



Relapse Prevention

Jennifer S. B. Moran, MA, TTS

Learning Objectives

- Describe cognitive, behavioral, and pharmacologic relapse prevention concepts that may be introduced early in a tobacco dependence intervention and applied throughout the counseling relationship.
- Identify common high risk situations and thoughts that may lead to a lapse or relapse, and discuss strategies for collaboratively addressing them.
- Discuss useful content for follow-up sessions, including strategies for recovering from a lapse.

Tobacco Dependence=Chronic Disease

- “A chronic disease model recognizes the long-term nature of the disorder with an expectation that patients may have periods of relapse and remission.” US Dept of Health and Human Services, 2008
- **Reminder:** Tobacco Dependence is similar to other chronic conditions, requiring ongoing, rather than just acute, care:
 - Diabetes
 - Hypertension
 - Hyperlipidemia

Relapse Prevention – Key concepts

- Relapse is common, but not inevitable.
- Relapse Prevention begins at the beginning – **at the initial assessment**, not after a relapse.
- Preventing relapse requires behavioral, cognitive, and usually pharmacologic components.
- Initial and follow-up counseling involves learning to anticipate and cope with the challenges which pull one toward relapse.

Relapse Prevention: Background

- More than 70% of smokers report wanting to quit, and 44% report trying to quit every year.
 - Most of these attempts are unaided and unsuccessful
- Of the 19 million adult smokers who attempted to quit in the US in 2005, 4-7% were likely successful (after 1 year)

US Dept of Health and Human Services, 2008

“Nine out of ten ex-smokers who have a cigarette after quitting later return to smoking.”

Thomas Brandon, PhD

Terminology

- **Abstinence:** no use of tobacco at all
- **Lapse:** isolated or single use of tobacco, a “slip”
- **Relapse:** return to regular use of tobacco, after a period of abstinence
- **Relapse Crisis:** any situation in which the temptation to smoke occurs

*Marlatt G., and Gordon, J.

Quitting Tobacco Use is a Process

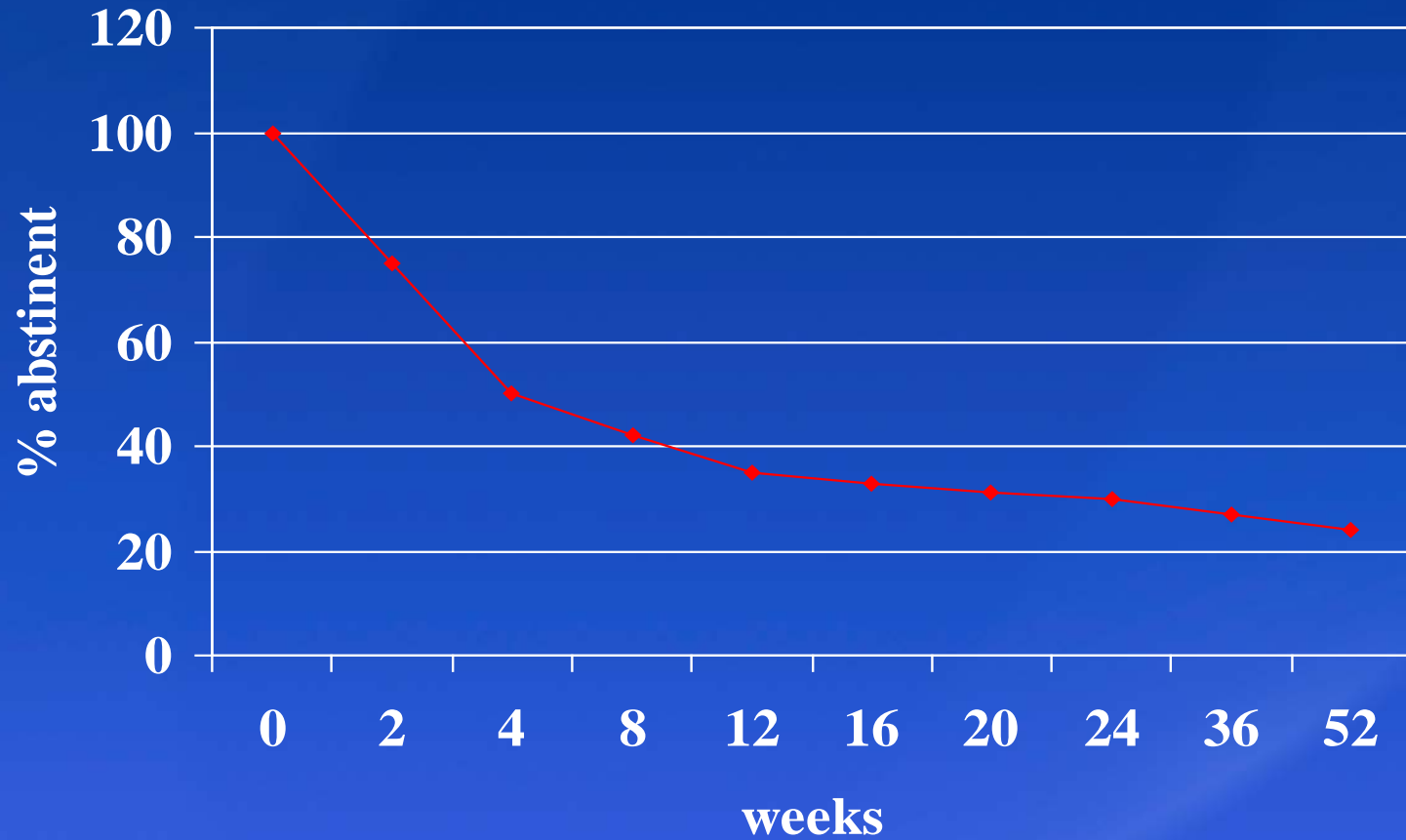
For most people, quitting doesn't happen overnight. It is more like embarking on a journey full of uncertainties, of undetermined length, fraught with challenges. Wrong turns are not uncommon.

