to them punitively as if these dynamics were behavioral problems.

Thus it is important for counselors to continue to examine their attitudes towards *lapses* and become more skilled in dealing with these slips in order to help the individual prevent a total relapse. Cognitive-behavioral interventions that promote understanding of the causes of *lapses*, and what can be done about them, are thought to be essential to assist individuals in recovery. Individuals who have ‘slipped’ are still considered to be in recovery. Those in full relapse require different treatment.

Using Schneidman's (1985) dimensions of suicidal behavior as a parallel, Gabe presents three aspects of *relapse*. These three aspects are similar to those discussed previously in the summary of Marlatt and Gordon's relapse prevention theory (1985), and in the Gorski/CENAPS (1990) relapse prevention model discussed in the following section of this paper. The three aspects of relapse are *situational, cognitive and affective*.

The *situational* aspects involve precipitating events or *high-risk situations* that correlate with unendurable psychological pain and frustrated psychological need. Commonly

perceived frustrated needs include the need to feel competent, the need for acceptance and the need for support and love. High-risk situations increase the individual's frustration, which leads to increased pain, which leads to the ‘medicating the pain’ phenomenon. Helpful interventions involve the concept of delaying gratification of fulfilling the unmet need, in order to avoid the individual’s seeking immediate relief by drug or alcohol use.

The *affective* dimensions of relapse involve feelings of hopelessness and helplessness, incompetence, loneliness and ambivalence towards abstinence. Gabe believes that individuals in early recovery do not have much practice in understanding and managing their feelings. They become quite easily frightened, confused and bothered by their emotions. Using drugs and alcohol has helped them not to feel in the past. Chemicals also have helped them to deal with the guilt and shame associated with the loss of valuable time, and grief for the loss of youth and innocence. While in recovery, individuals nw must cope with potential losses of old lifestyles, prior self-image and familiar peer groups. Thus, relapse is a real and imminent danger.

In working to assist individuals in dealing with these feelings, counselors should aid in addressing feelings of helplessness and hopelessness by giving individuals an opportunity to grieve their losses. Interventions include sharing perceived losses in groups, writing "goodbye" letters to old lifestyles and to their drugs of choice, writing a letter of forgiveness to themselves and making amends to others who have been hurt in the past.

The *cognitive* dimensions of a relapse are strongly rooted in *denial*. Gabe defines *denial* as the faulty logic that makes sense to the individual, with the end result being an illogical conclusion that appears sensible. *Relapse logic* starts with the desire to use, which leads to the emotional discomfort of guilt and shame, which leads to thinking that "I would be more comfortable in a mood-altered state." Therefore, "I will use in order to change the way I feel." What follows next in the denial process is to rationalize in order to make the use okay. Controlled drinking and drugging is an attempt to rationalize a *lapse*. Faulty thinking may include: "If no one finds out, my use will not be a problem." This denial process leads further into a *cognitive constriction*, which causes the individual to see only limited options and to see the use of drugs and alcohol as a magical solution.

Interventions to deal with the cognitive dimensions of the relapse process must help the individual explore the faulty logic. As a result of having to verbalize one's thinking, often the faulty logic emerges and the individual can ‘re-think’ the process in order to arrive at a different solution to dealing with the painful feelings. Teaching individuals to identify their ‘druggy thinking’ assists them in anticipating their use of denial in future high-risk situations and developing alternative ways of coping with negative emotional states.

Gabe (1993) discusses six phases of the development of a total relapse during the recovery process for individuals with mental health and substance use disorders. The client characteristics of these six phases are described below:

Phase I: Adjustment Difficulty

(1) Feeling uncomfortable with a drug-free image
- Failing to fit into a new peer group.
- "Uncertainty about who I am if not a druggy."
- Feeling the need to return to the old peer group out of loneliness.

(2) Lack oconfidence in the ability to do things successfully
- Having only one plan to solve all problems.
- Second-guessing oneself about making good decisions.
- Feeling overwhelmed and not able to make the changes.
- Becoming afraid of new feelings.
- Becoming preoccupied with problems adjusting to a new life style.

(3) Failure to develop appropriate social supports
- Feeling bored, lonely, and isolated.
- Feeling reluctant to take risks.
- Feeling uncomfortable in social situations without using drugs or alcohol.

(4) Experience of having no rewards for being drug-free.
- Beginning to get in touch with painful issues avoided by using drugs and alcohol.
- Viewing recovery only in terms of what has been given up.
- Getting stuck thinking about the past or future while trying to avoid the present.
- Feeling angry about being addicted and the need for recovery.

(5) Inability to acknowledge ambivalence and conflicts associated with recovery
- The "I'll never use again" all-or-nothing attitude sets up failure.
- The "I can do this my way" rigid thinking results in not seeing other alternatives.
- Becoming critical and hostile when there is perceived lack of progress.
- Becoming intolerant of lapses by others in support groups.
- Failing to acknowledge urges, problems or feelings.
- Losing contact with sponsors and support people.

Phase II: Emotional and Behavioral Crises

(1) Failure to thrive.
- Loss of structure and balance in life.
- Sleep disturbances.
- Work performance difficulties.
- Isolation tendencies.
- The recovery plans begin to fall apart.
- Conflicts with family and friends increase.
- Evidence of a return to old behaviors
- Loss of self-esteem.

(2) Anger
- More unhappiness about the addiction.
- A building up of resentments.

- A blaming of others.
- Becoming more critical.
- Increased associations with an unhealthy peer group.

(3) Emotional crisis
- Becoming locked in crisis behaviors.
- Losing the ability to problem-solve or to see healthy alternatives to current behavior.
- The surfacing of core personality issues with things coming to a head.
- Beginning to feel panicky.
- Returning to impulsive behavior.
- Becoming more frustrated and irritable.
- Over-reacting to stress.
- Feeling increasingly depressed and confused.
- Becoming increasingly preoccupied with getting high.

Phase III: Setting up the Relapse

(1) Going to parties and not using.
(2) Making rationalization statements:
- "I was just testing myself."
- "I wanted to see if I could be around drugs and say no."
- "It didn't bother me to be around drugs and alcohol."
- "I don't have to change my lifestyle or friends in order to remain drug-free."

