Solutions for Families Facing Alcoholism and Drug Addiction in Loved Ones

RELAPSE AFTER ADDICTION TREATMENT – ADVICE FOR FAMILIES

A Detailed Inquiry into Relapse, What Went Wrong, Assessments and Developing a Plan to Address Relapse, For Family Members and their Loved Ones

RELAPSE PART ONE
WHAT IS RELAPSE AND WHAT TO WE KNOW ABOUT IT

A. What is Relapse
1. **Relapse Rates**
2. **Exceptions: Doctors/Pilots & Daily AA Attendance**

B. What Do We Know About Relapse?
1. **Relapse is Common**
2. **Relapse Should be Discussed in Treatment**
3. **Relapse is Reasonably Predictable**
4. **Relapse is Preventable**
5. **Failure Leads to Low Self Esteem**

A. What is Relapse[1] ?

Relapse – the inability to maintain behavioral changes over time.

- A person's ability to maintain recovery may be related to skills that are different from those needed to initiate change.

In other words, the decision to seek treatment does not mean the person has the desire to maintain abstinence or commit to the hard work of long-term recovery. **Keep this important distinction in mind.**

Your PWP needs to be open to learning and practicing the skills to maintain recovery.

- Many get to treatment, find out what is needed and say to themselves "Forget it".

Their goal then becomes how not to get caught again by their families.

1. Relapse Rates

90% if defined as consumption of any amount of alcohol

- Common for some periods of abstinence between use
- So much for the **Silver Bullet** and promises from treatment centers/interventionists

Rates vary by definition of relapse, length of treatment, elapsed time after treatment

2. Exceptions To Low Rates

- Airline pilots: 92% Continuous abstinence at two years
- Doctors: 74% Continuous abstinence at five years

Both groups have specialized program run by their oversight boards that require participation for at least two years. (These programs are not available to other groups.)

But – 90% at one year, if treatment followed by daily attendance at AA

- Twenty-eight days in treatment, plus daily attendance at AA and weekly aftercare counseling for a year is said to result in 90% abstinence at one year.

[1] Infra ps5-7

I believe this is for middle class males with an intact life (job, housing, family) and no co-occurring conditions, such as a learning, mental health, or trauma.

B. What do we know about relapse? The Basics

1. Relapse is Common[2]

- 90% will pick up a drink or a drug within one year of treatment
- 50% will have returned to the same severity of use as prior to treatment

2. Relapsed should be Addressed in Treatment[3]

Duty of the clinician

- It is wrong to assume that discussing relapse means it will occur
- Individualize understanding of vulnerability for circumstances of each patient

Clinical follow-up for monitoring should be part of post-treatment obligations of the treatment center, but this is often a hazy area. What happens if relapse occurs? Is anyone notified.

Many treatment centers still believe that discussing relapse prior to discharge increases the likelihood of relapse. This is nonsense. Because relapse is so common, far better to come up with a plan in the event of relapse, discuss it in a family conference and **put it in writing**. Also, very important to discuss potential relapse triggers or environments as part of the relapse plan.

3. Relapse is reasonably predictable

Patients must understand:

- General precipitating situations
- Personal triggers

Examples:

- General emotional danger zones
- HALT (hungry, Angry, Lonely. Tired)
- General social situations
- Personal emotions
- Personal situations

Address these in post-treatment plan while in treatment

But does the patient have a commitment to stay clean?

<u>Example, Harry who went to treatment to comply with licensing board demand</u>

Harry attends quarterly professional meetings out of town, including the social hour. Harry does not tell his colleagues he is in recovery. Harry joins friends at their table in a bar. He goes to the bathroom and returns to find a beer on the table in front of his chair. He drinks it.

[2] Infra 6
[3] P 3

Three days later Harry's brother has to fly in, haul him out of his hotel room and bring him home. Why did he not tell his colleagues he was in recovery? *"I did not want them to think less of me.* Was he ashamed? Did not accept the disease concept? I have a disease – not a moral weakness? No, I think he just wanted to drink. He thought he could never be fired from his job due to statutory protections. (He was wrong!)

4. Relapse is Preventable

In addition to abstinence maintenance and self-monitoring activities, combining active involvement with:

- AA or other support group
- Office based personal counseling
- Religious group
- Fitness/health
- Any lifestyle inconsistent with substance use

I would add drug testing, family therapy, stable housing and income, and reliable support group in the community. But you can set all this up, but if motivation lacking, relapse probable

5. Failure leads to low self-esteem

- Earnest but failed efforts at abstinence can produce low self-esteem, depression and a sense of hopelessness.

For the professional, well-off or well-known there is the double shame of falling from high places – not measuring up to high standards. This sense of shame can be exacerbated when some siblings are successful and the PWP is so obviously a "failure" in comparison.

