



# Relapse Prevention and Follow-Up

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# Learning Objectives

- Provide a rationale for addressing the issue of Relapse Prevention before it ever occurs.
- Distinguish between a lapse and a relapse.
- Understand the research evidence for common relapse triggers.
- Recognize the importance of including Relapse Prevention ideas in the Initial treatment plan in addition to follow-up sessions.

## Learning Objectives (cont.)

- Identify high risk situations common to relapse and less obvious relapse triggers.
- Identify cognitive-behavioral methods for managing relapse triggers and/or relapse itself.
- Develop individualized relapse prevention plans through the use of case studies.

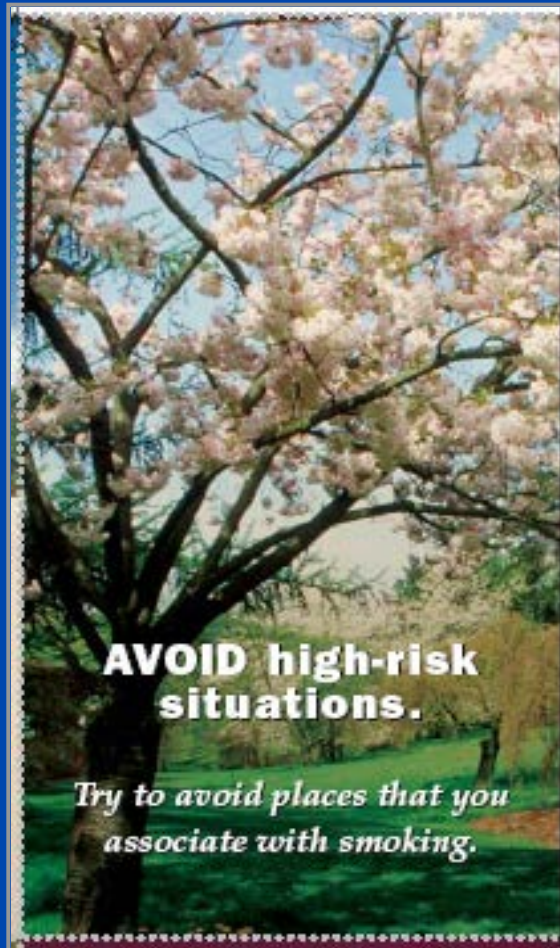
# Why even talk about Relapse and Relapse Prevention?

- Doesn't talking about it encourage it?
- Doesn't bringing up the topic assume the person is bound to relapse?
- Aren't we giving a double-message by initiating conversations about Relapse Prevention while simultaneously telling people, *“Now, don't you go and relapse!”*?

# Relapse Prevention

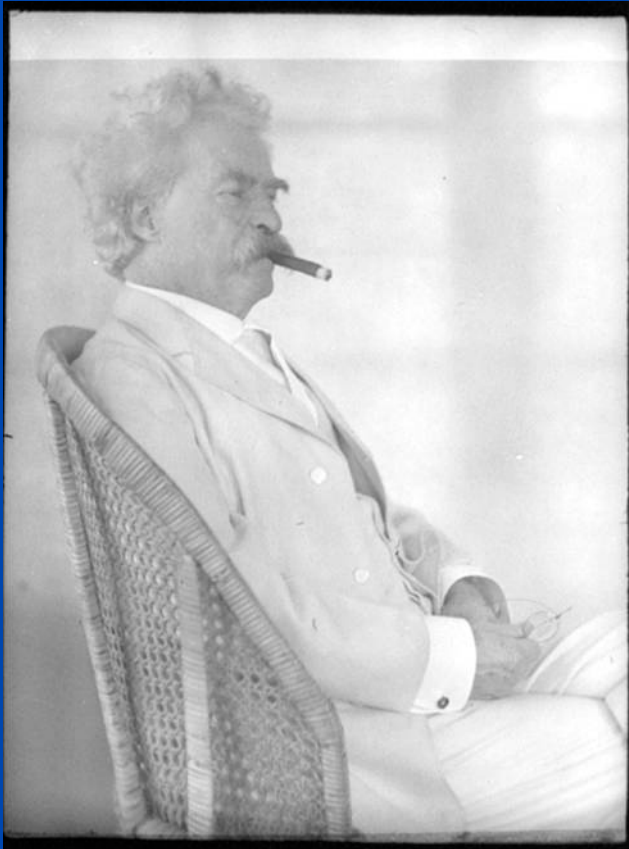
- Relapse is common, but not required.
- How to anticipate and cope with the problems which pull one toward relapse.
- Requires both behavioral and cognitive components.
- Relapse Prevention begins at the beginning – **at the initial assessment**, not after they've relapsed.

# Coping cards



**On my path...**

*I will avoid these high-risk situations:*



- “To cease smoking is the easiest thing I ever did...

