Relapse Prevention Strategies in Outpatient Substance Abuse Treatment

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Drug-free outpatient substance abuse treatment has historically consisted of a loosely organized set of mental health techniques. The development of the relapse prevention (RP) approach has provided an organizing principle and conceptual foundation for the creation of clearly defined substance abuse treatment protocols. The work of Marlatt and colleagues provided the cognitive–behavioral base and numerous techniques. Other researchers and clinicians developed and evaluated specific protocols for the treatment of alcoholism, cocaine abuse, marijuana abuse, and heroin addiction. Several groups incorporated RP techniques into integrated outpatient models. This body of knowledge has given the drug-free outpatient treatment of substance abuse a clear focus and direction. Investigators, in clinical and research reports concerning these approaches, are optimistic about their value as part of the treatment system.

Drug-free outpatient treatment is included as one of the modalities in virtually all of the reviews of major substance abuse treatment approaches. Unfortunately, as noted in the review by Hubbard et al. (1989), it is difficult to evaluate the efficacy of this approach because the methods used lack standardization. Unlike such modalities as methadone maintenance and therapeutic communities, the modality of drug-free outpatient treatment has historically lacked a central organizing principle. In some settings, drug-free outpatient treatment is similar to some schools of psychotherapy or family therapy. In other settings, this form of treatment more closely resembles case management or crisis intervention. Still other approaches adapted Alcoholics Anonymous (AA), Narcotics Anonymous, and therapeutic community techniques for use on an outpatient basis. For the most part, until recently, drug-free outpatient treatment has involved the idiosyncratic application of some collection of “therapy” techniques to address the problem of substance abuse. In many cases, however, it is difficult to conceptually explain how the chosen interventions were selected to produce a reduction in substance abuse behavior.

Within the last decade, the techniques categorized as relapse prevention (RP) strategies have provided an organizing principle around which drug-free outpatient treatment has been designed. Common elements to these strategies are a cognitive–behavioral framework and a theoretical basis in social learning theory (Bandura, 1977, 1981, 1982). These techniques are appealing to clinical researchers in the field of substance abuse treatment because they have a solid conceptual foundation and can be empirically evaluated. Use of these techniques provides outpatient, drug-free treatment with a clear theoretical and methodological focus and allows for the systematic development of protocols that can be replicated and evaluated.

RP is defined as follows:

Relapse prevention is a generic term that refers to a wide range of strategies designed to prevent relapse...
in the area of addictive behavior change. The primary focus of RP is on the crucial issue of maintenance in the habit-change process. The purpose is twofold: to prevent the occurrence of initial lapses after one has embarked on a program of habit change, and/or to prevent any lapse from escalating into a total relapse. (Marlatt & Gordon, 1985, p. xii)

The purpose of this article is to review the use of RP strategies in the treatment of substance abuse disorders. This article presents a review of the common treatment elements, which are grouped under the general framework of RP. The conceptual basis of the RP approach is briefly described. A number of researchers created well-defined protocols for treating specific substance abuse disorders. These protocols are reviewed, along with some description of the evaluation data. Other researchers used RP methods as the basis of integrated outpatient models of treatment. These models are described, along with preliminary data regarding their effectiveness. Finally, a summary is presented that recommends the use of the RP paradigm as a unifying concept in the development of outpatient drug-free substance abuse treatment.

**RP Content Areas**

The techniques that have been used within the designation of the RP category include seven groups of strategies: psychoeducation, identification of high-risk situations for relapse and warning signs for relapse; development of coping skills; development of new life-style behaviors; increased self-efficacy; dealing with relapse—avoiding the abstinence violation effect; and drug/alcohol monitoring.

**Psychoeducation**

An important ingredient in most of the RP models is the use of information and education about a variety of addiction-related topics. Central among the issues taught to substance abusers during the course of treatment are the following topic areas: brain chemistry and addiction; conditioned cues and craving; drug and alcohol effects; addiction as a biological disorder; drug use and acquired immunodeficiency syndrome; addiction and the family; need for life-style change; and relationships between substance abuse and other compulsive disorders. The psychoeducational material is often presented in classroom format or group discussion and is integrated into individual counseling sessions. Many of the models use videotape and slide presentations and provide clients with written materials to encourage review of educational materials.

