EFFECTIVE RELAPSE PREVENTION
FOR A CLINICAL PRACTICE
(Understanding Cravings)
( a 6 unit CEU course)

The objectives of this CEU course on Effective Relapse Prevention, for a clinical practice, (Understanding Cravings) are: (1) to give you a better understanding of cravings and how to apply this understanding for improved sobriety; (2) to help you vastly improve the prognosis for the addicts whom you treat; and (3) to understand recovery treatment guidance and recovery treatment management. (4) You will also learn how to create an individualized written chart, which we consider a relapse prevention plan. (5) You will know how to apply this chart, on an individual basis for each of your recovering patients. This information can be applied to any addiction: drugs and alcohol, gambling, sex, computer, etc.

The World Health Organization (WHO) claims that Crystal Methamphetamine is the most widely used illicit drug, with the exception of Cannabis. It is estimated that there are over 26 million regular users of Crystal Meth. There are about 16 million Cocaine users and about 18 million users of Alcohol. With these ever increasing numbers, we believe it is becoming more and more necessary for Psychotherapists and Social Workers, in a clinical practice to know how to help these patients create an effective relapse prevention plan.

The American Medical Association defines addiction as a disease, a genetic predisposition towards a dependency. They also go on to say that cravings can be as powerful as the need for food or water. This gives us a good example of the power a craving can have. Dr. Alex Stalcup, a well respected addictionologist, from Northern California, says that cravings are like a drive state, often over powering. We tell our patients that they are suffering from a disease. This is very important, as many addicts feel shame about their addiction. We believe the disease model does fit, as addictions are chronic, progressive and they can kill. We have found this knowledge very beneficial for our recovering patients.

Rick Glantz, a cravings expert, says “triggers are interpreted by the emotional Thalamus, which sends a message to the Amygdala. Then the information, in this case, the craving, is sent to the neo-cortex”, the brain’s memory center. However, in cases of emotionally overwhelming feelings, the brain simply cannot react, (in this over simulated state) it just goes dead. This is why the addicted patient is likely to slip and use, as the craving state is overwhelming.
Studies from the National Institute of Drug Addiction (NIDA), the National Institute of Health (NIH) and Yale University show that cravings take place in the Amygdala. Studies from the Scripps Institute and Cambridge show that the extended Amygdala also receives information when in a craving state. We know that the craving response is similar to an anxiety response. It is a very uncomfortable state of being. These are some of the physiological changes and experiences that effect our recovery patients. It is certainly not mind over matter.

Glantz goes on to say that there are three types of people. If you can understand which category fits for your recovery patient, then you will have more information on how to help him/her manage their cravings. The first kind of person is a *leader*. About 10-15% of the general population are natural leaders. When overwhelmed with emotional information and/or emotional situations, they know how to take charge and react appropriately. This group will predictably have the most success working with their cravings.

Then we have the *follower*. About 70-80% of the general population are followers. They have no idea on how to manage highly stressful situations, nor emotionally overwhelming moments. They will, however, do what they are told to do. This is problematic, as we cannot be with our patients 24/7. Patients in this category are likely to relapse, as they do not have the ability to think these hard situations through. This is the job of the therapist, to teach the patient how to create their relapse prevention plan, very early in their treatment. They must know their plan well in advance of their cravings, or it is predictable that they will relapse.

Finally there are the *hysterics*. About 10-15% of the population are hysterics, those who have a total meltdown when they crave. They simply cannot manage any stressful situation. When they are emotionally overwhelmed, they buckle, and relapse is almost a given. This group will generally have the most difficulty staying sober and managing their cravings. Some people are just naturally better equipped, actually predisposed, than others to handle a craving. Although in general, cravings are challenging for the best of our patients, all of them need a strong, clear, and effective relapse prevention plan.

Managing cravings is the centerpiece of getting sober and staying sober. It may well be the single most important concept which will help your patients remain clean and sober. Getting sober is different than staying sober. Each stage is handled differently, in an effective treatment program. Getting sober will include aspects of the following: intervention; family treatment; a psychiatric evaluation or an evaluation from an addictionologist; an individual treatment plan; 12 step meeting attendance, and working the 12 step program.