I ought to know; I’ve done it a thousand times.”

- Mark Twain

# Relapse Prevention: Background

- More than 70% of current smokers have had at least 1 quit attempt
- 44% of adult smokers try to stop each year but <5% achieve long-term smoking abstinence

U.S. Department of Health and Human Services, June 2000





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

Thomas Brandon, Ph.D.

# 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

# 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.

# Relapse Prevention

The nature of smoking cessation:

**It is a process**

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

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

# Relapse Prevention

- Teaching patients how to anticipate and cope with the problems 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.

# Predictors of Tobacco Abstinence

## Increased:

- Older
- Fewer Cigarettes
- Lower Fagerstrom – level of dependence
- High Motivation
- High self-efficacy

# Predictors of Tobacco Abstinence

## Increased:

- Supportive social network
- Previous quit attempts
- 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
- Low self-efficacy



# Relapse Process

- Relapse seldom occurs as the response to a single event. Typically, it is the result of moving slowly, incrementally further away from one's "path".
- Loss of a "recovery mindset".
- Relapse then occurs.

# High Risk Situations

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

# Situations and coping skills

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



# “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.

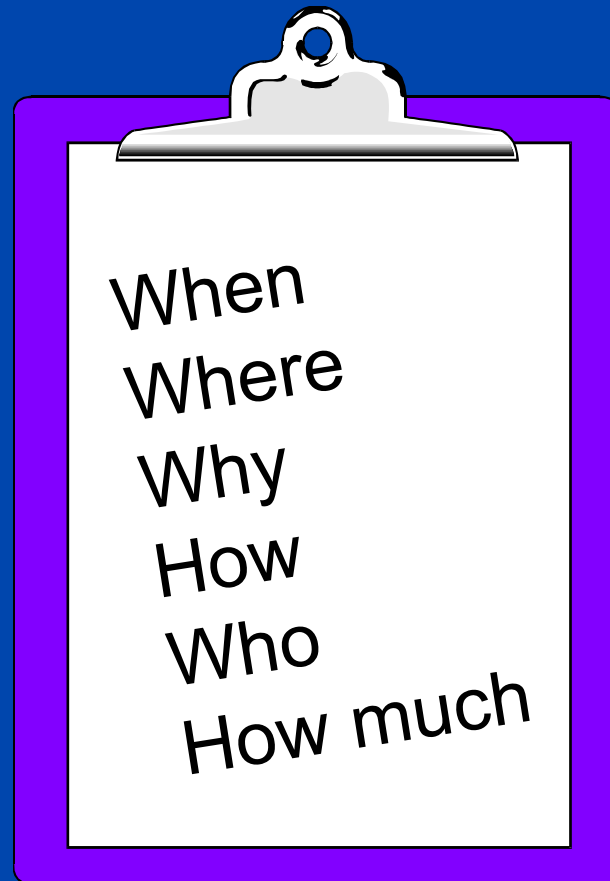
# Reaction to a Lapse

- “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.

# Developing a relapse prevention





# What you bring to the session: 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



# Cognitive-Behavioral Approach

- Emphasizes recognizing negative thoughts or “red flag” thinking
- Focuses on positive self-affirmations and may include rewards
- Teaches 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.