As a family member or friend, It is important not to blame. Instead, encourage your PWP to visit with his/her counselor to review what happened

RELAPSE PART TWO
REVIEWING MOTIVATING FACTORS AND TREATMENT EFFORTS

C. What Factors Lead to Long-Term Recovery?
1. **Severity of Negative Experiences**
2. **Developing Internal Motivation to Recover**

D. Review Past Attempts at Helping Your LO
1. **Quality of Professional Assistance?**
2. **ASAM: Six Criteria For Placement in Treatment or Out-Patient?**
3. **What Goals Were Completed in Treatment?**
4. **Reviewing the Quality of Treatment?**
5. **Blaming the Substance User For Relapse**

C. What Factors Lead to Long Term Recovery?[4]

Your LO has relapsed. And you are wondering if there is any information about what might work for to support long term abstention from drugs and alcohol

1. Severity of Negative Experiences

Study of men showed those who became abstinent tended to experience a number of medical, legal, or social consequences due to use.

- Those who did not tend to believe they do not have a significant drug or alcohol problem.

This is a big problem for affluent addicts who usually do not suffer many external consequences. They need to figure out ways to make the disease real to them in their lives. Bending one's will to adhere to treatment recommendations is one way to do experience consequences.

The AA Big Book talks about people needing to lose everything in order to develop the willingness to recover. But in the second set of stories, with the preface title, ***They Stopped in Time,*** the message is that by focusing on the emotional, relationship and spiritual degradation due to alcohol and drug use, along with examples of physical deterioration, one can be motivated to stop without losing everything. But this likely requires a strong therapeutic alliance with an experienced counselor.

2. Developing Internal Motivation to Recover

Motivation plays a large role in recovery

- Higher motivation for those in treatment than those not in

a. Inspiring Motivation

Motivation can be inspired in two ways:

- External Pressure from others to change

[4] Infra p. 18

- Internal Pressure from oneself

Internal motivation is a more powerful predictor of recovery than external. Need to keep external pressure in place until internal motivation comes into play as people experience the benefits of recovery.

b. Converting External Motivation to Internal Motivation

Good literature on this topic

- Pilots, Health Care Professionals and Drug Court participants have the highest rates of recovery.

Strong external motivators for these groups to continue following treatment recommendations or lose licenses to practice or face incarceration. Families need to create similar strong external motivational tools, but they will need help in doing so from an experienced counselor.

In my practice, I worked with clients to use access to money and resources for trust fund beneficiaries and members of family business to good effect- therapeutic leverage to obtain treatment compliance. See Using Leverage to Support Long Term Recovery. Also, contingency management, below.

c. Positive Therapeutic Milieu

Creating safe space for clients, (See above and blog on "safe spaces" – setting the conditions conducive for change.) Positive relationship with therapist.

d. Addiction Treatment as Motivation Enhancer?

Measures of success(?) in treatment[5]:

- Recognition of addiction improved from 50% to 60%
- Ambivalence about recovery decreased from 30% to 20%
- Taking action for recovery increased from 60% to 70%

Comment: "28 days", as measured here, has little effect on improving recovery rates. Reinforces the need for post-treatment services and compliance incentives.

e. Contingency Management (CM)

What is it? Contingency Management involves giving patients tangible rewards to reinforce positive behaviors such as abstinence.

- Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) principles.

Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions **are highly effective in increasing treatment retention and promoting abstinence from drugs.**

[5] (Measured by the Socrates – Stages of Change Readiness and Treatment Engagement Scale – Miller/Tonigan)

From New York Times;
This Addiction Treatment Works. Why Is It So Underused?
An approach called contingency management rewards drug users with money and prizes for staying abstinent. But few programs offer it, in part because of moral objections to the concept.
https://www.nytimes.com/2020/10/27/health/meth-addiction-treatment.html?smid=em-share

D. Review Past Attempts at Helping Your LO

You as a family member or friend may have been involved in finding (and paying) help including interventionists and treatment center options. Let's review the process to see where things might be improved next time around;

1. Quality of Professional Assistance?
Did someone help you get your LO into treatment? If so, what were their qualifications?
We urge hiring a professional who either:

- Holds degrees from an accredited, reputable college or university, or
- Is licensed or credentialed as per applicable state standards and guidelines

for the presenting behavioral health concerns.
Also, any professional authorized to prescribe medications should be certified by ASAM (Society of Addiction Medicine) or under the direct supervision and direction of an ASAM-certified professional.
Note: Any person who helps you should be independent of any treatment facility. (See future blog on finding help)

2. **ASAM: Six Criteria for Placement in Treatment or Out-Patient?**
Did you or your helper use the ASAM Placement Criteria for deciding where and what kind of treatment your LO needed?
The American Society of Addiction Medicine evaluates SIX areas for determining whether or not a person with a problem needs in-patient or out-patient treatment. The six elements are:

Dimension 1: Acute Intoxication and/or Withdrawal Potential:

- Ranging from no withdrawal risk to high withdrawal risk requiring full hospital resources

Dimension 2: Biomedical Conditions/Complication: Physical health, medical problems, physical activity and nutrition:

- Ranging from none, or stable to requiring 24-hour in-patient medical and nursing care,

Dimension 3: Emotional/Behaviors/ Cognitive Conditions and Complications.