“...virtually all successful quitters had prior unsuccessful attempts.”

Seidman, D., F. and Covey, L. S.

Relapse after cessation

Early follow-up is crucial



“Once we understand the nature of recovery, the various risks are laid out before our feet like traps along a jungle trail. They’re only dangerous if you can’t see them, or if you fail to take the necessary steps to avoid them. Like those of the jungle, the traps of relapse can be baited to seem quite seductive.”

Ronald L. Rogers, “Relapse Traps,” 1992

Predictors of Tobacco Abstinence

Increased:

- Older
- Fewer Cigarettes
- Lower Fagerstrom
- High Motivation
- Higher self-efficacy and confidence
- Supportive social network

Predictors of Tobacco Abstinence

Increased:

- No evidence of depression
- Low nicotine dependence
- No alcohol
- Hospitalized – Smoking related disease
- Nonsmokers for major support system

Predictors of Tobacco Abstinence

Decreased:

- High nicotine dependence
- History of psychiatric comorbidity
- High stress level
- Negative affect

Relapse Prevention: Background

- Relapse is common, but not inevitable!
- Most relapse-prone period is first few days after quitting
- Staying quit during the first week is a positive predictor of long-term abstinence
- Odds for long-term abstinence generally improve as the number of smoke-free days increases

Relapse Prevention

- Strategizing with patients how to anticipate and cope with the challenges which pull them toward relapse.
- Requires both behavioral and cognitive components.
- A self-management program designed to strengthen the maintenance stage of the change process.

“Fire Plan”

- Put it out - get rid of tobacco.
- Think of that cigarette as a “slip” instead of a “relapse”.
- A “slip” doesn’t mean all is lost.
- The sooner you try to quit, the easier it will be.
- Use coping skills
- Rather than punishing yourself, learn from your experience.

Abstinence Violation Effect (AVE)

- Lapse creates dissonance with self imposed rule (abstinence)
- Negative feelings: guilt, shame, blame
- Self- attribution: lapse caused by personal weakness, character flaws
- Reduced ability to resist the next one

Marlatt G., and Gordon, J.