(3) Calling old friends who are using drugs or alcohol.
(4) Decreasing going to support group meetings.
(5) Cutting ties with recovering peers.

Phase IV: Active Relapse

(1) A return to using drugs or alcohol produces one of three outcomes:
- Individuals will tell someone they are using and try to get back into recovery.
- Individuals will tell someone they are using and be ambivalent about recovery.
- Individuals will not tell anyone and slip into a full relapse.

(2) Attempting to control use:
- Using drugs other than those of choice.
- Attempting to set limits on use.
- Thinking drug use is under control because they have used once and nothing happened.

(3) Withdrawing totally from support groups.
(4) Losing touch with recovering friends.
(5) Returning to denial and "self-conning" statements.
- "I just wanted to see if I could get a better high after not using."
- "I wanted to see if I could use a little and not increase use."
- "I was getting fat and needed to lose weight."
- "I just like the taste of beer."

- "If it gets bad I'll quit again."
- "I'm not addicted after all. I quit for seven days."
- "Things are so bad that I may as well use. It can't get any worse."

Phase V: Total Relapse

(1) Return to heavy and regular use.
(2) Return to dysfunctional life style.
(3) Return to old peer group.

Phase VI: Feeling Hopeless

(1) Recognition of loss of control.
(2) Development of a self-defeating attitude.
(3) Feeling that those who have helped are angry and have given up.
(4) Development of self-contempt.
(5) Emerging feelings of guilt and shame.
(6) Development of suicidal ideation.

From the above discussion, it seems clear that the processes of recovery and relapse are intertwined. And just as therapeutic interventions for treating illnesses should be designed to address the active symptoms of the illness, so should relapse prevention strategies parallel the threats to recovery at varying stages in that process. Interventions during the early stages of recovery need to focus on abstinence from the use of substances and on crisis management. Later recovery work needs to emphasize skills and supports necessary to maintain stable functioning and a drug-free lifestyle. These latter interventions are highly dependent upon empowering individuals to learn and manage the threats to recovery that could result in a relapse to drug use and mental illness symptomatology. It is primarily through acquiring self-management skills that individuals with dual disorders can maintain a healthy lifestyle and avoid relapse.

As can be seen from the preceding description of relapse prevention theory and dynamics, one particular concern of many relapse prevention specialists is the management of *high-risk situations* that may induce relapse. Since the earlier work of Marlatt and Gordon (1985), relapse prevention specialists have developed models that have been shown to be effective in teaching individuals in recovery how to manage high-risk situations. The Gorski/CENAPS Relapse Prevention Counseling model is one that has grown out of earlier cognitive-behavioral approaches to relapse prevention and has evolved into a model that can be effective for many disorders in addition to substance abuse.

Description of the Gorski-CENAPS Relapse Prevention Model

The Gorski-CENAPS system for addiction recovery has been under development since the early 1970's. The evolution of this system has integrated recent advances in medical, psychological and social sciences and encompasses a description of theoretical

formulations, therapeutic interventions, self-help methods and psychoeducational materials. The system is a comprehensive treatment program designed to "break the cycle of addiction and teach the basic skills of sober and responsible living" (Gorski, 1990). As a system that theorizes a developmental process of recovery from addiction, treatment interventions are described for six stages of the recovery process: *transition stage; stabilizatio; early, middle and late recovery stages*; and *maintenance*. The purpose of this section is to describe the system's model for *relapse prevention* as it relates to the developmental process of recovery.

The Gorski-CENAPS model views *chemical dependency* as a chronic, biopsychosocial disease resulting in abuse of, addiction to and dependence upon mood-altering chemicals and a disease that has a tendency to relapse. Thus *relapse* is seen as a normal process for many individuals in recovery. *Relapse* is defined as the process of becoming dysfunctional in recovery as a result of renewed alcohol or other drug abuse. The model views abstinence from alcohol and other mood-altering drugs, and improvement in biopsychosocial health, as the most effective goal for a relapse prevention program. This goal is based on the belief that total abstinence plus personality and lifestyle changes are essential for full recovery from chemical dependency (Gorski, 1990).

The theoretical basis for the Gorski-CENAPS system integrates the concepts of the disease model of chemical dependency, abstinence-based counseling methods and recent advances in cognitive, affective and behavioral therapies. The system has been heavily influenced by the Cognitive-Behavioral Relapse Prevention Model developed by Marlatt and Gordon (1985), with the major difference being the goal of abstinence-based treatment and greater compatibility with 12-step programs. It integrates the fundamental principles of *AA* with cognitive-behavioral therapies. Treatment is holistic in nature and incorporates the role of brain dysfunction, personality disorganization, social dysfunction and family-of-origin problems in the processes of recovery and relapse. It incorporates the use of structured group and individual counseling sessions, self-help methods and psychoeducational programs to achieve these sequential results: (1) getting individuals off drugs and alcohol; (2) stabilizing mental status; (3) identifying and controlling high-risk situations that could lead to relapse; and (4) working on core personality and life style issues to maintain abstinence and improvement in biopsychosocial health (Gorski, 1989).

Treatment, self-help methods and psychoeducational programs are organized into three basic components that coincide with the six developmental stages of recovery: a *stabilization and assessment program; a primary recovery program and relapse prevention program*. The *relapse prevention* program consists of two parts: *relapse prevention counseling*, which teaches individuals to identify and manage the *high risk situations* that lead to relapse; and *relapse prevention therapy*, which teaches individuals to identify and manage the *core personality* and *lifestyle issues* that lead to relapse after a stable period of recovery has been achieved.

The two components of the Gorski/CENAPS relapse prevention program are taught in sequential order, beginning with relapse prevention counseling. The remainder of this

section summarizes the description of the *relapse prevention counseling* model as described in the *Relapse Prevention Counseling Training Manual*, (Gorski, 1997) and presented at the Relapse Prevention Counseling Training & Certification Course held in Portland, Maine, in September 1997.

The Gorski-CENAPS Relapse Prevention Counseling curriculum is designed to teach individuals in recovery to recognize and manage high risk situations that could result in relapse to using alcohol and other mood-altering drugs. This counseling process is appropriate for individuals who are in any of the three stages of recovery (early, middle and late) and who are facing situations that put them at immediate risk of relapse. The counseling process usually can be completed in seven to fourteen sessions and is compatible with brief strategic counseling and cognitive-behavioral therapy methods.