- Thoughts, emotions and mental health issues, vulnerability due to trauma

Dimension 4: Readiness to Change Dimension

- Assess motivation for readiness and interest in changing behavior.

Low levels bode against in-patient treatment.

Dimension 5: Relapse/Continued use/ Continued problem potential.

- Concerns about continued substance use, mental health issues or a relapse.

high-risk behavior?

Dimension 6: Recovery Environment- Risk of Relapse

- Living situation, interactions with people, places and things and financial support.

BOTTOM LINE: Whenever, there is recommendation for treatment, make sure whomever is making the recommendation discusses these six components with you AND has the credentials and schooling to do so. (For more on the six placement criteria see subsequent blog.)

3. What Goals were Completed in Treatment?

There are several different approaches for measuring progress in treatment. The Stages of Recovery are one measure. For relapse review purposes, the first three stages are the most important:

a. Transition: Recognition of Addiction

b. Stabilization: Recuperation – Five Tasks:

- Achieving Recovery From Withdrawal
- Interrupting Active Preoccupation
- Creating Short-Term Social Stabilization
- Learning Non-Chemical Stress Management
- Developing Hope and Motivation

c. Early Recovery: The Process of Changing Addictive Thinking

These tasks take much longer than 28 days. Did your LO's treating professionals discuss with you how she/he was progressing through these stages, developing awareness of her disease and increasing motivation to change? For more on this topic, see Stages of Change and Attitudinal Breakthroughs.

4. Reviewing the Quality of Treatment?

a. Was the treatment facility ASAM certified?

ASAM is now certifying treatment centers to:

give patients, loved ones, payors, and regulators the knowledge that a given treatment program is capable of administering evidence-based addiction treatment that is appropriately matched to a patient's individual needs.

Use of The ASAM Criteria, the most widely used and comprehensive set of guidelines for addiction treatment, improves patient outcomes by establishing a continuum of care that reflects the modern understanding of addiction as a chronic disease. As a patient's condition improves or worsens, they move along the continuum of care to the level most appropriate for their needs.

At last, you as the consumer of SUD treatment along with your LO can look to a reliable resource for judging the quality of SUD treatment centers. (Reference to The ASAM Criteria®.)

b. Was There a Continuum of Care?

Was your LO recommended to do the following?

- At least 21 days of inpatient
- Plus, out-patient
- Plus, involvement (vs attending) in AA

Continued participation in recovery activities for a year bodes well for abstention

c. Quality of and Involvement in Post-Treatment Planning.

SUD users recover in their communities, for the most part. Were you asked to participate in your LO's post treatment planning process? Was it written down and signed off on by your LO?

Was a plan in place in the event of relapse? Did your LO sign the plan?

5. Blaming the Substance User for Relapse

It is common for treatment centers to blame the patient for relapse by not following treatment recommendations. In my view, an addict/alcoholic in early recovery is still a vulnerable adult, often suffering from post-acute withdrawal symptoms (PAWS, look it up) and is likely not to make good decisions regarding his/her recovery.

- This is one reason why you need to be a good advocate for your LO.

See my article, Dual Track Case Management and Monitoring: The Key to Recovery from Addiction and Other Behavioral Disorders, for more on effective family involvement in supporting post-treatment recovery.

Relapse Part Three
Relapse Triggers

Relapse Triggers
1. **What are they?**
2. **For the Person in Recovery Only or a Family Concern?**
    a. **Sink or Swim on Your Own**
    b. **Versus Constructive Family involvement**
    c. **Is it Treatment or Punishment?**
3. **Are You Part of the Problem or Part of the Solution**
4. **Keep Hope Alive**

E. Relapse Triggers
Where the Pedal Meets the Road After Leaving Inpatient Treatment
Relapse triggers are significant hurdles that your LO attempting to stay abstinent must manage to remain on the path to stable sobriety. Because at its core, substance dependence is a learned behavior of the autonomous system, triggers can cause an almost overwhelming urge to use or drink, despite our firm commitment not to do so.
- Much of recovery is learning ways to deal with triggers without picking up.

From personal experience, it's not easy to manage triggers, and I know many people who did not successfully do so. What do triggers have to do with you as a family member or supportive friend. Plenty!!

1. What are they?
Environmental and interpersonal cues leading to urges to drink or use:
- Stress
- People or places connected to addictive behavior
- Negative or Challenging Emotions – Interpersonal Conflict
- Seeing or sensing the objection of your addiction
- Times of Celebration
- Social pressure
- Financial Pressure (too much or too little access to money/resources)
- Within an individual – person's mood or coping style

Triggers are often subjective states in the sense that it is the attitude and perspective of the person in recovery who is experiencing the urge to drink or drug. They are often brought on by interpersonal events, but a lot of what goes on in the heads of people in recovery remains there – they don't talk about it – often due to fear of a negative reaction.

As part of my counseling work with families in early recovery, I spent a great deal of time helping families understand triggers and how they might respond positively so their LO might better manage cues and the desire to use. Before describing some of

those situations, let's get into the controversy about whether families should even bother to worry about their LO's struggles with using urges.