Brains re-wire themselves with drug and alcohol abuse. Therefore when the brain is in a state of withdrawal, cravings set in. Cravings can be emotional or physiological. An emotional craving will become a physiological craving if the craving lasts long enough. By that time, it is just about guaranteed that the patient will relapse and use. This is why we must teach our patients how to build a relapse prevention plan and chart. If we can help the patient use their plan/chart before their cravings reach the physiological state, they have a greater chance of staying sober.
As clinicians, treating addicted patients can be very frustrating, however, if the patient has come for treatment, then he/she clearly wants help. The first stumbling block will be **denial**. When they clean up, their lives will improve in dramatic ways which will be far more impressive and exciting than any other population of patients you have ever treated.

Sandi was a very depressed, closet alcoholic woman, about 35 years of age with massive denial. She worked as a support staff member of a small company. Mondays were hard for her, and she often missed work, generally due to being hung over. She presented herself in a professional way, wearing business suits and she was soft spoken. She did not understand why she had been depressed for years. I have never met an addicted person who was not depressed.

Occasionally, during her treatment, Sandi would call and leave a phone message to cancel her appointment. When she called, she would slur her words. It was very obvious that she had been drinking. When she would return the next week for her session, she denied drinking. This pattern continued throughout her 3 year treatment. I found Sandi very frustrating to work with. She never addressed her alcoholism, therefore she would not talk about any relapse prevention plan. We never got that far in treatment. She lived in deep denial. One day she joined Weight Watchers (WW).

Although Sandi was not that much over weight, she joined WW at a time, many years ago, when Alcohol consumption was on the WW list of foods or drinks to avoid. She lost the few pounds she needed to lose, but better than that, she sobered up. Sandi was a case of massive denial. Her denial was so strong, that she, herself, really didn’t understand her alcoholism. As she worked the WW program, her life improved dramatically. Her depression lifted, without the benefit of medication. She became a success in her own right. Let’s remember that WW is a self help group and the group support was most useful for Sandi.

Over the years I have had many recovery patients who asked themselves if they were really addicted. When everything in their lives pointed to an affirmative answer, they were still not able to embrace their addiction. Denial is a powerful defense mechanism. Although Sandi never got beyond her denial, she did clean up in a most creative way. She terminated therapy, feeling successful, as her years of depression were gone. So was her drinking. She never made the connection. I always found this rather odd, but success is success.

Staying sober, in the early phases, has everything to do with treatment guidance and treatment management. Psychotherapy starts later in the treatment process with addicted patients. Generally psychotherapy will naturally begin after many, many, months of sobriety, and often not until the addict reaches their first year of sobriety. Why wait to start psychotherapy until this time? The reason is because the lives of addicts are in ruin, with much confusion, often involving the legal system, financial devastation, fractured personal relationships, employment distress, and primarily compromised brain power due to the substances used. You will know when your patients are ready to go from guidance and management to Psychotherapy. It will be obvious, as 33
the patient will begin to process material differently. Over time, you will both recognize that the brain is repairing itself.

What does treatment guidance and treatment management mean? It generally means Cognitive Behavioral and Directive Therapy. Helping the patient follow through with their individual treatment plan, is only part of the expectation. Has the patient begun to detox? How many days of sobriety do they have? We ask them on a regular basis. Has the patient seen the psychiatrist, or the addictionologist? If not, we need to encourage the patient, keeping a steady focus in this direction, and to continue to motivate the patient to follow through. If you believe the patient needs medication and they have not had an evaluation, they have reduced their chances of staying sober. They will likely slip. Tell them this, it is vital that the patient understands what they can do to help themselves, as the 12 step program may confuse them with the concept of powerlessness. The patient has the power to see the doctor for medication, yet is powerless over drugs and alcohol. The concept of powerlessness is really about surrender, which is imperative for recovery.

How long will it take for the patient to start to sober up? It can begin before the patient arrives in your office, at the first session, or this can take months, years or never. Unfortunately, it will not be possible to be successful with every patient. It all depends upon how “ready” the patient is to clean up and how skilled the therapist is, in this process. How much support does the patient have outside of the office? Do they have a 12 step sponsor? Is their family involved with their recovery treatment? It takes a village to help these people, so one therapist and one patient do not constitute a recovery program. This is why the patient must attend 12 step meetings, and begin working the program with a useful sponsor. Not all sponsors help patients, some are on power trips, others do not know how to lead without being punitive when the patient slips. However many sponsors with significant years of sobriety do a fine job and assist us in helping the patient remain sober. Often times the sponsor becomes the ad hoc co-therapist.