Six admissions criteria are used to assess an individual's appropriateness for Relapse Prevention Counseling (RPC):

(1) The individual has entered treatment as a result of problems related to alcohol or other drug use.
(2) The individual has stopped using alcohol and drugs, has recovered from the symptoms of intoxication and withdrawal and has a stable mental status.
(3) The individual recognizes the relationship between presenting problems and alcohol or other drug use.
(4) The individual is willing to make a commitment to stop using alcohol and other drugs, at least for the period of treatment.
(5) The individual is facing immediate, high-risk situations that could result in using drugs or alcohol, in spite of the commitment not to.
(6) The individual is willing to complete the RPC clinical course and participate in treatment sessions without becoming resistant or disruptive.

Each individual who meets the admissions criteria for RPC will develop a treatment plan to help identify and effectively manage the immediate high-risk situations that can cause relapse. This plan, which aims to assist the individual in achieving the goal of maintaining abstinence and improving biopsychosocial functioning, includes the following components:

I. The Abstinence Contract

This contract is intended to obtain a commitment from the individual to abstain from alcohol and drug use for a specific period of time. Often, the period of time stipulated corresponds to the effective time period of the treatment plan and is renewed each time the treatment plan is updated. Components of the abstinence contract include: a summary of presenting problems; the relationship between the presenting problems and alcohol or drug use; identification of the logical consequences of continued use; the commitment to not using for a specific period of time; the identification of immediate high-risk situations; and a commitment to complete the RPC process.

II. The Relapse Prevention Plan

This plan is intended to prepare the individual to stop using alcohol or drugs quickly should a *relapse* occur. The plan consists of three questions and answers:

(1) What is the counselor supposed to do if the individual relapses or fails to honor the treatment contract?
(2) What is the individual going to do to get back into recovery once there is a relapse?
(3) Who are three significant others who can be mobilized to help and what is each of them supposed to do if a relapse occurs?

III. Identifying and Personalizing High Risk Situations

Identifying the high-risk situations that produce the urge to use drugs or alcohol is the first step in helping the individual regain control over self-defeating behaviors and using substances to suppress painful feelings and irrational thoughts. Gorski believes that it is the individual's ability to eventually lead to full recovery. In this exercise, individuals learn to *personalize* their high-risk situations by titling them in their own words and developing a brief one-sentence description that helps them own personal responsibility for the actions they take in the situation and will make the situation easy for them to remember.

IV. Mapping High Risk Situations

Mapping, or describing the exact sequence of behaviors and events of a client's identified high-risk situations, assists in analyzing the motivations that result in the client's actions. Mapping of past high-risk situations that ended in alcohol or drug usage helps the client to identify and understand the automatic and unconscious thoughts, feelings and behaviors he/she has used in coping with a high-risk situation that makes the client feel there is no choice but to use alcohol or drugs. Mapping past high-risk situations that ended without alcohol or drug use helps identify strategies used by the client that did not require the use of alcohol or drugs and helps to identify potentially new and more effective ways of coping with future high-risk situations. Mapping of immediate future high-risk situations helps identify intervention points where new coping responses can be used.

V. Analyzing High Risk Situations

This section of the treatment plan further analyzes the client's identified high-risk situations by describing the *client's thoughts, feelings, urges, actions, and reactions of others* in each situation. This chain of events is described as the **TFUAR Sequence**:

- thoughts cause feelings
- thoughts and feelings cause urges

- urges and decisions cause actions
- actions cause reactions from others

Once each high-risk situation is broken down into these five components, the client and counselor can work to re-shape the client's self-defeating actions that lead to relapse through focusing on irrational thoughts, inappropriate feelings and impulsive urges and then relating the responses of others' to the client's choice of actions. Behavioral change will come about once the client develops control over the thoughts, feelings and urges that lead to an undesirable action and the client becomes motivated to change the undesirable social response to the client's behavior.

VI. Managing High Risk Situations

This is a problem-solving activity that begins by identifying *addictive thoughts*, irrational thoughts that lead to seeking instant gratification, and teaching *feelings management* techniques in order to help the client gain control of *self-destructive urges* and *impulsive behaviors*. This problem-solving activity consists of the counselor assisting the client in identifying future high-risk situations, then identifying *three intervention points* for each high-risk situation in order to prevent a relapse to alcohol or drug use. These intervention points ask the client to respond to the following questions:

- What can you do differently (near the beginning, near the middle, and near the end) of the situation to produce a better outcome?
- How can you think differently?
- Manage your feelings differently?
- Fight your self-destructive urges differently?
- Act differently?
- Treat other people differently?

The final exercise in this section of the treatment plan focuses on having the client *generalize* the learned responses to avoid relapse in immediate high- risk situations to other high-risk situations that may arise in the future that will put the client at risk of using alcohol or drugs.

VII. Developing Recovery Plans

The final component of the relapse prevention treatment plan is developing a list of activities for the client to engage in to maintain a drug-free lifestyle and promote biopsychosocial health. These activities may include some or all of the following: *professional counseling, self-help programs, proper diet, an exercise program, a stress management program, a spiritual development program and morning and evening inventories.* Any activities chosen by the client are written into the recovery plan and a weekly schedule of these activities is outlined.

Summary

The *Gorski-CENAPS Model of Relapse Prevention* is a comprehensive system for diagnosing and treating substance use disorders. The system is based on a biopsychosocial and developmental model for treating substance use disorders. The complete model has five levels of components: *assessment and treatment planing, relapse prevention counseling, motivational recovery counseling, primary recovery counseling and relapse prevention therapy. Relapse prevention counseling,* as described in this paper, focuses primarily on teaching individuals in recovery to recognize and manage high-risk situations that may lead to a relapse to alcohol or other drug use.