**Identification of High-Risk Situations for Relapse and Warning Signs for Relapse**

Clients are taught that there are behaviors and environments as well as cognitive and affective states that are associated with drug or alcohol use. Through individual and group discussion, as well as in homework assignments, clients are assisted in learning the specific set of conditions that have the greatest association with drug or alcohol use. Some examples of these conditions are as follows:

- **High-risk states:** certain times of day, being around drug-using friends, bars, the presence of money, idle time
- **Behavioral warning signs:** "addict" behavior, compulsive and impulsive behavior, time with drug users, stopping recovery activities, returning to secondary drug use
- **Cognitive warning signs:** euphoric recall, relapse justification, drug dreams, rationalizations to discontinue new recovery behaviors
- **Affective warning signs:** periods of emotionality previously associated with drug use (positive affective states, e.g., excitement, arousal, celebration; negative affective states, e.g., depression, loneliness, anger, boredom)

**Development of Coping Skills**

It is hypothesized in these models that substance abusers have maladaptive coping skills when placed in high-risk situations. Much of the individual and group "counseling" is focused on teaching and reinforcing alternative responses that will not lead to drug or alcohol use. These new coping skills are discussed in sessions. Options are explored, and in some cases, new skills are role played or homework assignments are given to practice the new coping response. Examples of these coping skills include how to say "no" to an offer of drug or alcohol use; types of alternative behaviors to engage in during high-risk periods (e.g., exercising rather than going to a bar for happy hour); methods of expressing affective states rather than using drugs or alcohol; new
cognitive strategies, such as thought stopping, to avoid drug thoughts and craving.

Development of New Life-Style Behaviors

Once drug or alcohol use has been suppressed, it is viewed as useful to reinforce the development of alternative activities to serve as intrinsic reinforcers of abstinence. Group discussions and homework assignments are used to assist drug and alcohol users in acquiring and maintaining new leisure, recreational, and employment activities that will support a non-drug-using life-style. Exercise, hobbies, family activities, community activities, and self-help involvement are the types of activities that are reinforced by program staff and group peers.

Increased Self-Efficacy

According to Bandura’s theory of self-efficacy, the methods that initiate behavior change may not be the best methods for producing generalized change or long-term change (Bandura, 1977, 1981, 1982). This self-efficacy theory proposes that when people enter high-risk situations for drug or alcohol use, they choose each response on the basis of their appraisal of their ability to cope with the situation. If they view themselves as competent, they will abstain from using drugs or alcohol. If not competent, they are at increased risk to use. To facilitate the development of the self-perception of competence, clients are given homework assignments that involve entering high-risk situations and using new responses. It is hypothesized that repeated success in coping with these situations in new, non-drug and non-alcohol-using ways will increase self-perception of competence and self-efficacy. The development of this self-efficacy is viewed as critical to long-term abstinence. These techniques are used to prepare the client.

Dealing With Relapse—Avoiding the Abstinence Violation Effect

Within these models, the reality of relapse is addressed. Clients are taught to view a return to drug or alcohol use as “slips” or “lapses” that need not lead back to full-blown relapse and readdiction. This cognitive reframing of a lapse from a catastrophe into an opportunity to learn how to improve the treatment plan reduces the shame and failure often experienced in the event of a slip or lapse. This approach in dealing with a return to alcohol or drug use can interrupt the cycle in which a lapse turns into an extended relapse episode.

Drug and Alcohol Monitoring

Although not specifically an RP technique, all these models make use of urine and breath testing to monitor drug and alcohol use. These techniques are viewed as critical for promoting client accountability, and they serve as a dependent measure of program effectiveness.