How many 12 step meetings will the patient agree to attend at the intake meeting? Does the patient follow through with 12 step meeting attendance? If not, that patient has just reduced their probability of getting and remaining sober. We will use the term “sober” although we are referring to all addicts, drugs and alcohol, gambling, sex, computer, shopaholics, over eaters, over spenders, etc.

Since many new recovery patients are afraid, anxious and unable to go alone to a 12 step meetings, we actually have a fellow patient take them to their first meeting. This makes a major difference in the new patient’s ability to attend a 12 step meeting. We call another recovery patient on the phone while in session with the new patient who is in need of support. Try to make a good match with patients who take others to meetings, as it will make or break the early phases of recovery. Of course, due to confidentiality issues, we never say I am going to send you to a 12 step meeting with another patient. This would break all confidentiality rules. However, we do say, I would like to call this person I know and have him take you to a meeting. Then we encourage these two to talk to one another about recovery and meetings, etc. When matching fel-
low patients to take new patients to meetings, it may be best for a cocaine addict to take another cocaine addict. Likewise, a crystal methamphetamine addict will take another crystal methamphetamine addict and similarly for one alcoholic to take another alcoholic to meetings. Do the best you can, as you may not always have a fellow patient available to take a new patient. Should that be the case, send the patient to a meeting anyway.

Be prepared to give all new recovery patients an AA directory, at the first session. You can purchase these directories for $1.00 each by going to the local, Los Angeles AA office, located at 4311 Wilshire Blvd, Suite 104, Los Angeles, California 90010, or call (323) 936-4343, toll free (800) 923-8722, or via fax (323) 936-8927, or email lacoaa@aol.com. If you are out of the Los Angeles area, just go online to AA meetings and list your city. You will then locate a local directory for your patients. Directories tend to be valid for many months following their edition date, located on the top, right hand side of the front cover of the directory. It is noteworthy that there are more than 2500 AA meetings in Los Angeles county each week. This gives you an indication of the tremendous need for these generally beneficial meetings.

Why do we recommend sending all recovery patients to AA, even if they have been addicted to Crystal Methamphetamine, or Cocaine, or other drugs? In our experience, we send them to AA because addicts who attend AA meetings have far more sobriety than CMA (Crystal Methamphetamine Anonymous) for example. This is due to the tweaky nature of those attending the CMA meetings. “Tweaking” is the current terminology for someone who is high on Crystal Methamphetamine. Tweaky behavior seen in addicts is a state of being that can potentially set off a craving in our newly sober patients. People who have recently used Crystal Methamphetamine, and may actually be sober, can still put off tweaky vibrations. This is due in part to the lengthy detox of Crystal, which is a full 15-17 days. It may also be due to the lingering and residual changes in brain chemistry from using Crystal Meth, which can be present for up to 1 year following detox. Therefore, AA meetings may be more comfortable and less stimulating than CMA meetings. So, it is safer for our patients to attend AA. They gain far more support, and begin to build a support network with other recovering addicts, who are not tweaky. Building a new social system is what will naturally happen as these addicted patients continue to attend 12 step meetings. This is very important because if the newly sober patient continues to socialize with their old, using friends, they will generally slip.

Matthew was a Crystal Meth addict of many years. He had worked very hard, with a seasoned sponsor, and he had more than 9 months of sobriety when he arrived for treatment. He was suffering from untreated, intense paranoia. This psychotic state was a drug induced psychosis. He believed that the police were always following him, and that random license plates had meaning for his life. He could drive no where, without these paranoid beliefs. Sometimes, when he would arrive for his recovery treatment, he would be shaking, due to his paranoid experiences on the road as he drove to treatment. Matthew came in for treatment, with his sober boyfriend. They had a long term relationship, and now the boyfriend, was beginning to be very worried about Matthew and his ever increasing paranoia. This patient was in need of a Psychiatric evaluation. Matthew was referred to a Psychiatrist who fully understood Crystal Meth, the pa-
tient was prescribed medication to alleviate the horrible paranoia. It took several months for the meds to be properly adjusted, while the patient continued to show signs of distrust and continued paranoia.