As an evolutionary system, this model is constantly being revised, integrating already proven effective interventions with newly emerging research and practices in the field of behavioral health. Its past history shows that it is a model that is adaptable to a wide variety of treatment programs, settings and client needs. Presently, this relapse prevention training model is pioneering new strategies for assisting individuals with dual disorders of mental illness and substance abuse to improve their recovery rates and decrease risks associated with relapse. One recent initiative involves the application of the CENAPS model to Cluster B personality disorders among offenders in the national correctional facilities. Some adaptation of the CENAPS model also is currently used in most offender programs in correctional facilities and in community settings.

Another of the model's primary strengths is that it allows practitioners in a wide variety of treatment settings and from varying backgrounds to apply their skills directly to relapse prevention. Thus, it is ideal for use in settings that employ multidisciplinary treatment teams. It also can be effective when used in a psychoeducational format for family and consumer support group settings.

Summary of Training Initiative: Lessons Learned

The *Gorski/CENAPS Relapse Prevention Counseling Training Manual* 1997 formed the basis for the relapse prevention training conducted by Terence Gorski in September 1997. The 68 participants included behavioral health specialists, consumers and family members from the Greater Portland area of Maine. The participants were divided into diverse agency and disciplinary teams which included consumer participation in each team. The teams provided a setting in which to experience and learn the material in a cross-disciplinary format

The training manual consists of 12 modules, with each module having a standardized rating sheet using a 5-point Likert scale. The purpose of the rating sheet after each training module is to have the participants evaluate the effectiveness of the training module in terms of skill acquisition and applicability to the participants' various clinical settings.

The results of tabulating the scores from these rating sheets are summarized here:

(1) Participants' rating of their relapse prevention counseling skill level increased 47%.

(2) Overall skill acquisition rating of the Relapse Prevention Counseling curriculum increased 42%.

The inclusion of individuals in recovery from mental illness and substance abuse in this training program offered a unique and first-time experience for the presenters. Terence Gorski and Alan Trundy had not taught this relapse prevention counseling course to such a diverse audience, including consumers, prior to this training. The feedback from the presenters and participants was highly positive regarding the involvement of consumers. There was consensus that not only had participants been able to participate meaningfully in the training exercises, but that their perceptions, knowledge and experiences added a wealth of additional information to the training program. The participants strongly suggested including individuals in recovery in future training programs on relapse prevention.

Participants' subjective evaluations of the RPC training were gathered in another questionnaire developed by the CCDDC. The questionnaire asked participants to describe what they considered to be the major strengths and limitations of Gorski's training model and for suggestions for further adapting this model for use with individuals with dual disorders. The questionnaire also allowed participants to share their perceptions of the utilization of this relapse prevention training model in their work settings and asked participants for feedback on any systems barriers they would perceive in the implementation of this model in the greater Portland service area. There were a wide variety of responses to the questionnaire, due to the diverse backgrounds of the participants and their various work and living situations.

Below is a list of strengths and limitations most frequently listed by the respondents:

Strengths:

(1) The cognitive-behavioral approach to identifying, assessing and coping with high-risk situations is applicable to individuals with dual disorders.
(2) The repetition of skill acquisition exercises increases the clients' ability to apply learned skills to new high-risk situations.
(3) The highly structured training sessions help overcome learning anxiety.
(4) The "mapping" of high risk situations by having clients describe thoughts, feelings, urges, actions, and reactions helps to problem-solve and develop new coping skills.
(5) The focus on empowering clients through skill acquisition and understanding of their high-risk situations helps develop responsibility.
(6) The training is based upon a developmental model of relapse prevention.
(7) The model can be used in a variety of clinical settings.
(8) The model's emphasis upon sequential learning and skill building, critical thinking and self-awareness makes it applicable to multiple life situations.
(9) The model may be used in both individual and group settings.
(10) The development of concrete skills gives clients a sense of accomplishment and progress.

Limitations of this model in working with individuals with dual disorders were perceived as:

(1) Individuals in *early recovery* may still have some attention and concentration deficits that may limit their ability to readily assimilate the material.
(2) Individuals with *cognitive disabilities* may feel overwhelmed by the material to be learned.
(3) There is insufficient focus on addressing the symptoms of mental illness for individuals with dual disorders.
(4) Individuals must be psychiatrically stable and rid of post-acute withdrawal symptoms in order to gain maximum benefit from this model.
(5) Individuals with reading and writing deficits may have difficulty with the exercises.
(6) Individuals' attention spans need to be high in order to sit through a training module.
(7) Individuals need high motivational levels to gain maximum benefit from this training.
(8) The model may be too overstimulating and overwhelming for individuals with histories of trauma and abuse.

System-related issues that were felt to limit application of this model in local clinical settings included:

(1) The growing emphasis on short-term treatment limits the time practitioners have to work with clients.
(2) Group work is under funded and thus under utilized.
(3) The average group counseling session is only 50 minutes, so learning modules need to be shortened.
(4) Funding barriers may exist for some settings, such as shelters and acute care facilities.

Adaptations to Dual Diagnosis

During the winter of 1997/98, the CCDDC convened meetings of local providers and consumers to discuss implementation of the Gorski/CENAPS Relapse Prevention Counseling model in the Greater Portland area. These local focus groups made recommendations for adapting the model to accommodate the needs and limitations of individuals with dual disorders. These consensus recommendations are presented here.

A large number of adaptations of the Gorski/CENAPS model related to the wide cross-section of individuals in recovery from mental illness and chemical dependency being served by the representative provider communities. The provider community has recognized the need to adapt its strategies to work with individuals very early in their recovery period. Due to the lack of control over substance use and symptoms of mental illness in individuals who are in a *pre-treatment* stage of recovery, these individuals may

not be stable enough nor have clear enough cognitive processes to benefit from the full relapse prevention counseling curriculum. Pre-treatment services and interventions, such as intensive case management, shelter services, crisis intervention and stabilization programs and assertive community treatment team services, attempt to assist individuals whose illnesses have not yet been stabilized to benefit from active treatment and rehabilitation. One of the primary goals of these services is to increase the individual's acceptance and motivation for treatment. Psychoeducational approaches are commonly used to assist in increasing crisis management skills, overcoming resistance to treatment and addressing issues of denial in individuals who are pre-abstinent. A significant number of providers work with individuals who are pre-abstinent and pre-motivated for treatment.