2. Relapse Triggers – For the Person in Recovery Only or a Family Concern?
Relapse triggers are a difficult concept for families to get their heads around. There are two competing and radically opposite views:

a. Sink or Swim on Your Own
On the one hand, your LO in early recovery is responsible for maintaining abstinence. To this end, the common advice from treatment providers and the AA community is that families and employers should not adjust their behavior or environment at all for a family member in recovery.

- It's up to the person with the problem to refrain from using!!

If he/she is experiencing consequences from their past using life or from triggering events, so be it, let your LO deal with whatever is happening. This attitude is reinforced by Treatment Centers, Alanon and Family Program advice about "Letting go". Families and their advisors are told to do nothing to accommodate their LO's recovery (except send money to treatment providers.)

- Example: One family business founder asked at a family program what he should do about his son returning to his marketing job after treatment.
- The answer: nothing.

The son went back on the road, soon was drinking again and the business sold due to lack of a competent heir.

b. Versus Constructive Family Involvement
On the other hand, the family, home, social, and work environments are full of potential triggers. There is a growing body of neurological data to support the anecdotal experience of people in recovery who report what can be an overwhelming emotional response to triggers – think of Pavlov's conditioned response. If you are truly committed to supporting your LO in his/her recovery journey, you most absolutely be attentive to and willing to learn about potential triggers.

- *Oh No,* you say, *my PWP caused so many horrible problems when using, now I've got to forgive and forget? No way!!*

The goal here is to change negative enabling to positive enabling by learning how to engage in constructive interactions with your LO, particularly in early recovery. Do so, not to forgive, but to avoid relapse and potential death.

- A common phrase is "You didn't cause it and you can't fix it"

This is actually a very simplistic concept that fails to acknowledge the very important role family systems play in the addiction and recovery process, as proven by research. I have spent many hours with client families working to disabuse them of this misguided, too often fatal, advice.

One role of the counselor or friend or family member is to be a good listener, validate the feelings and experiences and help our client/LO work through the process of

identifying and responding to triggers. This can almost be an impossible role for family members to play in early recover without the guidance of an experienced counselor. But it is well worth the time and money spent for professional help.

c. Is it Treatment or Punishment?

The idea that substance users need to suffer consequences to develop the motivation to overcome triggers, i.e., not relapse, is related to the concept of "Letting Go" – that people need to recover on their own. The critical and often overlooked factor here is that once your LO is in treatment, it is time to stabilize the situation and create positive incentives for recovery. Otherwise, continued consequence can easily become punishment.

I've seen misguided, often malevolent, advice given to family members by interventionists and treatment counselors in the name of suffering continued consequences:

- Don't pay your brother's bills or call his clients while he is in treatment
- Don't maintain your son's house while he is long-term treatment (son gave his father a POA for the house – dad did not turn on the heat and the pipes froze).
- Don't give your LO access to any money

A young man I know – a lawyer – relapsed and was advised by his AA sponsor to spend several months at a sober home where he lived in a basement apartment with a roommate. It was a very negative living situation and our man became depressed and despondent. The message received was he was a bad person for relapsing, and this was his punishment. No!

Question: Is it better to be in a comfortable environment with a robust program and oversight or a crappy setting with little content or accountability? The former works much better – let's use carrots for people who stop using and leave the sticks, if therapeutically warranted, for people who won't stop.

3. Are you Part of the Problem or Part of the Solution

One reason recovery rates are so low is that the view is due to the sink or swim mentality. Sink or swim advice is well-received by family members because they are often angry and frustrated by their LO's use and associated negative behaviors and actions.

- Fine to have these feelings, just don't let them lead you to engage in self-defeating behavior in your interactions with your LO.

Or Is it going to be too difficult for you to accept that you are part of the problem and now must be part of the solution? A tough task for many family members, particularly the patriarch/matriarch and their advisors.

Counselors advise *"Adjust your lifestyle to your recovery, not your recovery to your lifestyle"* Can you as a family member do the same? Some examples for families to consider:

- Keeping alcohol in the house, including the sacred wine cellar
- Vacationing at resorts with limited or no alcohol present
- Mandatory attendance at social/family events and annual meetings where alcohol is the primary social lubricant.
- Willingness to adjusting work/life schedule to accommodate recovery activities
- Being OK with LO attending AA meetings while on vacation
- Having to continue to work in the family business to maintain lifestyle
- Creating stable income streams versus annual determination by matriarch
- Dictating which recovery meetings/activities are acceptable.

Are you viewing addiction and alcoholism as a moral failing (*we don't drink to excess in our family*) or a medical illness?

Much of my professional career involved helping families understand how to support their LO's recovery, including:

Recovery Plans

- Developing, implementing, and managing a recovery plan intended to assist the PWP in managing triggers, including regular supervised drug testing.

Drug testing means he/she knows there is an immediate consequence for picking up. These plans include measured access to family resources, including money, commiserate with progress as an incentives to continue to comply with on-going treatment recommendations. Positive Reinforcement does in fact work.