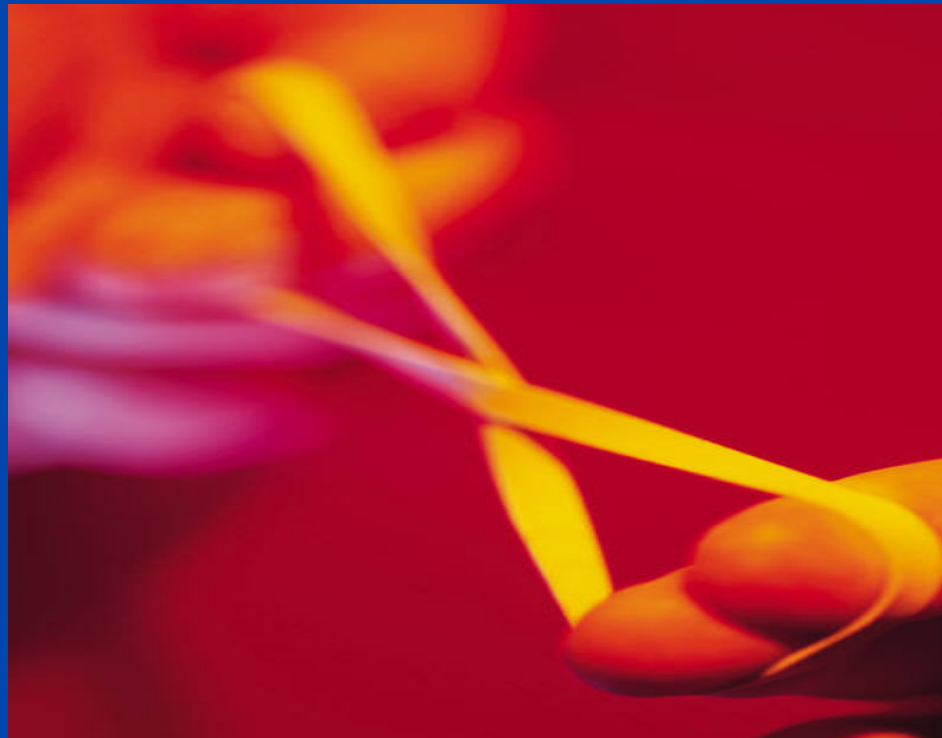
# Cognitive Coping Skills

## 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 does not work:

- Relying on “willpower” alone.

Even the Lone Ranger had Tonto!

- “I am just not going to smoke.”
  - No real, practical plan.
  - Become worn down by urges.
- “Beat up” on 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: \_\_\_\_\_

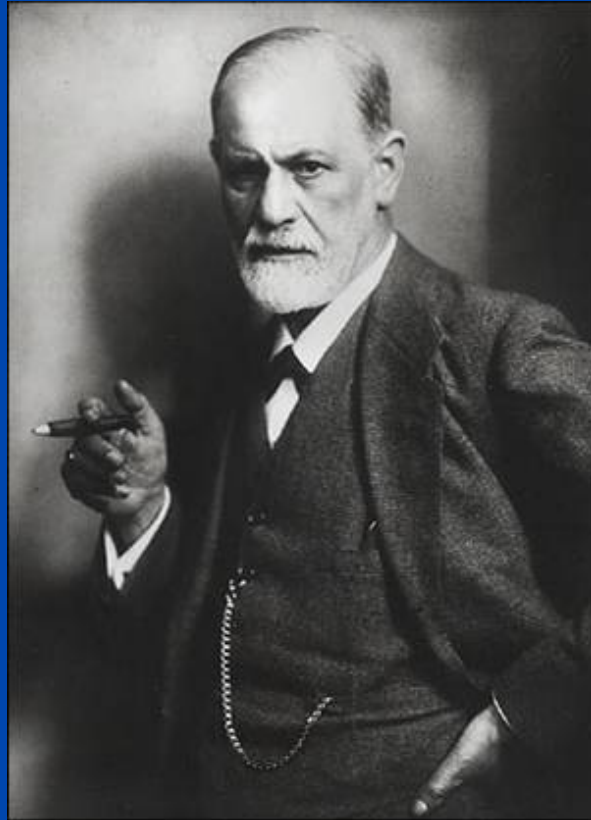
The good news is that within *hours* after your last cigarette, your CO level begins to decrease, and within *days*, it's out of your system, so your body can begin to heal.