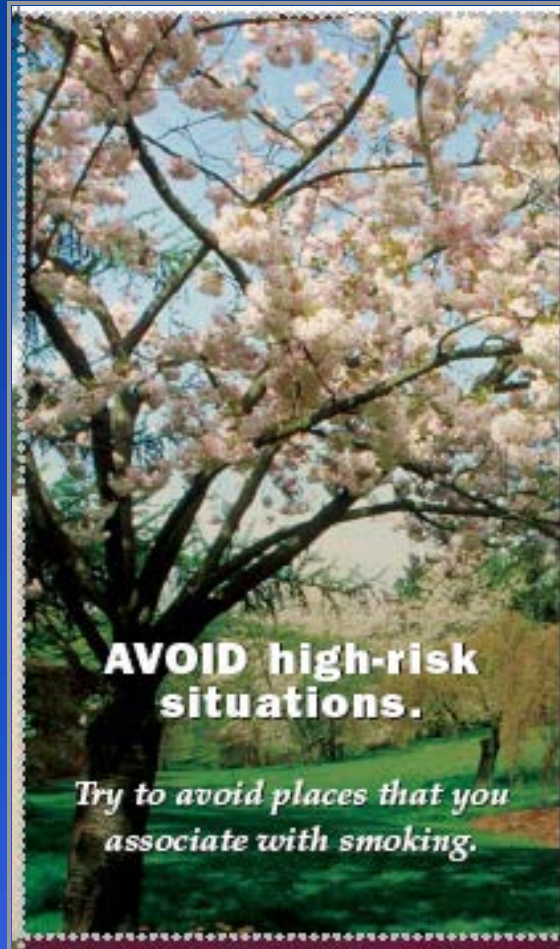
Reaction to a Lapse

- “Cognitive and affective reactions to the slip or lapse, exert a significant influence that may determine whether or not the lapse is followed by a relapse” Marlatt and Gordon
- Not a failure.
- Not “all or nothing.”
- Opportunity for learning/insight.

Benefit from a lapse

- A lapse can provide useful information.
 - The When, Why and How lapse occurred.
- How to anticipate its occurrence in the future.
 - Develop an action plan.
- A lapse is a common experience within the recovery process.

Coping cards



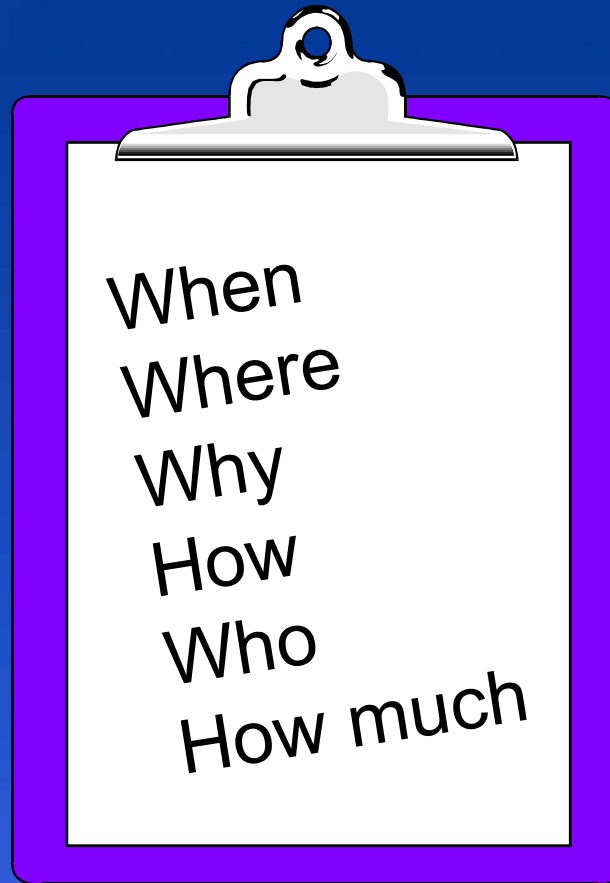
On my path...

I will avoid these high-risk situations:

High Risk Situations

- Negative emotional states
- Interpersonal conflict situations
- Social pressure situations

Developing a relapse prevention plan starts at the beginning, at the initial assessment.