4. Keep Hope Alive

It is common situation for people in early recovery to be partially or fully dependent on a spouse, parent or grandparent for support. This puts the payor in a very powerful position – one that needs to be exercised with professional advice - to achieve the right balance between too much and too little.

- Trustees giving their beneficiary a jaguar to replace the one he sold for drugs – No!
- Having your son with eight months clean time and an active recovery program living in a dump – No! Time to reward that progress with an improved (and safer) living situation

The key here is to hold out hope for a future where at least some of the benefits of belonging to a family are restored as recovery progresses.

Relapse Part Four
Assessing Underlying Conditions and Treatment Elements

Assessing Underlying Conditions and Treatment Elements

1. **Checklist of Underlying Conditions**
2. **Analyze Primary and Secondary Treatment Elements**
3. **Chart of Interrelationship of Underlying Conditions**

One common treatment theme: Stabilize the substance use disorder so that people in early recovery can begin to work with counselors to address underlying conditions driving their use.

- The first order of business is "putting the cork in the bottle", committing to abstention and following treatment recommendations.

Once this process is progressing, time to look into what might be factors that make using the preferred alternative to introspection and self-examination. *Something's wrong – but let's drink or drug these feelings and problems away! Now that's over and the dark night of the soul is upon us.* This is often where your LO in treatment or early recovery loses resolve – too difficult to deal with without help. AA Slogan- Our minds are too scary places to enter alone

Underlying Conditions- Why this Concerns You

Why are you, as a family member or friend an integral part of this analysis? One important point to keep in mind is that your relapsing LO very likely lacks the insight to evaluate what might be childhood experiences, traumatic events, learning and mental health concerns.

- When using, we can be very emotional – angry, tearfully sentimental, blaming.

But these expressions, while real, tend to stem from our ingested substances. Your support in helping your LO focus as well as your experiences growing up or living together can be very helpful to counselors and other professionals working together to create a relapse response plan.

1. Checklist of Underlying Conditions

<u>Anger and frustration</u>

Learning to express anger in a constructive fashion

- Frustration – unable to complete goal or activity
- Frustration towards self – feelings of guilt or incompetence
- Frustration directed towards those perceived as blocking a goal

Justified anger can be a real stumbling block. *Why did my father beat me? And why just me, not my brothers?* Good questions with no sensible answers.

<u>Stress</u>

Stress is the body's response to events that a person perceives or feels as potentially harmful

Nervous system of substance dependent is hypersensitive, particularly for trauma victims. It is reported that 59% of women and 30% of men presenting for treatment experienced significant trauma.

- Question: Is the intervention and treatment process leading to more or less trauma?

Many people are watchful, scared and do not feel comfortable in the treatment environment. Reviewing an **abuse wheel** identifying various types of abuse is often a good starting point for this discussion.

Affluence and Trauma

Many affluent people do not consider themselves trauma victims for being made fun of, exploited and resented due to family wealth or for absent and inattentive parenting. *We had it so good, how can we complain?*

- As with the abuse wheel, it its helpful to review an outline or check list potential trauma inducing experiences.

We need a safe environment and a supportive, understanding listener for these conversations to be productive (vs intrusive and frightening).

Problem Solving Skills Helpful in Early Recovery

Problem solving coping styles are said to be better than emotionally focused styles for stress and addressing relapse triggers. This means using approaches like CBT – Cognitive Behavioral Therapy - to reframe precipitating thoughts or events.

Prescribed and OTC Medications

ADD medications and opioid substitutes are significant contributors to relapse. All medications including legal drugs or chemical substance must be prescribed by an ASAM board-certified medical doctor, psychiatrist or provider in a current program of treatment supervised by such doctor or psychiatrist or provider.

Other addictive behavior

You name it! Gambling, internet, pornography, spending, sex, eating, the list goes on and on.

Relationships

Often in shambles with SO and extended family. We stop drinking/using and feel a lot better, while those close to us are still angry and alienated. The Alanon slogan – *We never forget, we never forgive* – runs smack dab into learning to live in the present moment – The treatment mantra: can't change the past, can't predict the future. "I'll do it once because I'm horny and again tomorrow because you completed treatment, but after that, forget it."

Positive Emotional States

Good times lead to use – based on "conditioned experience of what leads to "pleasure". Need to reframe pleasure as being spiritual, meditative – not material

Overconfidence

Self-efficacy or confidence increases as the PWP learns or practices skills of recovery by not using drugs in specific situations. Versus:

- An unrealistic assessment of his or her ability to refuse alcohol or drugs without the essential skills to do so, or
- Not understanding the difficulties of maintaining long-term changes in ways of thinking and acting

Good to have a healthy fear of relapse.

Psychiatric Co-occurring Conditions

Withdrawal symptoms mimic depression, anxiety and psychotic disorders

- 30% and 59% of women have PTSD

Often undiagnosed in the affluent plus group because they don't identify or want to talk about it.

(Long time caregiver fired by mother, when mom realizes nanny is closer to child than she is – leads to abandonment and attachment issues – but who can talk about it – let alone cry over it?