In an attempt to utilize relapse prevention principles to assist individuals to begin their recovery processes, the focus groups looked for ways to adapt the Gorski/CENAPS model to their client populations. In individuals who are in a pre-motivated stage of recovery and who have not yet recognized their alcohol or drug use as a problem, there is a high level of denial and resistance to change. The focus of interventions, as stated previously, needs to be on building trust and therapeutic alliances, which will lower the defense mechanism of denial. Then, motivational techniques may be utilized to build self-efficacy and the need for change. An adaptation of Gorski's Relapse Prevention Counseling program for use as a psychoeducational tool to help empower individuals to recognize and manage the situations, thoughts and feelings that precipitate a relapse may prove valuable at this time.

On April 9, 1998, Hilary Ryglewicz, ACSW, in a presentation in Portland to members of the CCDDC relapse prevention training program, discussed supplemental strategies to modify treatment barriers for individuals with dual disorders who are in pre-treatment stages of their recovery from mental illness and substance abuse. These strategies include the following:

(1) For individuals who are still pre-motivated towards abstaining from the use of substances, provide motivational interventions in the mental health treatment setting or in an informal, non-treatment setting in the community.

(2) Use an educational/low-key/ non-confrontational approach such as:

- Motivational interviewing (Miller & Rollnick, 1991).
- Psychoeducation (Ryglewicz & Pepper, 1996).
- Personal engagement (Osher & Kofoed, 1989).

(3) Accept *denial, retreat, delay, non-commitment, ongoing* or *intermittent use of substances* as a normal part of the recovery process for those in a pre-motivational stage.

(4) Set limited goals for motivational/psychoeducational interventions. Expected client outcomes may include:

- Attending psychoeducational groups.
- Participating in psychoeducational groups.

- Signs of developing trust in the group and its facilitator.
- Signs of questioning or thinking about alcohol/drug use and effects.
- Talking about/acknowledging problems with alcohol/drug use.
- Talking about efforts to limit or suspend use.
- Showing interest in exploring other ways to manage negative moods/feelings.
- Asking questions about substance abuse treatment.

(5) Adapt the material, pace, style and expectations to the level of client functioning and specific problem areas. Consider such client characteristics as:

- Information processing skills.
- Reading/listening skills.
- Concentration and memory.
- Disorders of thought process and content.
- Tolerance for stimulation.
- Frustration tolerance.
- Mood/affect/emotion tolerance.
- Vulnerability to PTSD responses.
- Vulnerability to anxiety.
- Depressive thoughts and attitudes.
- Preoccupation with reality stressors.
- Suspicion, cynicism, mistrust.

(6) Anticipate special psychiatric, emotional, and social support needs to assist clients to move towards and maintain abstinence. Examples include:

- Medication compliance
- Family and social support.
- Support in AA/NA/12-step programs.
- Stress/emotional management skills training and support.

One of the major factors, therefore, in treating individuals with dual disorders lies in the greater probability of interference of thought disorder, apathy or withdrawal, overwhelming depression or anxiety with the process of developing motivation to achieve abstinence. Individuals who are in a *premotivational* or *pre-treatment* stage of recovery from mental illness and/or substance abuse comprise a large number of clients presently being served by the providers in the CCDDC. For the majority of these individuals, adaptations of Gorski's model that help to address client limitations resulting from major mental illness may prove useful.

With this recognition, the focus group participants presented recommendations for modifying the Gorski/CENAPS Relapse Prevention Counseling approach to accommodate the possible interference of the above factors in a successful program for individuals in pre-treatment stages of recovery. These recommendations include:

(1) Slowing the recovery program down:

- Using longer periods of time to cover each training module.
- Repeating verbal instructions until the exercise is fully understood.

- Taking more frequent breaks to accommodate short attention spans.

(2) Simplifying the standard questions in each module:
- Writing complex questions on a blackboard or flip chart to make use of visual cues.
- Using large visual aids to supplement written and verbal presentations.

(3) Increasing practice time for acquiring each recovery skill:
- Making liberal use of role playing to enhance practical skill acquisition.

(4) Using less of a cognitive-behavioral approach to *thought and feelings management*, and more of a psychoeducational approach.

(5) Using the Relapse Prevention Counseling curriculum on an individual basis for clients whose ability to participate and benefit from group work may be limited by mental illness or for individuals with trauma histories who may be 'flooded' by hearing others' stories of abuse or trauma.

(6) Establishing good group boundaries at the beginning of the training sessions to create a safe atmosphere for individuals with personality disorders.

(7) Using consumer study groups and ongoing support groups for cross-learning and for helping clients to master skills through repetition.

(8) Adapting the training modules and the level of recovery skills taught to address issues related to specific mental illnesses, motivational level and degree of abstinence.

Further Comments on Mental Health vs. Substance Abuse Recovery in the Dual Recovery Process

Following up on the consideration early in this monograph of the differences in the meaning of key terms of substance abuse relapse prevention when applied to mental illness, anxiety and depression, post-traumatic stress disorder and personality disorder,
it may be useful to consider how the responsibilities, choices, targets for change and prevention and expectations may differ, depending on the person's specific mental/ emotional or personality problems, and how these may affect recommendations for treatment. First,
Who is responsible for ***maintaining recovery*** and ***preventing relapse***?
How and with ***what means*** are these goals expected to be met?
In substance abuse:

Client is responsible for not initiating alcohol/drug use ('picking up') for utilizing coping skills and drawing upon available supports.
Client is to avoid substance use, attend program/meetings and utilize coping skills, 12-step groups, lifestyle changes. In other compulsive Similar responsibility and means. Controlled use and specific diets: re: eating disorders.

In major mental illness:

Client (and/or close others) is responsible for remaining on medication, with monitoring by psychiatrist and laboratory and for compliance with any other aspects of treatment plan, e.g. day program, group home regimen, psychotherapy, but not for episodes. Psychoeducation, skills training, substance abuse treatment may be offered. It is generally assumed that acute episodes will occur from time to time; goal is reduced frequency and severity.