Foundation of RP Models: Marlatt and Gordon

The most conceptually well-constructed model of RP is that created by Marlatt and Gordon (Marlatt & Gordon, 1980). In the first five chapters of their book, Marlatt and Gordon laid out the foundation for the entire field of RP (Marlatt & Gordon, 1985). The topic areas presented in this book include (a) a theoretical rationale and overview of the model; (b) situational determinants of relapse and skill-training interventions; (c) cognitive factors in relapse; (d) cognitive assessment and intervention procedures; and (d) life-style modification. Although a synopsis of Marlatt’s model is beyond the scope of this article, there are a number of noteworthy key points that have given direction and impetus to the field.

Marlatt (1985) has provided a compelling conceptualization of addiction as a set of habit patterns that have been reinforced by pharmacological and social reinforcement contingencies. Consequently, addiction treatment is a process of habit change. The techniques that have been developed to facilitate this process have their roots in social learning principles. This view of addiction and addiction treatment is contrasted with the view of addiction as a disease, a position widely held by many, including proponents of the AA program. A second important issue discussed by Marlatt and Gordon is the nature of relapse. Their position—that relapse is the result of a
predictable series of cognitive and behavioral events that lead to a return to drug or alcohol use—has been tremendously valuable in demystifying relapse. The observation that relapse has clear antecedents and warning signs has provided a perspective that allows the relapse process to be dissected and systematically studied.

Marlatt’s (1985) work provided a framework within which the situations and circumstances that place addicts and alcoholics at high risk for relapse can be studied. By describing a range of coping responses to these high-risk situations, they have given clinicians a broad range of behavioral strategies for addressing client needs. Their application of self-efficacy principles from the work of Bandura (1977, 1981, 1982) has given addiction researchers an approach for addressing the cognitive aspects of addiction. A related concept described by Marlatt is the abstinence violation effect. This phenomenon, explained in terms of attribution theory (Weiner, 1972, 1974, 1976), presents a rationale for explaining why addicts and alcoholics often respond to a single lapse by returning to a full-blown readdiction episode. Marlatt and Gordon also emphasized the value of using education and information in the treatment process. As part of this educational process, they suggested using metaphors for explaining addiction and recovery-related concepts. Finally, recovery from addiction is conceptualized as a type of life-style modification in which achieving balance and developing alternative behaviors are key ingredients.

Marlatt’s work (1985) provided a foundation for much of the theoretical and empirical writings on RP. Most of the models described in this article have borrowed extensively from his writing. Marlatt’s contribution to this field is unmatched.

Other Models

Gorski’s Cenaps Model

Gorski’s Cenaps model has had a major impact in the private chemical dependency treatment system. The RP materials developed by Gorski et al. (Gorski, 1989a, 1989b, 1990; Gorski & Miller, 1986; Miller, Gorski, & Miller, 1982) popularized the use of RP techniques in inpatient chemical dependency units and in commercial outpatient treatment settings. Gorski’s work does not have the extensive theoretical foundation of Marlatt’s work, but it does have a wealth of clinically valuable insights that are presented in a cognitive-behavioral framework. Gorski’s work has received little empirical evaluation because the model describes broad clinical recommendations without presenting a specific format or methodology that can be tested in a controlled manner. The majority of Gorski’s RP work has focused on alcoholism recovery and more recently cocaine addiction. His recognition of the neurological factors in the recovery of alcoholics and his attention to the postacute withdrawal syndrome in recovery have been valuable adaptations of research findings to clinical practice. By moving RP concepts and terminology into the private, commercial chemical dependency system, Gorski broadened a system that was previously exclusively spiritual and emotional.

Gorski’s work emphasized the value of involving the client in taking responsibility for, preparing for, and anticipating problem areas for relapse. He provides clients with an education regarding the sequence of events that leads to relapse. He teaches clients to create their own list of relapse warning signs, such as irrational thoughts, unmanageable feelings, and self-defeating behaviors. His model teaches people alternative coping behavior for responding with those events without the use of drugs or alcohol. In addition, lists and schedules are used to assign clients exercises that will help them participate in upcoming events without relapse.