Severity of Addiction

Long term alcohol and drug use

- More difficult for severely dependent individuals to learn new skills
- Impulse control harder

One reason why "Letting Go" is not a solution. Also, many affluent addicts keep drugging and drinking until severely dependent and health deteriorates, can't recover.

Social Pressure and Environmental Cues

- Direct pressure: Alcohol in the house/spouse drinking
- Indirect pressure when attending activities where other are using

People, places or things – environmental cues

I am a big believer in advising significant relationships to adopt alcohol and drug free lifestyle for first six months of LO's early recovery. But few do. *With a spouse like you, I need a drink* (*or two).*

Access to Money/Other Resources

Too much or too little? Is someone in the family, a friend or former using body undermining the recovery plan? (Examples: Dealer giving drugs for free after treatment. Aunt passing cash under the table.)

Genetic Load

This is big one for many of us. Lots of family secrets and minimizing by relatives. Can inspire motivation. *I am going to be the one to set a new example for future generations.*

Are there Gender Differences?
Women are said to do better in same sex groups – have less relapse. However, when negative emotions take over, the group can do down together.
Men are said to be more prone to relapse when feeling positive and tend to drink alone.

2. Analyze Primary and Secondary Treatment Elements
What did the treatment Center offer and How was the experience for you and your LO?

Treatment Center Environment
The treatment center environment can be a cross between a high school locker room and a fraternity/sorority. Easy to be distracted. Particularly difficult in co-ed environments.
One must have a focused commitment to follow all advice and benefit from assignments.

Safe Spaces
If your LO does not feel safe in a treatment center, behavioral change is unlikely to occur. (See separate future blog on safe space analysis.) Resentment by fellow patients against the affluent is a commonplace.
Hard to speak your truth and be accepted for who you are – the essence of recovery – when your peers and counselors are prejudiced and have trouble comprehending key pieces of your story.

- *Why are you complaining about being beaten when he buys you all those expensive gifts??*
- *What's wrong with being left all the time with your au pair – whatever that is?*

Halfway House
For those with few social supports or chronic use, the evaluation is on developing a self-management plan. Where can I go for a safe environment while I learn how to stay clean?

- The usual recommendation is for a halfway house.

Observation – a young man uses heroin every three weeks or so to the extent he needs a "babysitter" to make sure he does not OD. This man is in school, has an intact family system and financial security.
But due to his chronicity, he needs a half-way house. Don't be fooled by outward appearances.
Note this does not mean a Sober House which very often has minimal to none programmatic support and oversight – despite what they advertise to induce you to pay for your LO's time there.

Coexisting Conditions

Ideally, treatment centers should offer comprehensive psychiatric evaluations, basic learning screening for ADD and similar issues and non-medication solutions to chronic pain. Many do not and the resulting failure to address these coexisting conditions is significant relapse factor. Examples of needs assessments

- Level of psychiatric symptoms treat with medications
- Level of learning and attention issues
- Chronic pain management issues

Assessments should lead to planning that is compatible in supporting recovery and address the coexisting condition.

Alternatives to AA

For those who don't like AA, acceptable alternatives to patient such as SmartRecovery, LifeRing, Woman for Sobriety, SOS (Secular Organizations for Sobriety)

Communications With Family

Was the communication up to your expectations and did your LO meet with your and his/her counselor to discuss treatment progress and post-treatment plans.

Signed Releases

Did your LO sign full and complete releases to the counselor who works with you?

Drug testing

Did the center offer it? Did your LO agree to it? If so, was it daily, supervised testing with reports to your counselor?

3. Chart of Underlying Conditions/Treatment Elements

Underlying Conditions	**Your Perception**	**Your LO's Perception**
Anger/Frustration		
Stress/Abuse		
Trauma (Hidden for Affluent)		
Problem Solving Skills		
Prescribed and OTC Medications		
Other Addictive Behavior		
Overconfidence		
Psychiatric Co-occurring Conditions		
Severity of Addiction		
Social Pressure/Environ. Cues		
Access to money/resources		
Genetic Load (family history)		

Gender Differences		
Other??		
TREATMENT ELEMENTS		
Treatment Center Environment		
Safe Spaces		
Coexisting Conditions		
Half-Way House		
Alternatives to AA		
Communication with Family		
Signed Releases		
Drug Testing		
Other?		

Now you have a better idea of what might be driving the Substance Disorder, time to work on the Relapse Plan.

RELAPSE PART FIVE

Preparing For The Relapse Prevention Plan

Preparing For The Relapse Prevention Plan

1. Key Fundamentals for Developing a Relapse Plan
- **a. Led by a Professional**
- **b. Participation by LO in Planning Process**
- **c. Payment for Treatment**
- **d. Family participation**
- **e. Use Insurance? – NOT!**

2. Reviewing What Happened
- **a. Assess Precursors to Relapse:**
- **b. Review Drug Testing Procedures**
- **c. Degree of Motivation**
- **d. Review Past Attempts at Recovery**
- **e. Review Relapse Triggers**
- **f. Explore Anti-Affluent Prejudice (Wealthism)**

3. Prioritize Underlying Conditions and Treatment Factors

Preparing For The Relapse Prevention Plan

My visions for developing a relapse prevention plan is a collaborative process involving family, professional advising the family, and your LO. That is the base group. I like to keep the numbers on the small side, so it is easier to remain focused on looking at solutions and to avoid "splitting" by your LO. Divide and confuse can happen when too many people are involved. (Also, avoid in-laws, if possible.)