Matthew attended regular 12 step meetings, but with his paranoia out of hand, he never talked to anyone, but his sponsor, who he had learned to trust. While meeting attendance is absolutely necessary for sobriety, it is better for the patient to interact, to share, and to talk to others at these meetings. Showing up, and being withdrawn is not useful for the patient’s sobriety. Therefore, this patient had many slips during this time of treatment. As the months went on, the paranoia was greatly reduced. Then Matthew could address how destructive his Crystal use had been. The patient slowly improved, but only with Psychiatric intervention. When Matthew began to interact with other recovering addicts in the 12 step meetings, his sobriety took on a new meaning, with a stronger connection to staying clean. The patient struggled for 2 years to stay sober, with little success. It was very tough for him, and he needed many Psychiatric appointments to get balanced. This patient was a dual diagnosis patient, which is far more difficult to treat. Success will not happen with all of our patients.

Over the years, many of our patients who chose to attend CMA have slipped following the meeting. Of course this can happen to any recovering patient, as the meetings can be triggers. This is yet another reason for our recovery patients to create their relapse prevention chart, which we will learn to create soon. This is why we insist that our patients begin to understand their cravings at the first session.

How to ruin your marriage? Keep drinking and keep lying. This is a case of a woman, in her early 40’s who looked like a model, tall, slender, and beautiful. She arrived for therapy with lovely, yet provocative, sexy, inappropriate, clothing and plenty of make-up. She was a successful business woman, who used liquor to close deals. Let’s call her Gail. Gail had a long term marriage with several children, and a husband who was getting very tired of her drinking problem. Gail didn’t think she had a problem with alcohol, just a problem with her husband. Of course, drinking was having a major, negative influence upon her marriage.

Gail arrived for her first session smelling of booze, obviously not a good sign. She was very concerned about her marriage, and did realize that her marriage was in big trouble, as her husband had found her cheating on him. It became apparent that Alcohol was the problem, but not to Gail. She simply could not stop drinking, not even for 1 day. What is a good working definition of addiction? Not being able to stop using or drinking, in spite of knowing there are adverse consequences. Gail was definitely addicted.

Whereas Gail had this long term pattern of drinking and cheating on her husband, he had just figured it out. Remember since we are now in the information age, with computers, we can learn quite a bit about others, and they may not know the information is being collected. Johnny, her husband, was extremely computer literate, as he hacked into her computer, on a regular basis finding numerous letters to business associates. These letters were more about affairs, and less
about business. This added to the stress in their marriage, as the distrust mounted. Lying is a big problem with most addicts, as it is their defense to continue using. Gail remained in denial with her husband about her excessive drinking, and her affairs, being unaware that he had been hacking.

Gail was ultimately a success, but it didn’t come easily. When she would slip, she would drink multiple bottles of expensive wine. As her addiction advanced, she began to drink Gallo, not the top of any wine list, but she didn’t care. Frequently, while drinking, Gail would Black Out, including while traveling on business trips. In fact, her extra marital affairs were sometimes news to her, as her black outs blocked her memory of these events. However, then she would receive an email from some guy, which alerted her of her inappropriate sexual behavior.

She attended AA meetings, and was able to embrace the meetings along with the steps. She found a wonderful sponsor who guided her quite well, through the steps. While her marriage was being challenged, she did prove to be a devoted wife. As she cleaned up, the sexual affairs stopped too. She continued to be a successful business woman, now with integrity. She was shocked to come to the understanding that liquor took her down to such low places. Of course, she did realize that she could still be a success in her business without the alcohol which led to sexual favors.

The last time I saw Gail, she had years of sobriety, looked healthier than ever, felt far better about herself, and was continuing to attend 12 step meetings. Even with all the damage she had brought to her marriage with her alcoholism, she was still working on improving her marriage. Since she had shattered the trust with her husband repeatedly over many years, she was still trying to prove to him that she was clean, sober and faithful. This would naturally be a lengthy healing process.