Wallace’s RP Materials for Crack Cocaine Users

Wallace (1991) reviewed the current body of treatment information for cocaine and crack cocaine abuse. She also provided a clinical model adapting RP strategies for use with inner-city crack cocaine smokers (Wallace, 1989, 1990). Many of the strategies she described have been adapted from Marlatt and Gordon (1985) and Miller, Gorski, and Miller (1982). Her recommendations for implementing RP strategies with crack cocaine smokers (Wallace, 1990) gave clinicians a relevant set of techniques for working with this population. She made extensive use of the psychoeducational approach of using metaphor to illustrate important issues in recovery from crack cocaine addiction. The principles and the illustrations of those principles are derived from psycho-
dynamic and cognitive-behavioral theory. The topics include discussions of ways to identify, label, and manage emotions; dysfunctional families; self-esteem; self-image; workaholism; use of 12-step programs; triggers; and cravings. Her model has not been formalized into a specific methodology for evaluation.

**Annis’s RP Approach for Alcoholism**

A model for applying RP strategies to the treatment of alcoholism has been created by Annis and associates at the Addiction Behavioral Foundation in Toronto (Annis, 1986, 1990; Annis & Davis, 1988, 1989). Annis used the concepts developed by Marlatt and Gordon (1985) to identify categories of high-risk situations and combined them with the self-efficacy theory of Bandura (1977, 1978, 1986) to teach clients how to resist temptations to drink. Annis developed two assessment scales—the Inventory of Drinking Situations (IDS) and the Situational Confidence Question (SCQ)—which are important to her model. The IDS provides clinicians with an inventory for assessing situations in which clients are at greatest risk for drinking. The SCQ is a self-efficacy measure of a client’s perceived ability to cope with alcohol-related situations. In this model, knowledge of these two dimensions is viewed as critical to the creation of a client’s RP treatment plan. The rationale for Annis’s model is that, once high-risk situations for drinking are identified, it is possible to teach alcoholics to resist the temptation to drink in these situations. The main technique used in this teaching exercise is assigning homework and allowing the alcoholic to gradually experience more difficult assignments while not drinking. Homework assignments involve going into situations previously associated with drinking and practicing alternative behaviors. The homework assignments are individualized to increase the relevance for specific clients. It is hypothesized that repeated exposure to these high-risk settings without the use of alcohol will increase feelings of competence and self-efficacy. These positive feelings will reinforce the maintenance of alcohol abstinence.

In a controlled trial using random assignment, alcoholic subjects were assigned to either the Annis RP model or to a traditional counseling protocol. There were no differences found between groups at 6-month follow-up. However, there was a significant reduction of alcohol consumption by a specific subgroup of alcoholics who received the RP method. Those clients whose drinking had been associated with a specific set of situations or conditions benefited more from the RP program than from the traditional counseling program. For those clients whose drinking was more generalized to a wide range of settings, the RP approach did not demonstrate superiority (Annis, 1990). This latter finding led Annis to hypothesize that RP procedures may be useful with a specific type of alcoholic but are not necessarily a superior treatment for all alcoholics.

**Roffman et al.: RP Treatment for Marijuana Dependence**

Roffman and Barnhart (1987) constructed an RP approach that adapted material from Marlatt and Gordon (1985) for the specific needs of marijuana users. The treatment model was delivered in a group format consisting of 10 sessions that were scheduled over a 12-week period. In this approach, clients were taught to analyze the situations and antecedent conditions for their marijuana use. Discussions of craving and patterns of use helped clarify high-risk situations. Alternative coping skills for those situations were selected and role played. Self-talk exercises were used to counteract negative cognitions, and slip episodes were reframed to counteract unproductive negative attributions. Planning sessions were used to deal with upcoming high-risk situations. Relaxation training, behavioral rehearsal to recruit social support, and homework assignments to instigate life-style change were also included.

This treatment model has been evaluated in a controlled study comparing subjects receiving the RP model with a group receiving a social support procedure (Roffman, Stephens, Simpson, & Whitaker, 1990). The results of the study suggested that the RP procedure produced a greater reduction of marijuana use than did the social support procedure. Subjects in the RP group used marijuana on fewer days during the preceding month and had fewer total episodes of use in the previous 30 days. There was, however, no significant difference in the number of subjects who abstained from marijuana use over the 30-day follow-up period. Also, the other findings from this study suggested that RP group subjects rated
their treatment experience more positively than the social support group subjects and the RP group subjects reported using treatment information more often than social support group subjects. Subject reports from both treatment conditions indicated that the cessation of marijuana had very significant beneficial effects on their functioning.