1. Key Fundamentals for Developing a Relapse Plan

Before reviewing the many issues discussed in the previous four sections, several key concepts need reinforcing:

a. Led by a Professional

Don't try this on your own – chances of success in the long run are slim.

- This includes future adjustments in the plan as progress occurs.

Example: LO at halfway house wants to go to family reunion. Parents say yes without checking in with professional. LO relapses. Cannot return to halfway house.

b. Participation by LO in Planning Process

Hopefully, your family professional is in communication with your LO, is helping overcome intense feelings (shame, hopelessness, anger) and is encouraging a positive attitude towards the benefits of recovery versus continued use:

- Emphasizing high relapse rates and inadequate treatment can help with this process
- Reinforcing the disease concept versus moral failing.
- Your professional can also discuss future incentives resulting from recovery.

This latter point is critical. To this end, the person in the family who controls incentives has to be on board with the professional for the relapse plan to be successful.

c. Payment for Treatment

This is sore subject for many family members who have either spent a lot of money for treatment or are so angry they are refusing to pay for additional treatment – or both.

- Keep in mind that you probably spent a lot of money for lousy treatment – not the fault of your LO.
- Not paying for good treatment will likely jeopardize the health of related family members

Example: Ex son-in-law is finally willing to go in-patient to deal with addiction and childhood trauma. No one is willing to pay for private dual diagnosis treatment, so he goes to a center covered by his insurance. He relapses – Who suffers? His children, who now need extensive therapy, are depressed and failing in school.

d. Family participation

If you are too angry, frustrated or disappointed to participate in the process in a rational manner, do not do so. But be sure to discuss with your professional goals for the meeting and what you are willing to provide for incentives, with the understanding that relapse planning is a dynamic process. (Don't try to control it in advance.)

- Nothing wrong with the professional having to check back in with you for approval of any proposal that involves funding.

This includes funding authorizers such as trustees, deep pocket relatives or family business owners. For this group, much better to stay away from the planning meeting. FYI – Trustees who say they know all about addiction are actually engaged in malpractice if they try to run the show. (Not credentialled. trained or licensed in behavioral health.)

e. Use Insurance? – NOT!

I strongly advise against using insurance to pay for treatment because the goal of these companies is to provide the minimal amount and your goal is to provide the maximum amount of treatment. Insurance:

- Does not cover most of the services you need post-in-patient.
- Requires continued reauthorizations, leading to over-pathologizing your LO's condition and time away from counseling your LO
- Creates a permanent record of a pre-existing condition that very likely will result in much higher premiums or inability to obtain coverage, even with many years sober.

The biggest draw back from using insurance is that you lose control of the process.

- The advantage of private pay is that you, as the payor, have a huge influence over where your LO goes to in-patient and what services are provided post-treatment.

At all costs to you, avoid going to treatment insurance factories, which are now trying to capture patients (and their family payors) for both in-patient and post-treatment services.

2. Reviewing What Happened

a. Assess Precursors to Relapse:

Precursors to relapse can be behavioral

- Not following treatment plans, secretive, missing appointments

Performance, not intention, is the key here.

Precursors can be subjective – something does not feel right

- Distorted thinking, behaviors and emotions
- Struggle with thinking clearly, manage their emotions, regulate behaviors, especially in stressful situations

Be alert to dysfunctional, cognitive, emotional, and behavioral warning signs.

Example: Family agreed to decrease drug testing intervals at request of their LO. Shortly after their relapse "antenna" registered bad vibes, but before they could take action, LO overdosed. One good reason for assigning these decisions to recovery manager/family's counselor is to avoid pressure from LO for premature relaxation of oversight.

b. Review Drug Testing Procedures

- Supervision, Notice for Testing, LO Availability Requirements
- Who initiates test request, who gets notice?
- Tests: Soberlink, patch, urine and hair

Drug testing is the key to the early intervention model for a chronic disease. Also, testing acts as restraint to prevent relapse. For comprehensive language, see my suggested model provisions for drug testing (future blog).

c. Degree of Motivation

Need high level of commitment to the whole recovery process (not just drying out)

- If low, review motivational interviewing (future blog)

Assess motivational fulcrums – points of engagement

- Review non-explicit leverage points (future blog)

Review any trust, business or estate planning documents to modify or "decant" to put in place language for behavioral health disorders limiting access to funds.