Staying sober has other focus points. Once the patient has made a personal commitment to 12 step meetings, the treatment will take a new turn and the work will generally be far more satisfying for both the patient and the clinician. However, this is only the beginning of recovery. Within the first 30 days of treating the patient, it is time for the clinician to support the need for the patient to find a 12 step sponsor. The sponsor needs to be worth his or her salt, or the patient can develop secondary problems, which are all avoidable. For example, a secondary problem might be trying to please the sponsor in ways that are not useful, like doing special projects for the sponsor, or cleaning the sponsor’s house. These activities are not about any 12 step program. This is a confused sponsor. Our patients need not become slaves to sponsors. Staying sober will include regular 12 step meetings, working with a beneficial 12 step sponsor, often some family treatment, individual recovery treatment, and applying the Relapse Prevention Plan, which of course involves understanding cravings.

Understanding cravings is absolutely necessary to maintain sobriety. Some patients who have been in an inpatient program, supervised daily, in early sobriety, often relapse during transitions. Some of these patients will find you, so be aware of this risky transition time for many. When
they come home, or to a sober living house, they need to re-adjust to life without drugs and alcohol. Many of these patients find this very stressful, and they therefore, want to use. We teach our addicted patients that stress equals cravings. The first few days home from the detox center, recovery home, or inpatient program, are often very difficult. In fact, we see this time as a critical period for the addict. Lack of structure, following a lengthy period of highly structured time, can be challenging to many patients in recovery. The sooner this patient begins treatment as an outpatient, the better their prognosis for extended sobriety. As clinicians we set the stage for grounding the patient.

All new recovery patients, who come to you for treatment, need to understand their cravings, no matter how long they have been an inpatient or in a sober living home. For many, the information you will now provide for them, will be new. It is essential information for all addicts to understand.

As the patient learns to identify a craving, and how to manage their cravings, then the patient will increase their chances of staying sober in a significant way, compared to others who cannot, do not, or will not understand their cravings. If however, the patient will not work with their cravings, they will most likely continue to slip and use. This is a common problem, early on, in the treatment of these addicted patients. It is our job, as clinicians to educate, support and find methods that encourage these patients to do the work necessary for recovery. Remember, the rate of recovery for these patients is, unfortunately, extremely low.

It is documented throughout the literature that patients who attend Inpatient Recovery Treatment Programs recover at the rate of 5-20%. For this reason, be prepared to motivate these patients on a regular basis. We have found positive reinforcement, in all forms helpful with these recovery patients, over time. What kind of positive reinforcement works best? Intermittent reinforcement is the most powerful, according to the work done by Pavlov, the Father of Operant Conditioning. We have found all kinds of positive reinforcement, such as verbal support, and contingency management which translates into sobriety awards, (gifts) work very well to reinforce sobriety.

These patients require non-traditional methods of treatment to really recover. Please remember it could take 2 or more years of treatment to reach that first year of sobriety, as relapse is what the patient and the clinician are up against, all the time. Our philosophy differs from other recovery programs.

ROAD TO RECOVERY PROGRAM
PHILOSOPHY

“Everyone needs beauty as well as bread, places to play in, places to pray in, where nature may heal and cheer and give strength to the body and the soul alike”
The Road to Recovery Program is an individually customized outpatient recovery program for alcohol and drug dependent patients. Each patient has a unique and personalized outpatient program to fit their needs. The Road to Recovery Program is designed as a hybrid treatment program, somewhere between a hospital (inpatient treatment program) and traditional psychotherapy. For some patients, The Road to Recovery Program is a hospital without walls.

For example, one crystal meth recovery patient, who could not get stabilized and who could not afford an inpatient treatment program, was treated 4 times a week, for a 3 week period. During this short, yet intensive treatment period, the patient, who had been in a crisis, became stabilized and was able to continue with his education, without interruption. The treatment for this patient took place in a nearby park setting, where we walked and talked as the patient worked out his problems. Constant movement was the only thing that “contained” this over stimulated patient. Following the 3 week intensive treatment program, the patient then returned to twice weekly sessions. Today this patient just achieved 1 year of sobriety. This patient now is gainfully employed and has just celebrated another milestone, a 3 year anniversary with his spouse.