The protocol and treatment materials created by Roffman et al. (1990) provide an excellent framework for an outpatient treatment approach for marijuana dependence. The specificity of the materials to the issues experienced by marijuana users gives the treatment approach great credibility with clients. Client retention appeared to be enhanced by the relevance of the information.

Carroll et al.: RP for Cocaine Abuse

During the 1980s, RP strategies were quickly adapted for the treatment of cocaine abuse (Rawson, Obert, McCann, & Mann, 1986; Rawson, Obert, McCann, Smith, & Ling, 1990; Washnton, 1987, 1989; Wallace, 1990, 1991). The group at Yale University also provided clinical guidelines regarding the value of RP techniques for the treatment of cocaine abusers (Carroll, Rounsaville, & Keller, 1991). The components they incorporate into their RP approach include strategies to address ambivalence; measures to reduce cocaine availability; techniques to teach patients to identify and address high-risk situations; information about the phenomenon of craving and coping with craving; assistance in identifying “apparently irrelevant decisions” that may lead to high-risk situations; direction in making life-style modifications that are useful for maintaining abstinence; information and prevention strategies concerning the abstinence-violation effect.

The Yale University group conducted the first well-controlled evaluation of an RP protocol for the treatment of cocaine abuse. The study evaluating their 12-week protocol involved the random assignment of 42 subjects to either an RP condition or a similar amount of contact with a therapist using an interpersonal psychotherapy approach (IPT; Carroll, Rounsaville, & Gawin, 1991). There were a number of indicators that suggested that the RP approach appeared somewhat superior to the IPT approach but, because of the relatively small sample size, the group differences did not achieve statistical significance. Two thirds of the RP group were retained for the 12-week protocol. During the course of treatment, there was a very substantial decrease in cocaine use for subjects in both groups. Comparisons of Addiction Severity Index (ASI) scale scores suggested a significant improvement in social functioning on all seven ASI subscales, with the Psychological Functioning scale indicating superiority of the RP group. Of significant interest is the finding that, with a subsample of severely addicted cocaine users, the RP approach did result in a significantly more positive treatment outcome on two measures of abstinence at follow-up.

The combined data from this study suggest that the RP protocol provided substantial clinical benefit for cocaine abusers. The methodology used in the study protocol involved a well-constructed format with exceptionally well-designed controls to ensure protocol compliance. Treatment retention and analysis of outcome by severity of drug use and psychiatric severity measures, along with the ASI, provide an evaluation methodology that could be widely used for future research on RP models.

Integrated Outpatient Models

McAuliffe et al.: Recovery Training and Self-Help (RTSH) Model

McAuliffe et al. (McAuliffe, 1990; McAuliffe & Ch'ien, 1986; Zackon, McAuliffe, & Ch'ien, 1985) constructed an intensive outpatient treatment model combining RP strategies with self-help concepts. The model has been used primarily as an outpatient aftercare strategy for the treatment of opioid users in New England and Hong Kong. A manual has been constructed that presents the treatment exercises in detail to allow for replication and evaluation. The treatment model contains a set of training materials adapted from the work of Marlatt and Gordon (1985). In addition, clients are encouraged to develop group cohesiveness through involvement in a self-help component. This self-help component is not related to the 12-step program of AA but does promote a sense of addicts helping each other, which is common to all self-help approaches. This self-help component provides a forum that allows clients to plan and structure leisure and recreational activities together, expanding their non-
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drug-using behavioral repertoire. Within this component, there is also the opportunity for senior members of the program to gain self-esteem by serving as role models for new members.