In anxiety / depression, post-traumatic stress disorder:

Client is responsible for identifying symptoms of episode or 'relapse' and for seeking and choosing means of relief -psychotherapy and/or medication if desired - but not for preventing episodes. Psychoeducation and/or cognitive or interpersonal therapy may be offered. Lifestyle changes generally are not viewed as relevant, but specific behaviors (e.g., exercise,assertiveness) may be suggested.

In personality disorders:

Client is responsible for identifying, managing and/or changing problematic patterns of self-management and relating with others,as well as situational crises and anxiety/depression episodes that may result from personality dynamics. Medication may be offered for anxiety/depression symptoms. Crises may result in intervention by service providers. Suicidal or assaultive behavior may result in psychiatric hospitalization. Criminal justice intervention may be used. Personality disorders and appropriate treatment (cognitive/behavioral, interpersonal, psychodynamic) often are not discussed with the client and psychoeducation and treatment, if available, may be lengthy and turbulent.

Having noted that all of the terms in the vocabulary of relapse prevention change their meanings when applied to each category of mental/emotional disorders, what do we need to keep in mind in designing RP strategies for dual-disorder clients? Here are a few general considerations:

Recovery Process and Goals: Recovery for persons with substance use disorders (in an abstinence-directed model) means a process of behavioral change to support the goal of maintaining lifelong abstinence. It is a process with several stages and begins as a recovery process only when the person has committed to the goal, although stages of motivation or readiness for such a commitment to changed behavior have been identified. *'Recovery' from a major mental illness, an episode of anxiety and/or depression, and/or post-traumatic stress disorder means experiencing relief from or lessening of symptoms. The 'commitment' is to compliance with recommended treatment. 'Recovery' means recovering from a specific acute episode and learning to accept and manage a lifelong Vulnerability, but it does* ***not*** *mean that the person necessarily can prevent episodes by his or her own choices.*

Decision Points: Relapse prevention for persons with substance use disorders involves focusing attention on decision points and using critical skills in making and sticking to a decision not to use. *But a person with a major mental illness cannot 'decide' not to have an acute psychotic episode or exercise 'refusal skills' regarding such an episode. The same is true for episodes of anxiety and/or depression and for the symptoms of post-*

traumatic stress disorder. The decision points have to do with ***treatment compliance*** *and with* ***self-awareness and self-management*** *of the illness. And, of course, with the* ***decision not to use the substance as self-medication for the MH symptoms*****.**

While a person with substance abuse disorder can committ to abstinence and build an abstinent lifestyle through repeated, consistant decisions not to use and learn to use resources and coping methods to strenghten their ability to make those decisions, a person seeking relief from symptoms of mental/emotional (or 'psychiatric') disorders cannot commit to an inner experience (relief from symptoms) and can only decide to utilize resources and learned coping methods to manage these symptoms. At times, even this decision-making capacity may be compromised or unreliable due to the presence of a mental illness.

The person with a major mental illness does share with the person with substance abuse or addiction the situation of being *'in recovery'* for life. As the disease of alcoholism and the addictive potential of this and other drugs do not go away or become 'cured', the mental illness of schizophrenia or bipolar disorder is not cured, but rather *managed*, and the potential for acute episodes remains as real a threat as the potential for relapse in alcoholism and drug addiction, but, unfortunately, is less under the person's own control through a coping and decision-making process.

Further, the person with a *major mental illness*, and especially with *schizophrenia*, may suffer from changes in cognition, mood regulation and daily living and coping skills, even during periods of remission of acute symptoms. These changes may profoundly affect the person's ability to learn, practice and utilize the coping and decision-making strategies that are crucial to SA relapse prevention and, combined with lack of social network support, may make it very difficult to maintain the necessary commitment. This does not mean that an active process of recovery in substance abuse cannot be maintained, but it does imply that special supports are needed and that relapses may be more likely.

The person with *episodes of anxiety and/or depression* or with a *post-traumatic stress disorder syndrome,* by contrast, may expect, to achieve an MH recovery process that is not confined to effective management of an illness and does not assume an ongoing vulnerability to acute episodes, but rather reflects a process of effective *change in thoughts, feelings* and *ways of responding to experience and an increased ability to practice good emotional and social self-care, as well as self-awareness about recurrence of problematic emotional states.*

However, it is clearly important to identify the risks along the way for the person with *post-traumatic stress disorder* (PTSD), who commonly has been 'flooded' by traumatic experience without sufficient capacity to process it and therefore has utilized the numbing effects of substance use as a barrier to overwhelmingly intense feelings. For this reason, SA recovery for the person with PTSD must be recognized as requiring careful timing and a postponement of coming fully to grips with the experienced trauma until the

early stages are well under way of both SA recovery and cognitive-behavioral work on management of disabling thoughts and feelings.

When *personality disorder* is also involved, a need to work on *self-management skills* often persists for a considerable time, if not for life, but is combined, at least ideally, with the prospect of being able to achieve a *change in dysfunctional patterns of thinking, feeling and behavior* that can have a very pervasive effect on life functioning. If such change can be achieved, the person does not remain *vulnerable by definition*; that is, it need not be the vulnerability that is inherent in a lifelong disorder, as in the case of major mental illness.

Targets for Change and Prevention

Having looked at the various profiles of dual-disorder clients in terms of recovery and relapse and having clarified to some degree the differences in what relapse and recovery mean for people with various kinds of mental/emotional plus substance use disorders, what do we need to include in a comprehensive relapse prevention package? Some of the necessary elements are thoroughly spelled out in the relapse prevention training and in this monograph, while some have yet to be developed or need to be 'imported' from other lines of thinking in our fields. We can look at the present models in terms of the specific type of mental disorder involved, combined with the person's level of motivation or 'readiness for change'.

In all of the models described here, the *target for change is the substance use behavior*. The Gorski-CENAPS ***Relapse Prevention Counseling*** focuses on maintaining the recovery process and providing against relapse in substance use. ***Psychoeducational groups, Motivational Interviewing*** and Gorski-CENAPS ***Motivational Counseling*** are approaches tailored to a pre-recovery process of developing motivation for recovery, so *the more immediate target of change is the person's motivation for changing substance-use behavior*. Once the person has embarked on the recovery process with a commitment to abstinence, the focus is on two aspects of that process: a) *refusal skills*, or avoiding the action of using the substance ('picking up'), and b) protecting the person's *ability to choose that action* (choosing not to use) by identifying those *high-risk situations* in which the person would be most strongly tempted to make a different choice and working on the skills that offer alternatives to use.