# Pharmacotherapy and Relapse Prevention



**14 months of  
abstinence...**

**Followed by a  
relapse.**



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

# 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.

# The body's response to no more 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

anxiety

constipation

craving

depression

desire to smoke

difficulty concentrating

difficulty with sleep

fatigue

frustration

hunger

impatience

increased eating

irritability

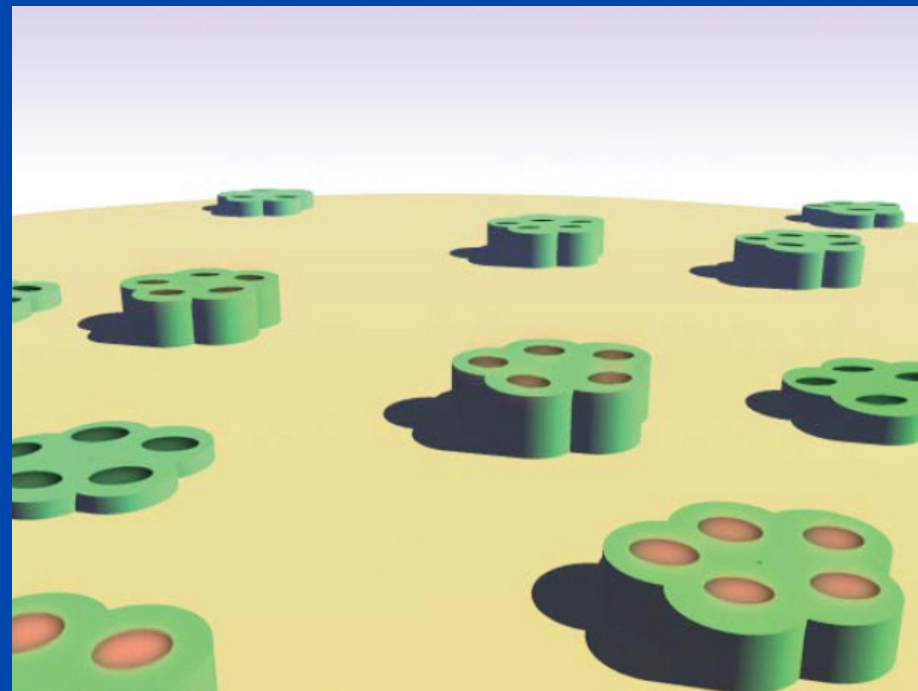
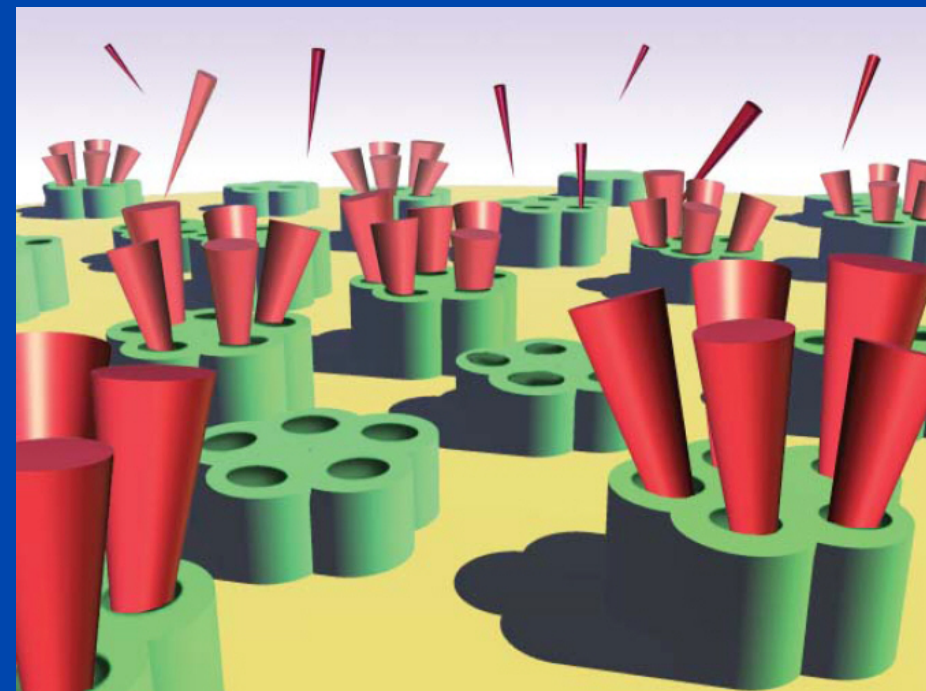
nausea

nervousness

restlessness

shakiness





# 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.

# Discuss “just one” thinking

- Clear goal – not a single puff.
- To do whatever it takes to avoid having any cigarettes.
- Addiction is addiction.
- “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)



*U.S. Dept. of Health and Human Services*

# 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”

*U.S. Dept. of Health and Human Services*

# 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

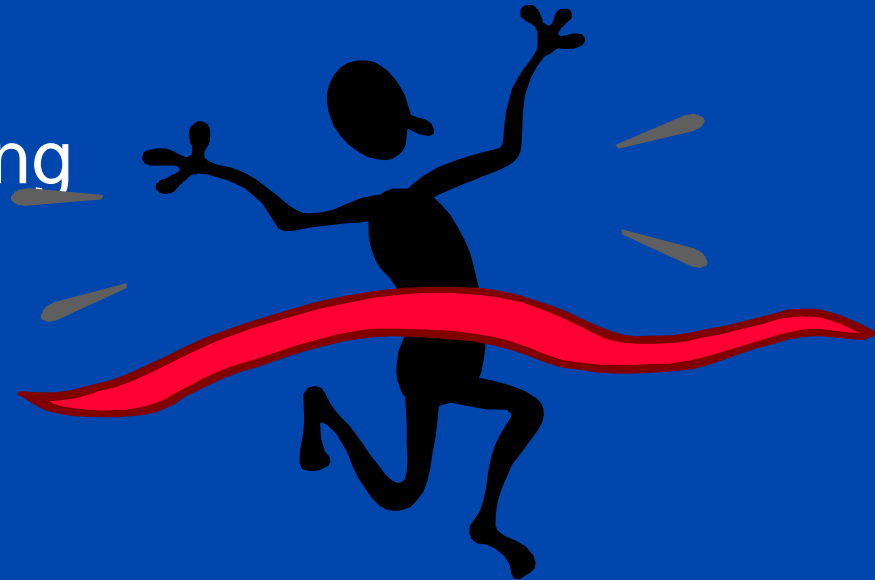
# STRESS MANAGEMENT

- 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.



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