The RTSH model has been evaluated in a large, controlled trial with random assignment (McAuliffe, 1990). In this study, 168 subjects were randomly assigned to either the RTSH program or a control condition that consisted of referral to another community-based aftercare program. All subjects were opioid addicts who had recently been detoxified from illicit opioids or from methadone treatment. This study, therefore, evaluated the RTSH model as an outpatient aftercare strategy and not as a stand-alone outpatient treatment approach. The results of the study were extremely promising. The RTSH program showed superior levels of opioid abstinence at 6- and 12-month follow-up points. In addition, subjects in the RTSH group demonstrated significantly more employment activity and less criminal activity by the 12-month follow-up point. Ratings of satisfaction by clients suggested that the RTSH group found their treatment experience more helpful than did the control subjects, and the mean retention rate of 4 months by RTSH subjects suggests that the program was able to sustain the treatment involvement of this group. It should be noted that, although the RTSH approach demonstrated significantly better outcome on important clinical measures, the abstinence rate at 12 months was only 30%. This finding underscores the difficulty of treating opioid users with nonpharmacological and nonresidential treatment approaches. It is possible that the outcome with this model could be improved by combining the approach with a pharmacological treatment such as naltrexone. Similarly, it is possible that the use of this model with other categories of drug users such as cocaine abusers or alcoholics might show higher rates of follow-up abstinence.

The RTSH model is the first attempt to build a structured outpatient treatment program around RP concepts and strategies. The development of a formal treatment manual and the controlled evaluation of this model are extremely important steps in systematically implementing RP procedures into the mainstream treatment system. Further refinement of the RTSH model for different populations will strongly influence the continuing development of viable outpatient addiction treatment.

Washton's Intensive Outpatient Model

Arnold Washton and Nanette Stone-Washton incorporated RP materials into a structured treatment model that is being used with a broad range of drug and alcohol users in a commercial treatment center in New York City (Washton & Stone-Washton, 1990). Washton's model, initially developed with cocaine abusers, provides a stand-alone outpatient treatment program for addicts and alcoholics. It can also be used as an aftercare program following inpatient and outpatient detoxification. His clinical perspectives on treatment issues with cocaine abusers have been documented in several books (Washton, 1989; Washton & Gold, 1987). His RP exercises have been structured into several workbooks that are used by patients during the course of treatment (Washton, 1990a, 1990b).

The format of the program includes three weekly group sessions for 4 to 6 months. The intensive use of group methods results in the group itself becoming a powerful instrument for change. Washton (1989) detailed key group conduct issues that facilitate treatment retention and behavior change. Strategies for engaging clients in treatment have also been developed to address client resistance and to discourage "traditional" confrontational methods of addiction counseling. Washton adapted the work of Prochaska and DiClemente (1986) on stages of change for use in clinical treatment planning. Understanding that addicts and alcoholics enter treatment at different stages in the addiction process can reduce therapist frustration with "unmotivated clients." With this change of perspective, therapists are able to create a treatment atmosphere in which clients can change at their own pace. Washton recently addressed this aspect of his treatment approach (Washton & Stone-Washton, 1991). Concurrent involvement in 12-step activities is strongly encouraged as part of the recovery plan. Frequent urine testing is emphasized as an essential part of the outpatient model.

Washton's model has now been used in a private outpatient setting for more than 5 years. It has gained acceptance by insurance companies and employee assistance programs as a treatment resource in the New York City area. This model and the model by Rawson and associates (dis-
cussed next) are the first intensive outpatient treatment models emphasizing RP strategies to be accepted in the mainstream commercial treatment system. This development is significant because it signals the emergence of commercially viable treatment models based on empirical principles rather than philosophical bias. The creation of treatment models specifically designed for outpatient implementation, rather than outpatient models adapted inappropriately from inpatient settings, is a promising development in the private treatment sector. It is hoped that additional empirical support will be forthcoming on the Washington treatment model to provide a clearer understanding of the applicability of this method.