It is in this second area, protecting the *person's capacity to make, again and again, the choice not to use*, that a broader range of skills, choices and responsibilities needs to be introduced for the dual-disorder client, identifying additional targets of change.

(1) *In major mental illness*: the person needs to commit to and practice the actions involved in taking medication, having it monitored, maintaining compliance and communication re: other aspects of the treatment plan (day program, group home, vocational rehabilitation, etc.), and utilizing support networks and resources as needed. It needs to be specifically recognized that a major mental illness, like the disease process of alcoholism, is *an ongoing vulnerability* and that this vulnerability, together with any deficits the person must deal with even in remission of the illness, affects long-term expectations for functioning after SA recovery, as well as the degree of choice, and therefore of responsibility, the person can achieve in MH recovery.

The dual-disorder client with a major mental illness needs to receive the message, as part of the SA recovery effort, that *neglect of compliance with medication and other treatments and resources and ignoring the impact of high-stress, and therefore high-risk, situations, places the dual disorder client at risk, just as 'picking up' a drink places the person with alcoholism at risk*. The relapse prevention strategies that protect the client with major mental illness from psychiatric relapse are somewhat more complicated, but no less important, if the capacity to choose not to use is to be protected. The person *cannot* choose not to have an acute psychotic episode. But she/he can and must choose to maintain the conditions -- not using substances of abuse and maintaining treatment and self-care that make an acute episode more likely.

In anxiety, depression, anger management problems, post-traumatic stress and personality disorder: what is needed to prevent, not simply an action of using, but the symptoms, feelings, behavior patterns and circumstances that may lead to that action, is still more complex, though these factors are much closer to those commonly addressed in SA relapse prevention programs. (See below.)

Gabe's *Cultures of Change* (1993) offers a detailed analysis of thoughts and feelings involved in progressive stages of lapse and relapse (*presented on pages of this monograph*). Again, the major thrust of this analysis is (not unnaturally) the SA relapse-and-recovery process. Gabe's perspective is relevant, especially to the needs of clients with *disorders other than major mental illness (anxiety/ depression, post-traumatic stress, personality)* and, of course, for other types of compulsive/addictive behavior. In its focus on *relapse*, it assumes that the client is involved in a *recovery process* with a goal of abstinence.

As in the previous models, we can see in Gabe's analysis that the primary target of change is in the choosing-not-to-use *action*, but the richness of such a detailed consideration for our purposes in working with dual-disorder clients lies in the underlying targets of *thoughts, feelings and behavior patterns* that may lead to *'relapse logic'* and the relapsing *choice to use*. In Gabe's analysis we see distortions of thought and painful feelings in their direct role in relapse, as precursors of a relapsing *choice;* but their broader, more indirect role in laying the ground of a sense for *helplessness, hopelessness* and *inability to cope with feelings and situations* offers another, equally significant window of opportunity in the possibilities for effective treatment.

While cognitive-behavioral interventions often are referred to in material about relapse prevention, the content of these interventions appears to be, for the most part, focused on the issue of use-or-refusal. In actual substance abuse treatment, however, and most prominently in the work of the *therapeutic community* (TC), broader issues of personality function and disorder (self-management, communication, problem-solving, identification of feeling states, ways of relating with others and, above all, making self- and group-responsible choices) certainly come into the foreground and become prime material of treatment. The TC historically has been regarded as the treatment-of-choice for personality disorder in the substance abuse treatment system and, indeed, it was at one time assumed that substance abuse necessarily reflected personality disorder as an underlying problem. Although we now recognize other reasons for use/abuse patterns, there is a case to be made for that viewpoint, acknowledging both that: a) a person with problems in affect regulation, self-management and interpersonal relating is vulnerable to

developing a pattern of substance abuse; and b) that a pattern of substance abuse, dependence or addiction over time depletes the ego strength and skills needed for healthy intra- and interpersonal functioning. The Pepper/Ryglewicz graphic of *The Loop and the Maze (Ryglewicz & Pepper, 1996, p. 138*) highlights the observation that the person who is abusing as a dysfunctional means of coping with/avoiding painful feelings, or who is using other forms of compulsive/impulsive behavior for that purpose, is at the same time bypassing normal opportunities for personality development through problem-solving and affect modulation. It is precisely those opportunities to develop skills and strengths through problem-solving in the 'maze' that need to be provided and practiced in treatment for personality, behavior and affect management disorders.

(2) *In personality disorders, then*: the person needs to overcome, not only the urge to use a substance to cope with/escape from a problem, conflict or painful feeling, but also the enduring and often ego-syntonic (acceptable-to-the-self) patterns of thinking, feeling and behavior that are expressed in more general problems: episodes of anxiety and depression; problems in self- and affect management; problems in relating with others and/or taking responsibility; and, in many cases, suicidal and/or assaultive behaviors. Interventions to be developed in these areas might include:

a) *Cognitive-behavioral work* with a broader focus than that already present in SA relapse prevention counseling, utilizing the work and workbook or self-help materials of such cognitive therapists as Linehan (1993), Young (1994), Young & Klosko (1994) and others, to address cognitive/emotional and interpersonal distortions on a level of detail comparable to that devoted to relapse prevention skills. Such work is usefully done in either the group or the individual modality, though, of course, group is preferable both as a natural laboratory of interaction and for time-effectiveness.

b) *Therapeutic community/milieu* in cases of severe personality disorder, especially involving antisocial and/or borderline behaviors. This might be provided in a modified TC or drug rehabilitation facility, a halfway house or an adolescent group home modified for the purpose of serving older 'young adults'. (The clinical group home, residential treatment facility and residential shelters utilized in the child foster care system can be seen as the historical counterpart of the TC, addressed not to drug use but to deficits in personality development and socialization, often resulting from inadequate family and community structure and support. We do not have a counterpart for adults living in our present society, except in the form of group homes for mentally ill persons and rehabilitation units for substance abuse treatment, neither of which is speci-fically focused on personality development; but, this does appear to be a sorely needed (if overambitious) community service, since so many adults have not experienced the structure and nurturing that are necessary for healthy personality development.)

c) In the absence of a TC in the form of a residence, a *modified day or evening program* directed to cognitive/emotional/behavioral learning and personality development, perhaps provided as an enhancement of a residential care, rehab or shelter setting.

d) Antidepressant medication may be used for overwhelming affect that threatens the treatment and recovery process.