The goal is to help the patient experience a “humane detox“, medically supervised, when necessary, to maintain sobriety, while remaining employed, living at home and being productive. We believe that these addicted patients have suffered enough and need not be punished for their disease. Some patients require hospitalization, an inpatient program, see the information on The Healing Hacienda, a psychiatric medication evaluation or the Prometa Infusion treatment program. See Prometa.com for further information on this new infusion treatment procedure.

Some patients attend our new inpatient recovery program, The Healing Hacienda, on the shores of Mexico. This is a 28 day inpatient program is designed with the individual in mind. One patient will be treated at a time at The Healing Hacienda, offering a unique opportunity for maximum benefit.

Since Alcohol and Drugs are toxic substances, they affect the brain in negative ways, causing Depression, and poor brain health. Improving brain health and brain plasticity, can be accomplished through sobriety. This is an important part of recovery, Change Your Brain, Change Your Life, a book by Dr. Daniel Amen, is another reference for our recovery treatment. It should be noted that it takes at least one year to recover from Crystal meth abuse due, in part, to the depletion of Dopamine.

Since Depression goes hand in hand with addiction, we have found that exercise, which increases blood flow to the brain is another useful part of our treatment program. Through movement, (walking) and being in a natural setting, the addict has a better chance to recover and heal more.
effectively. In treating more disturbed patients, those who have dual diagnosis, and in more advanced addiction cases, non-conventional recovery treatment methods are required. Many of our patients have already failed multiple recovery inpatient treatment programs before being treated successfully by The Road to Recovery Program.

What are non conventional treatment methods? There are numerous schools of thought involving movement and psychotherapy. Here are some examples: Somatic Counseling Psychology, integrates movement, cognition and emotions together. We apply movement therapy, with the patient in natural settings, as the gateway to unconsciously helping the patient begin to integrate the mind and body. We like the natural settings, like the beautiful, local parks, as a way for the patient to reconnect to mother nature while actively working on his/her recovery issues. See Somatic Counseling Psychology, Naropa, University.com for further information. Since nature affects many of us in a profound way, it will add to your strength in recovery.

The Feldenkrais Method, known internationally for awareness through movement, is another reference for supporting our philosophy that movement encourages a greater awareness of the body and mind connection. Addicts are typically disconnected from their bodies and mind, and have often used alcohol and/or drugs to disconnect and to stop feeling; to numb themselves against their psychic pain. See Feldenkrais.com for more information on this treatment method.

Somatic Expressive Therapy, has been used as a training method for the Massachusetts State Department of Substance Abuse and Mental Health. It is a powerful method of mind and body healing. This method heals the mind through body movement. See The Leven Institute for Movement.com for further information on this treatment.

All of these methods documented above suggest, as we believe, that movement assists with emotional growth, bringing accelerated healing and enhancing recovery. It is for these reasons that we utilize these methods of walking, in natural settings, while the patients process their recovery issues. We have seen tremendous growth using these simple and easily accessible, techniques along with other methods stated below.

What does our treatment program look like?
(1) Movement in nature
(2) Cognitive Behavioral and Directive Therapy
(3) Positive reinforcement, known as Contingency Management
(4) Alcohol and drug education and awareness
(5) Understanding cravings
(6) 12 step meetings
(7) Family treatment
These modalities all serve as the foundation for The Road to Recovery Program.
“Sobriety Awards” are earned at intermittent sobriety intervals. The literature demonstrates that, behavioral and positive reinforcement helps support extended sobriety. The longer the treatment, the better the outcome. See Richard Rawson, Ph.D., a UCLA substance abuse researcher, who has numerous articles supporting our philosophy and treatment design, both for inpatient and outpatient treatment.

With relapse rates, at about 90%, it is obvious that addicts do not recover with conventional methods. Applying our philosophy, as stated above, The Road to Recovery Program has a success rate of nearly 85%, for our patient population, who remain in treatment for 12 months or longer.

Now we will focus directly on creating the relapse prevention plan and the patient’s individual chart. This will be used with the patient on a regular basis. Let’s get started. To begin, think about a patient you know who is addicted and for demonstration sake, use the information about this patient to build your first relapse prevention plan and chart.