Rawson et al.: The Matrix Neurobehavioral Model

As the cocaine epidemic accelerated in the early 1980s, cocaine users began to seek treatment in large numbers. In 1983, the Matrix Center was established in Southern California to provide these people with a structured outpatient treatment experience. The program was designed around cognitive-behavioral principles with many of the RP techniques previously described. The model was labeled neurobehavioral because it was hypothesized that stimulant addicts experience a biological recovery from chronic stimulant abuse that results in clear stages of recovery (Rawson, 1990; Rawson et al., 1990; Rawson, Obert, McCann, & Ling, 1991). These stages result from the neurochemical and neurophysiological normalization that occurs on cessation of stimulant use. The stages are accompanied by a predictable series of affective, cognitive, and behavioral changes. The treatment materials that have been developed for the Matrix neurobehavioral model are sequenced to address the clinical issues in the order that they typically emerge. The treatment model provides intensive treatment contact during the initial 6 months. Along with the cognitive-behavioral emphasis, there is a significant amount of family participation in educational sessions and conjoint sessions. Urine testing is an integral part of the program, and involvement in 12-step programs is encouraged.

The Matrix neurobehavioral treatment model has been formalized into a 300-page treatment manual (Rawson, Obert, McCann, Smith, & Scheffey, 1989). This standardization of the model has allowed for replication and evaluation. The evaluation efforts have been a central element in the creation of the model. The ongoing evaluation of the model and individual treatment components has provided direction for the evolution of the treatment approach. An initial pilot study was conducted in 1985 that indicated that significantly fewer cocaine abusers who were treated with the neurobehavioral protocol on an outpatient basis were using cocaine at follow-up than those who received treatment in a 28-day hospital or a third group that received no treatment.

In a more recent study, treatment outcomes for cocaine users who were treated at two different offices of the Matrix Center were compared (Rawson, Obert, McCann, & Ling, 1991). The treatment protocols in both offices were identical, and the treatment was supervised by the same clinical supervisor. Although individual therapists differed in the two clinics, ratings of therapist effectiveness in the two clinics were comparable. The major difference in the two populations was social status, educational level, and employment level. In one clinic, the clients were predominantly middle class, college educated, and employed. In the other clinic, a majority of the clients were low income, high school educated, and unemployed. In the middle-class clinic, clients self-paid for treatment or used private insurance. In the lower income clinic, treatment was subsidized by the local health department and a small copayment. Drug use histories, route of administration, and amount of drug use at admission were similar for both groups.

The retention rate and 6-month drug-use status of the clients treated in the private treatment clinic were significantly better than those of clients treated in the lower income clinic. During the period of treatment involvement, however, drug use was virtually at the same level in both clinics. The results suggest that this model was extremely useful with the middle-class clients, but the lower income subjects experienced poorer treatment outcome. It is certainly possible that this disparity may be true for all modalities of substance abuse treatment. However, it is increasingly clear that, as this model is used with a higher proportion of indigent, underemployed, less educated crack cocaine abusers, the retention rates and follow-up abstinence rates have decreased.

Role of RP Models in Substance Abuse Treatment

During the past 10 years, the RP concept has become generally accepted within the field of
addiction. A recent issue of the Journal of Psychoactive Drugs, edited by Joan Zweben (April–June, 1990), presents an excellent collection of articles on the use of RP techniques for a broad range of substance abuse disorders. RP strategies have been adapted for use in multiple clinical settings. A compilation of some clinical applications of RP approaches has been published by Daley (1988).

The RP approach provides a conceptually consistent framework for the delivery of a nonpharmacological outpatient treatment model. It provides addicts and alcoholics with a set of tools and information that better equips them to understand the process of relapse. The techniques directly address factors that have been identified by clients as being problematic in maintaining abstinence from drugs and alcohol. In addition, the RP approach acknowledges the problem of relapse and presents the addict and the clinician with a framework for preventing minor lapses and slips from becoming major relapses leading to readdiction. The use of these strategies does not presume underlying causal mechanisms of addiction; rather, RP techniques directly address the drug using behavior. They provide clinicians with a set of interventions that are helpful in promoting the acquisition of responses that are incompatible with substance abuse disorders.

Clearly, the RP approach—its development and refinement—was the major nonpharmacological substance abuse treatment advancement of the 1980s. It is unclear at this time how extensively these techniques will be adapted. The enthusiasm for the use of the techniques is quite high. However, the evaluations of specific protocols and integrated models are at an early stage of development. Continued empirical testing of these techniques and models is essential to the development of this approach. Because the techniques are clearly definable and replicable, the systematic evaluation of the approach is very feasible. Use of treatment manuals that standardize protocols for replication and evaluation has improved research methodology.