(3) *In post-traumatic stress disorder*: (with or without underlying or resulting personality disorder) the person needs to go through carefully sequenced stages of intervention and treatment, acknowledging that the triggers for use, continued use and relapse are probably overwhelming affective states:

a) for which the person needs new supports and coping skills as alternative to substance use; and

b) that can emerge or worsen when abstinence is undertaken and/or when the traumatic material becomes a focus of treatment.

For these reasons, the treatment/intervention plan should *begin* with developing skills in *affect modulation and management* (relaxation, visualization, cognitive/ behavioral work), in the time span of the Prochaska/DiClemente *preparation for action* stage (p. *of the monograph*) and can continue concurrently with the beginning of *abstinence-based treatment and relapse prevention*. While PTSD symptoms are likely to be present or recur and, of course, need a response in the context of affect management, the more traditional therapy of 'flooding' and/or delving into past traumatic experience should follow a well-established SA recovery process or it may itself become a trigger for relapse and a serious risk to the client. The sequence suggested is from cognitive-behavioral work on affective states, through substance abuse treatment, followed by remaining psychodynamic and/or other post-traumatic therapies. Consideration should be given to techniques specifically designed for post-traumatic stress, such as EMDR (Eye Movement Desensitization and Reprocessing) (Shapiro, 1005, 1997) Antidepressant medication may be needed to treat symptoms of depression and anxiety during the recovery process.

(4) *In anxiety and/or depression episodes*: attention needs to be given to baseline or 'premorbid' (pre-episode) functioning. Was the person prone to disabling anxiety or depression previous to beginning substance use? While anxiety and depression are a familiar aspect of the post-withdrawal syndrome, there are dual-disorder clients whose vulnerability to these affective states puts them at chronic high risk of relapse. For such clients, as well as for those experiencing overly intense affect associated with PTSD and/or personality disorders, *antidepressant medication* is in order and may be used selectively for *anxiety* states as well, while anti-anxiety medications, and specifically benzodiazepines, need to be avoided. Cognitive-behavioral, interpersonal and/or psychodynamic therapy is likely to be indicated following or concurrent with establishment of an SA recovery process. The underlying sources of anxiety and depression need to be determined for each individual and therapy offered as needed. As with major mental illness, although to a milder degree, the person may not be able to avoid acute episodes even by practicing appropriate treatment compliance and self-care. However, again as with MMI, there does need to be psychoeducational and cognitive-behavioral work to offer information, skills practice and the message of responsibility for the choices and level of self-awareness that will make relapse on the mental/emotional continuum less likely.

In summary, the exploration of what *recovery* and *relapse* mean on the substance abuse and the mental/emotional disorders axes gives rise to an ambitious understanding of what

components, expectations and responsibilities need to be part of relapse prevention for the individual with dual disorders. Key to this effort are the principles of:
(1) Fitting the type of SA recovery intervention to the level of motivation (or stage of readiness for change) of the client.
(2) Fitting the pace and content of the SA relapse prevention counseling to the mental status and specific mental/emotional disorder of the client.
(3) Including cognitive-behavioral and skill training work, not only regarding substance refusal skills and high-risk situations for substance use, but also regarding the specific mental/emotional disorders, in the relapse prevention package.
(4) Including special supports, recommendations and medications as needed for specific mental/emotional disorders and affective states.
(5) Delivering a message of responsibility, not only for the *action* choice not to use, but also for the choices involved in maintaining treatment, medication compliance, utilization of support networks and other resources, and self-monitoring that may protect and help to maintain the mental status and/or emotional state that is needed in order to 'choose not to use'.
(6) Utilizing cognitive-behavioral and, if possible, community/milieu interventions and training to help clients to change problematic patterns of thinking, feeling and behavior that are involved in personality disorder and, in turn, give rise to affective states and crises that tend to provoke relapse.
Some of these elements are included or implied in the models of intervention presented in this monograph. Others may need to be developed within or supplementary to the Gorski-CENAPS and/or other systems of intervention.

Conclusion

Specialized treatment for individuals with mental illness and chemical dependency is relatively new. Interventions designed to assist individuals who are in recovery to minimize threats to their recovery continue to evolve as health care emphasizes maximizing benefits of treatment for the consumer and reducing the length of the time insurance companies will reimburse individuals in treatment. It is important to keep in mind that, although individuals with mental/emotional and substance abuse disorders do recover, they may not do so quickly or in a linear way. It is vital, however, that behavioral health specialists who are working with this population continue to believe in the hope of recovery for each individual and to continue to advocate for improved treatment interventions to assist that recovery process.

Regional service systems must continue to examine and assess a wide range of treatment/rehabilitation options to assist individuals with mental illness and substance abuse disorders through their recovery processes. A comprehensive continuum of care for individuals with dual disorders will include:

- Inpatient dual diagnosis services.
- Partial hospitalization services.
- Outpatient services in both mental health and substance abuse systems.
- Medication clinics.
- A wide range of residential services, ranging from transitional to long-term
- supervised/supported housing.
- Case management services.
- Preventive services.

- Natural and consumer support services.

The participants in this relapse prevention training initiative recommended that additional relapse prevention training programs include:

- The Gorski/CENAPS Relapse Prevention Therapy training program.
- Training for the development of consumer-run and professionally facilitated relapse prevention, aftercare, and recovery groups.

Wilson (1992) suggests that future research in the relapse prevention area address the following related issues in order to help advance relapse prevention strategies:

- Are the causes of relapse during short, medium, and long term recovery periods the same?
- Are the processes that initiate a relapse related to the basic mechanisms that are responsible for the original onset of the disorder?
- The need for measuring adherence to the skills learned in relapse prevention training after individuals have entered a maintenance stage of recovery.
- What are the differences between individuals who relapse and those who do not?

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