What you bring to the session: A Motivational Approach

- Stopping permanently is a process
- Average successful quitter makes several quit attempts
- Build on client's strengths
- Expect success: relapse is not inevitable!
- Congratulate any success in past
- Relapse prevention should be part of every treatment plan

Relapse Prevention

Provide Social Support

- Intra treatment: relationship between treatment provider and patient
 - Demonstrate good counseling skills
 - Pay attention to total counseling environment
- Extra treatment: Relationship between patient and his/her social environment
 - Identify sources of support
 - Help arrange support
 - Role play asking for support



Situations and coping skills

- “Relapse occurs at the intersection of a triggering situation and a deficient coping response”
 - Marlatt and Gordon



Cognitive-Behavioral Approach



- Emphasizes recognizing negative thoughts or “red flag” thinking
- Focuses on positive self-affirmations and may include rewards
- Explores with clients how thoughts affect feelings, behaviors and environmental events

Use Cognitive Skill Building

- Identify patient-specific previous relapse events, thoughts and feelings
 - Events: what preceded the first lapse?
 - Thoughts: what thoughts did you have about a lapse? (ie. did you give yourself an option of smoking if things got too bad?)
 - Feelings: what were you feeling when you lapsed? How did you feel after?

Use Cognitive Skill Building

- Develop a patient specific plan for events associated with past relapse
- Offer information on usual high risk situations (interpersonal stress, alcohol use, other smokers, social events, cravings, highly stressful event, weight gain, negative mood)
- Develop a “fire plan” for the “what ifs?”

Cognitive Coping Skills

- Tell yourself, “I can do this.”
“Smoking is not an option anymore.”
- Remember the reasons you want to quit.
- Tally the progress you’ve made so far.
- Remind yourself smoking will not solve any of your problems.
- Recall where you want to be and how smoking gets in the way of reaching your goal.

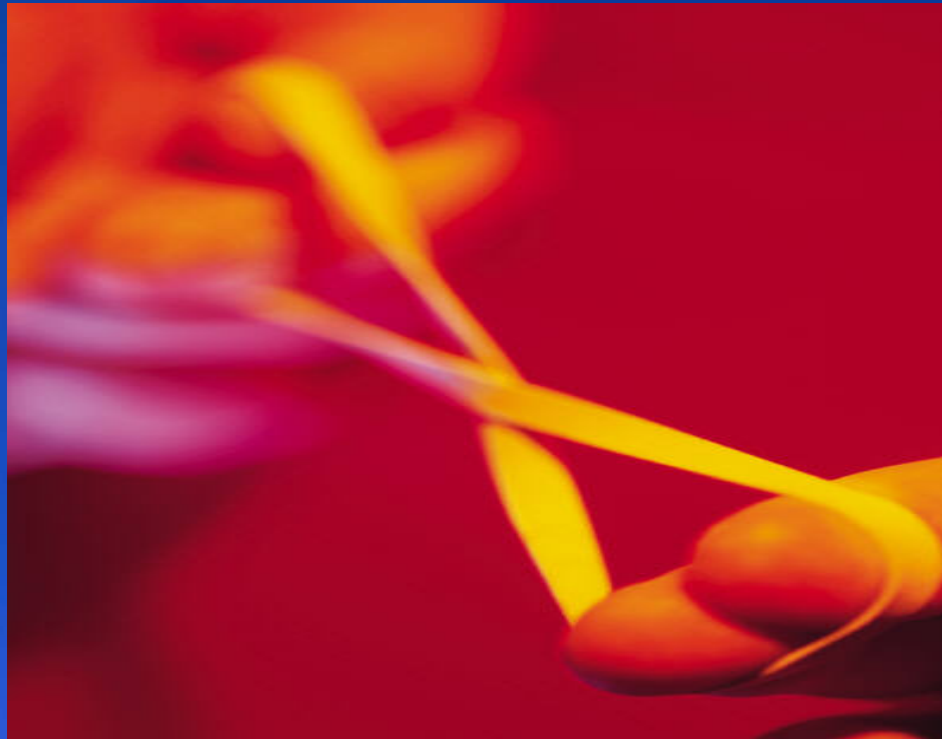
Cognitive Coping Skills

Imagery

- Elicit from the patient:
 - “How do you envision yourself as a non-smoker?”
 - “How will your life be different?”
- This kind of imagery is positive, motivating and empowering.
- Learn to call upon this imagery whenever you need it.

Behavioral Coping Skills

Assist clients with methods for coping with 5 minutes of craving



Behavioral Coping Skills

- Leave the situation
- Take a deep breath
- Chew gum
- Eat something
- Go for a walk
- Call a friend
- Exercise

What is counterproductive:

- Relying on “willpower” alone.