It appears likely that for some disorders, such as cocaine dependence, outpatient models built around RP techniques may provide viable treatment for a substantial group of addicts. For other types of clients, including alcoholics, RP models may apply for an identifiable client subset. For still other populations, including opiate addicts, RP strategies may be useful as aftercare but are apparently not sufficient with acutely addicted clients.

RP techniques are communicated to clients verbally and in writing. Clients must be capable of processing information and using cognitive techniques. The techniques have limited usefulness with clients who do not have the capacity or education to understand or use the treatment materials. Our clinical experience with this approach suggests that the specific treatment exercises need to be tailored to the needs of different populations. The treatment exercises used with stable, middle-class, well-educated, employed, intranasal cocaine users are quite different than those that are appropriate for inner-city crack cocaine smokers. Specific techniques chosen must allow for the client’s capabilities and the environment within which the client is living. RP techniques can be translated to a wide range of populations with appropriate construction of relevant concepts. Specific cultural and gender issues must be sensitively addressed. However, if these issues are accommodated, it does appear that the RP approach can be adapted successfully for a substantial range of substance abuse.

The context in which RP strategies are used is likely to affect the specific types of procedures used and the impact of these procedures. For example, relapse can be a frequent occurrence during the treatment process of an outpatient episode. Therefore, RP strategies used in this setting must include procedures for actively addressing this issue as part of the course of treatment. In residential settings, however, relapse is a much less common occurrence. Consequently, the discussion of relapse during treatment may have a very different significance, and a different response to relapse in this setting may be required.

A potentially valuable role for the use of RP models is to provide a psychosocial framework within which pharmacotherapies can be evaluated. Annis (1990) evaluated RP strategies with alcoholics in conjunction with the alcohol-sensitizing medication calcium carbamide. We are currently conducting evaluations of several medications for cocaine dependence in a treatment context in which all subjects are receiving treatment with the neurobehavioral model. Similarly, the same investigators are developing a manual based on RP techniques to facilitate the use of naltrexone with detoxified opiate users. The value of RP strategies in combination with medications
has not been empirically established; however, because of their standardization and replicability, they appear to provide an excellent protocol for this purpose. Also, because the techniques are flexible and modifiable to specific populations and settings, the protocols can be tailored to complement the pharmacological properties of the medications. For example, because medication compliance is problematic when using naltrexone in opiate-addiction treatment, RP techniques will address the discontinuation of medication taking as an important prerelapse indicator of return to opiate use.

Summary

The development of outpatient substance abuse protocols that can be empirically evaluated has been tremendously enhanced by the incorporation of RP strategies. Of potentially greater importance is the cognitive–behavioral foundation that the RP movement has provided as an organizing principle for the field of drug-free outpatient substance abuse treatment. The approach has given focus to a collection of psychosocial interventions that frequently lacked a clear rationale and purpose.

The RP techniques have been created to directly address substance abuse behaviors and the cognitions leading to those behaviors. Their rationale and application are understandable to patients. They provide tangible tools for therapists to give to patients and for patients to use to address their substance abuse disorders. Middle-class patients who have experience with non-substance-abuse-oriented psychotherapy often find RP techniques practical, refreshingly direct, and usable. They provide patients with direction for taking action in a positive, meaningful way to reduce their substance abuse behavior. For lower income clients who are less therapy sophisticated, the techniques allow for substance abuse treatment to be presented in a nonthreatening, supportive, yet directive mode.

The RP approach has provided the outpatient substance abuse treatment effort with some clear guidelines and protocols. Significant strides have been made in implementing these techniques and in constructing controlled evaluations of treatment models for numerous clinical populations. Outcome data are very preliminary, but the overwhelming attitude of clinicians and researchers is that this methodology of RP has given focus and standardization to a previously disorganized set of outpatient treatment techniques. Long-term follow-up data on the extended impact of these strategies are necessary to assess their value to the field. Continuing research in this area appears very likely to produce valuable new models and treatment approaches for substance abuse treatment.

References