Use the following to identify your cravings: Take out a piece of paper, draw a line down the center of the page, creating two equal columns. Name the column on the left side as “Triggers”. On the right side of this paper label this column “Escape Plans”. What is a trigger? A trigger is something that sets off cravings. An example would be work stress. For some patients work stress will trigger a craving to use or drink or seek sex or shop, etc. List all things that stir up cravings. Write each one down on the left side of this paper. Think hard. Since we know that “stress equals cravings”, every time, we teach this to the patient and help them reduce their stress, and to prepare for cravings. This is the primary value of the relapse prevention plan. Unlike conventional psychotherapy, we recommend revisiting this concept often, especially when you notice that your patients are more stressed than usual. This indicates a higher risk for relapse. Below is an example of how the Relapse Prevention Plan will look:

<table>
<thead>
<tr>
<th>TRIGGERS</th>
<th>ESCAPE PLANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loneliness</td>
<td>1. Call a friend</td>
</tr>
<tr>
<td>2. Driving by the dealer’s house</td>
<td>2. Take a different route</td>
</tr>
<tr>
<td>3. Seeing the drug on TV or Movies</td>
<td>3. Eat a candy bar</td>
</tr>
<tr>
<td>4. etc</td>
<td>4.</td>
</tr>
</tbody>
</table>

These are real examples and your patient will know their triggers as you walk them through this process. Other examples of a predictably high stress time would be the Holidays, Christmas and for sure New Year’s Eve. Help the patient carefully identify a plan on how they will celebrate without drugs or alcohol. Do they have a sober place to party? Help them create one, if they don’t know what to do. This may seem extremely basic, which is why we consider this treatment guidance and treatment management. Applying the escape plans will help the patient remain sober. So, be ready to walk them through their relapse prevention plan every now and then, and always at times of high stress. Also plan to update the chart, as needed, as more information is understood. For example, bereavement is a classic trigger, therefore we find that it is impor-
tant to be active with these patients. Ask them about how they are managing their cravings. Keep it an open dialogue for at least the first treatment year or longer should the patient continue to slip. Continued slipping means that the patient does not understand their cravings, is not applying their relapse prevention plan, is very self-destructive, may have a dual diagnosis and/or is simply not ready to stop using.

Now that you understand more about cravings and relapse prevention, we will show you how to get started with your recovery patients. We recommend that when you see the patient for the first session, you begin using Directive Therapy techniques. We are only interested in the drug and/or alcohol history at this time. We are not yet interested in the patient’s history, with the exception of the family drug and/or alcohol history. It is significant if the family has a history of drug and/or alcohol abuse. But it will not change the need for the relapse prevention plan. If a family history of drug and/or alcohol is present, the patient has an even greater need for understanding cravings and to create their relapse prevention plan, as soon as possible. Be prepared to spend 1 ½ to 2 hours with the patient for the first session. It can take this long to begin to collect the necessary information, to listen to the concerns of the patient, and then to start documenting the relapse prevention plan, with the patient.

Therefore, give the patient some blank paper and a pen and begin to instruct them on how to create their Effective Relapse Prevention plan and chart. We recommend telling the patient that this is a very useful tool, which will help them stay sober. We begin in the same way we had you create this plan and chart above. We directly ask the patient to draw a line down the center of the page, creating 2 columns. Name the column on the left “Triggers” and the column on the right “Escape Plans”. Now walk the patient through this process, by asking them what situations are they aware of which create cravings. This is known as triggers. So, have them begin the list now. Keep up the questioning until they have identified numerous triggers. Now, begin questioning them about what escape plans they can make. If they are stuck, as some may be, begin to recommend some ideas, as demonstrated above. Of course the more information the patient provides, the better.

When we work with patients, it is entirely likely that by working on their cravings, they can put themselves into a craving state. As clinicians, we need to ask the patient during this process, if they are experiencing cravings. If the patient says yes, it is time to move to step two, the escape plan immediately. Perhaps get out of the office and walk for 10-15 minutes and watch the craving reduce its power. Then process that with the patient. Also, should the patient enter into a craving state, it is a teachable moment, one that we, as clinicians strive to work with. So, it can be just the moment that we have waited for, it is that teachable moment, as you will see.

It is essential to know that cravings are normal. We tell our patients that cravings are normal. Remember, part of recovery treatment is to educate, so we do as much as possible. All people have cravings of one kind or another. Some for chocolate, others for pickles. When you have a
craving, you are at a choice point. There are many choices that you can make. You could use, and it may easily be your patient’s first thought.