Avoiding asking for support; avoiding NRT

- “I am just not going to smoke.”
 - No real, practical plan.
 - Become worn down by urges.
- Judge themselves for having urges.
 - “I am weak for wanting a cigarette.”
 - “I’ll never get over wanting to smoke.”
 - “This is too hard, I’ll quit some other day.”

Carbon monoxide: pre and post quit date

The dangers of carbon monoxide

One of the chemicals found in large quantities in cigarette smoke and one of the most harmful is carbon monoxide (CO). One reason it's so harmful is because it takes the place of some of the oxygen in your blood. Your organs, such as your heart and brain, need oxygen to function normally. When you smoke, CO prevents these organs from getting all the oxygen that they need. Your heart and your lungs have to work harder to get enough oxygen to the rest of your body.



You can measure the CO level in your breath with a CO monitor (at left).



Another CO source

My carbon monoxide (CO) levels

Today's level: _____ Date: _____

Follow-up level: _____ Date: _____

The good news is that within *hours* after your last cigarette, your CO level begins to decrease, and within *days*, it's out of your system, so your body can begin to heal.

Pharmacotherapy and Relapse Prevention



The body's response to the absence of nicotine

- If patients can anticipate these symptoms in advance they are more likely to:
 - understand** what is happening to them
 - plan** for what is happening
 - respond** appropriately
- Withdrawal symptoms and urges to smoke are not necessarily one and the same.

Signs of withdrawal vary from individual to individual

anger

frustration

anxiety

hunger

constipation

impatience

craving

increased eating

depression

irritability

desire to smoke

nausea

difficulty concentrating

nervousness

difficulty with sleep

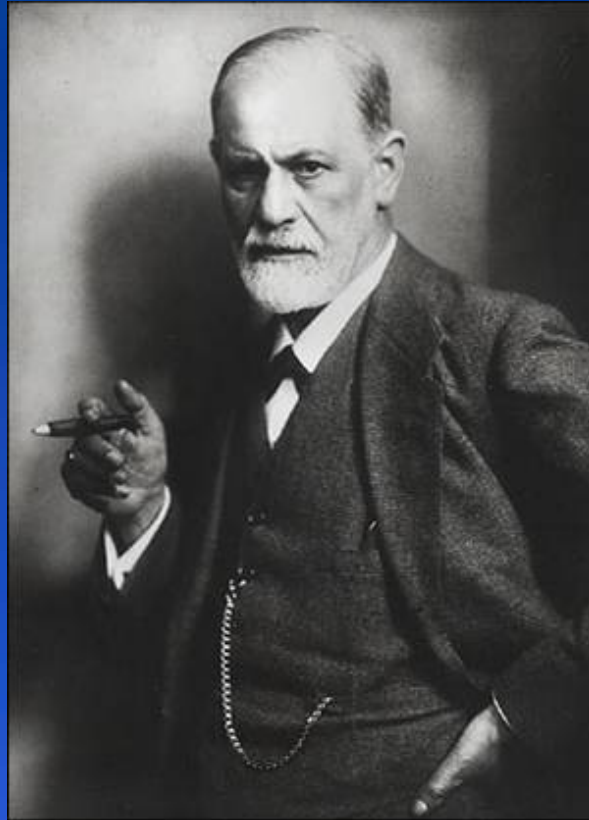
restlessness

fatigue

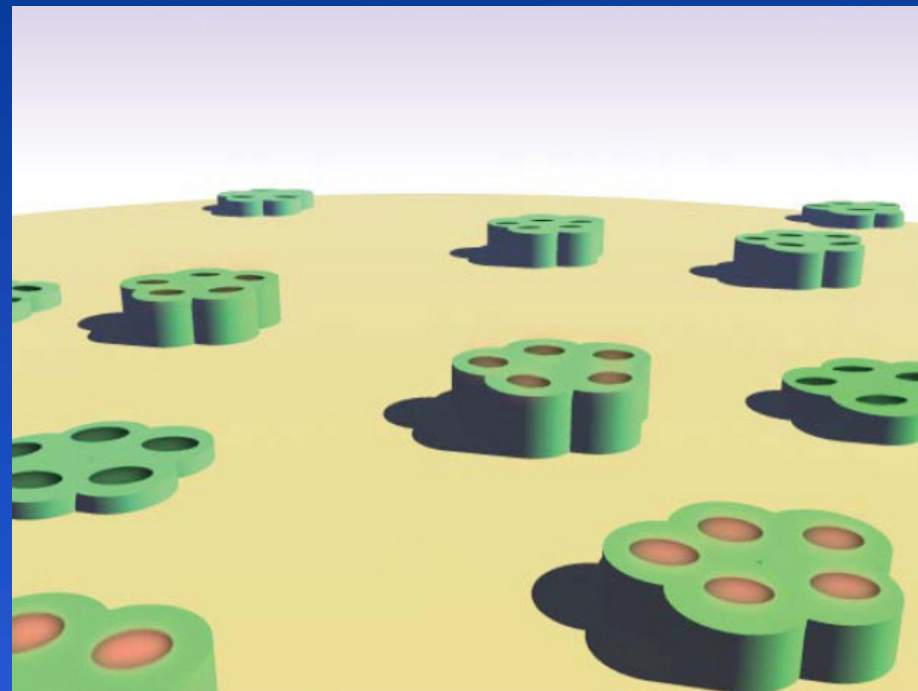
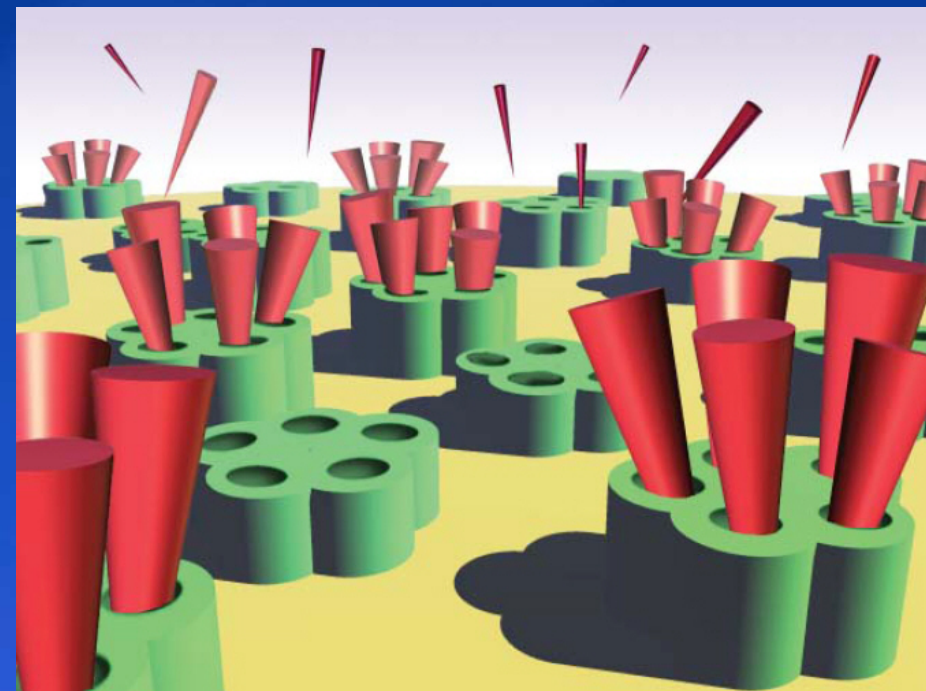
shakiness

**14 months of
abstinence...**

**Followed by a
relapse.**



**“[Not smoking]
Is torture
beyond
human power
to bear.”**



Relapse Prevention and Pharmacotherapy:

- Individualized medication plan.
- Medication education with options.
- Review previous use of medications.
- Optimizing by changing meds, increasing dose and/or length of treatment.
- Combination therapy.
- Empower patient to be “best judge” of withdrawal symptom management.
- Follow-up is essential.



Extended use of NRT's can prove very helpful:

- Relieving intermittent cravings occurring after a regular dose regime has ended.
- Enhancing refusal skills for severely dependent smokers who have a history of many failed cessation attempts after ending NRT.
- Coping with stressful situations which trigger urges to smoke even many months after stopping smoking.

Important points to recognize

- Urges or cravings are a normal part of the quitting process.
- Over time, the ability to recognize different types of urges develops:
 - Early-on cravings are recognized as physical withdrawal.
 - Issues related to emotional dependence often arise later on.
 - Over time thoughts and memories of smoking become easier to accept and manage.