We hope the patient will begin to think it through and apply what they have learned with the relapse prevention chart. Be aware that if the craving is very strong, the patient will need to already have their escape plan in place, and memorized. However, don’t depend upon the memory of any addict, and certainly not during a craving state. This is because when cravings start, they can increase rapidly and they can decrease only when you know how to manage your cravings. The patient will need to know what to do with their cravings, now, before they start. Cravings can feel extremely overwhelming. Knowing that you never need to use again, is a relief to many. It’s true, you never need to use again!

We educate our patients by giving them the following information: All cravings are brief, and generally end within 15 minutes, if you intervene with your Relapse Prevention Plan. However, if you feed a craving, through thought or through self deception, about the glories of using, then you will have more difficulty in recovery. If you convince yourself that you will only use this one time, you are fooling yourself. This is because you can extend a craving in about 15 minute intervals until you either drive yourself crazy or use. If you find the patient feeding their cravings, they will more than likely slip, until they begin to think differently about their drug abuse, and their desire for sobriety. Over time, the patient can and will learn how to get sober and how to stay sober, as they understand their cravings.

Good thinking is mandatory for recovery, and not so easy to access in the early days, and months of sobriety. Positive results can and will be attained by following a few new thoughts. Don’t be afraid of your cravings. Don’t try to stop them, but do be sure to address them differently.

We ask our recovery patients to choose some creative name for their Relapse Prevention Plan, and own it. Many have made up catchy names which have special meaning to them. Here are some examples of titles which our patients have given their relapse prevention chart, (1) My Absolute Confidence Kit; (2) MY Way to Remain Sober; (3) Mark’s Prevention Plan; and (4) How to Prevent A Slip. Those titles are just a few. We ask them to go home after they have created their relapse prevention plan and chart with us, and to reformat it in a way that makes more meaning to them. As they are doing this at home, it is a way for them to become more familiar with their triggers and escape plans. We then ask the patient to Fax it back to us. As clinicians we see this as a compliance indicator. If the patient does not work on their relapse prevention plan, it is an indicator of non compliance, which translates into this patient being at a higher risk for relapse. Those who follow through, renaming their plan, and owning it, are those who will take instruction which is very positive for sustained sobriety. Resistance is obviously something else to work on with these non compliant patients.

We ask our patients to make 4 copies of their relapse prevention plan for themselves. We recommend placing 1 copy on the fridge. Copy 2 goes in their wallet. The 3rd copy goes in the glove box of their car and the 4th to work. Know before a craving comes, not to fear them, not
to try to shut them down, but rather to take action based upon your needs. Remember any dis-
traction will end the craving if the patient will intervene sooner rather than later. Because if the
craving state goes on and on, it is predictable that the patient will use.

Have the patient read their Relapse Prevention Plan and get familiar with their escape plans, on a
regular basis. Escape plans must be understood well in advance, because when cravings come,
they often do not allow us to think. The mind goes dead and only the thought of using may be
present. Therefore, they must know their plans in advance, to remain sober. Cravings lie to us,
and sometimes tell us to hurt ourselves. We do not need to listen to this poor thinking. We tell
our patients to reject all thinking that brings them towards a slip. Some programs will tell you
that slipping is expected. We do not agree. It’s entirely possible for the patient to work with
their cravings and remain sober. It will take some honesty and some soul searching to actually
begin to apply this information. Doing this exercise will increase your patients ability to stay
sober.

The patients efforts will pay off, and this plan should be able to increase their chances of living
sober, more comfortably. A significant number of our patients, at The Road to Recovery Pro-
gram, who learned how to apply their relapse prevention plans, are now sober. They are enjoy-
ing a sober life, find themselves far happier, work lives have improved, relationships deepened
and enriched, and more. We want the patient to think of the ways in which they would like their
life to improve. Living a clean and sober life is a good thing.

Good luck to you as you learn how to help your recovery patients better understand themselves,
and their cravings. We know patients can beat their cravings, and stay sober. By creating this
relapse prevention plan, you have educated your patients and given them a specialized tool which
is created by them, to assist them with their cravings. Remember cravings are normal, and they
can be worked with in positive ways for increased and sustained sobriety.

THE END