Discuss “just one” thinking

- Clear goal – not a single puff.
- To do whatever it takes to avoid having any cigarettes.
- Urges to smoke can be very powerful, but are usually short!
- “I choose not to smoke today.”
- Promote a safe environment.
- Remind patient of the physiology of tobacco addiction.

Follow-up Plan:

- Congratulations and encouragement to remain tobacco-free.
- Discuss:
 - Abstinence experience- review positives/negatives
 - Withdrawal management and issues
 - Proper medication use, management and side-effects
 - Benefits of quitting
 - Planned behavior changes/discoveries along the way
 - Support
 - Check CO

Follow-up Plan continued:

- Reassess motivation
- Re-evaluate triggers -adjust coping skills
- Increase support with regular follow-up counseling or calls
- Need to address any other barriers to quitting?
- Schedule next follow-up



The Treatment Environment for the Patient who Lapses

- The counseling environment needs to be welcoming and nonjudgmental
- Be aware of the thought process related to the lapse (cognitive-behavioral approach)
- Support self-efficacy

Common Problems and Suggested Approaches

- Lack of support for cessation
 - Schedule visits/calls
 - Identify support sources
 - Refer to local support groups
- Negative mood or depression
 - Provide counseling
 - Appropriate medications
 - Referral

U.S. Dept. of Health and Human Services

Common Problems and Suggested Approaches

- Strong or prolonged withdrawal
 - Check dose of medication
 - Extend use of medication
 - Add medication (combined therapy)



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Common Problems and Suggested Approaches

- Weight gain
 - Encourage physical activity
 - Discourage strict dieting
 - Longer pharmacotherapy
- Reduced motivation (feeling deprived)
 - Reassure
 - Recommend rewarding activities
 - Educate about a “lapse”

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Common Problems and Suggested Approaches

- Many smokers report drinking alcohol during or prior to relapsing.
- Why is alcohol use such a high risk.
 - Habit- alcohol and cigarettes go together for many people.
 - After a few drinks it is more difficult to resist.
 - Cigarettes are often found at places where alcohol is served.

Common Problems and Suggested Approaches

- Stressful event or interpersonal stress
 - Identify short term stress management skills
 - Develop life style changes to reduce stress
 - Refer to specialist in stress management skill development

STRESS MANAGEMENT

- Sources of stress
 - Relationships
 - Job
 - Transitions
 - Natural occurring events
 - Health Problems



STRESS MANAGEMENT

- Strategies for managing stress
 - Problem solving
 - Decision making
 - Time management
 - Assertiveness training
 - Conflict resolution
 - Support



STRESS MANAGEMENT

- Behavioral Tasks
 - Exercise
 - Amount of sleep
 - Eating right
 - Deep breathing
 - Relaxation exercises
 - Hot baths
 - Music
 - Hobbies (fishing, painting, etc.)



Follow-up planning summary:

- Congratulates or reassures.
- Assesses nicotine withdrawal.
- Assesses proper use of medication and adequate withdrawal management.
- Discusses triggers/urges, and “new discoveries”.
- Discusses high risk situations .
- Assesses utilization of coping skills, makes adjustments.
- Discusses support system.
- Increases patient confidence.

Bibliography

Berkem D. (2003). The Influence of withdrawal symptoms and catastrophic thinking on smokers' self-efficacy. Addictive Disorders & Their Treatment, 2(3), 97-104.

Carmody, T. P. (1992). Affect regulation, nicotine addiction, and smoking cessation. Journal of Psychoactive Drugs 24(2), 111-122.

Corsinis, R. J. & Wedding, D. (1995). Current psychotherapies (5th ed.). Itasca, IL: F. E. Peacock Publisher, Inc.

Doherty, K., et al., (1995). Urges to smoke during the first month of abstinence: relationship to relapse and predictors. Psychopharmacology 119, 171-178.

Marlatt, G. A., & Gordon, J. R. (1985). Relapse prevention. New York: The Guilford Press.

Seidman, D. F. & Covey, L. S. (1999). Helping the hard-core smoker. New Jersey: Lawrence Erlbaum Associates, Inc.

U.S. Department of Health and Human Services, 2008. Treating tobacco use and dependence. Public Health Service.