Severity of Past Use/Addiction/Relapse

The higher the degree of danger, harm, or chronicity, the more elements needed to be added to the plan. For the affluent, lack of consequences usually means more consistent and intensive use

d. Review Past Attempts at Recovery

- Quality of Professional Assistance
- ASSAM Placement Criteria
- Goals Completed in Treatment
- Quality of Treatment

- Blaming Substance User?

e. Review Relapse Triggers

- Identify Triggers
- Whose problem – Family or Individual?
- Family willing to reintegrate LO in family system as recovery progresses.

Whether family is on board, including primary power sources, has a big effect on relapse planning.

f. Explore Anti-Affluent Prejudice (Wealthism)

Wealthism is common among treatment center counselors, staff and patients.
One question to ask your LO is,

- *Did you feel safe talking about your experiences, background and important influencers concerning your disorder?*

Unfortunately, affluent addicts often feel uncomfortable in groups and treatment for a variety of factors, including understanding lifestyle issues that affect our recovery. This is one reason there are specialized groups for lawyers and doctor:

- What did I hear in my home group on my five-year anniversary date? *You have money, you have it easy!* This was from a lawyer and psychologist, no less.

Some well-off addicts in recovery have their own informal support networks. I find it super cool when I am able to talk to other people in recovery from similar backgrounds because we can cut to the chase and not have to edit our conversations.

- News Flash: Coming from money or having a recognized name has both its pluses and minuses.

But most people don't get this. They think it's all a bed of roses.

3. Prioritize Underlying Conditions and Treatment Factors

Identify Treatment Elements from Checklist (Relapse Part 4)

Underlying Conditions	**Your Priority**	**Your LO's Priority**
Anger/Frustration		
Stress/Abuse		
Trauma (Hidden for Affluent)		
Problem Solving Skills		
Prescribed and OTC Medications		
Other Addictive Behavior		
Overconfidence		
Psychiatric Co-occurring Conditions		
Severity of Addiction		
Social Pressure/Environ. Cues		
Access to money/resources		
Genetic Load (family history)		

Gender Differences		
Other??		
TREATMENT ELEMENTS		
Treatment Center Environment		
Safe Spaces		
Coexisting Conditions		
Half-Way House		
Alternatives to AA		
Communication with Family		
Signed Releases		
Drug Testing		
Other?		

NOW IT IS ON TO CREATING THE RELAPSE PLAN

RELAPSE PART SIX-THE RELAPSE PLAN, PART ONE

The Relapse Plan, PART ONE

1. Address Current Use

2. Data Review
- **a. Prioritize Underlying Conditions, Treatment Elements, Triggers and Stressors**
- **b. Identify Additional Assessments & Medication Information**
- **c. Review Services in the Existing Plan**
- **d. The "Pillars of Recovery – Recovery Capital**
- **e. Assess Levels of Formal or Structural Therapeutic Interventions Needed**

3. Formal Therapeutic Interventions – Adding Resources
- **a. Case Management and Care Coordination Services**
- **b. Recovery Coaching Services (in home or remote)**
- **c. Relapse Supervision**
- **d. In Home Transitional and Life Coaching Skills**
- **e. Family Appoints Professional to Oversee the New Relapse Plan on Their Behalf,**
- **f. Clinically Appropriate Treatment to Improve Therapeutic Alliance**

1. Address Current Use

The immediate priority is to encourage your LO to get help and stop using. This often involves advance planning to identify incentives or motivators that help with this process. And also, to identify and eliminate or insulate people supporting use.

Use ASAM criteria to address acuity of current alcohol/drug and options for treatment.

- Listen to your LO if his/her suggestions seem rational and there is a back-up plan in the event of failure

Example: Ex wants father of her children to attend 28-day in-patient after father relapses. Father quits using, drug tests every day and goes to out-patient at night. Dad is able to maintain job. Signs release so his counselor can report on his progress. He agrees to go to in-patient if there is another relapse.

2. Data Review

a. Prioritize Underlying Conditions, Treatment Elements, Triggers and Stressors

Keep in mind that in reviewing all of these factors designed to support a renewed effort at recovery, the aim is to develop:

- A commitment to abstinence
- A strong sense of self-efficacy

- Coping skills for stress and relapse-inducing situations
- Improved social functioning during in-patient/ out-patient treatment
- Ability to identify Relapse Cues

Consider limiting the list to the two to four range, otherwise it is easy to lose focus. Also, difficult to measure progress. We want to keep it simple so your LO's eyes are on the prize. (Rewards for accomplishments.)

b. Identify Additional Assessments & Medication Information

Now you should have a solid information base, including what additional areas may need exploring. In particular, assessments are often sought for co-occurring conditions:

- Level of psychiatric symptoms and see if treatable with medications
- Learning and attention issues
- Chronic pain management issues
- Medication management: What is the plan and is it being followed?
- Prescription Meds being Supervised by ASAM trained prescriber?

More than once, a thorough assessment has led to identification of issues that, when addressed, led to stable recovery.

c. Review Services in the Existing Plan

Review existing post- treatment plan (if it exists): to see what needs to be improved. Typical plans include:

- Attend weekly aftercare group or step down out-patient
- Maintain medications under supervision of a physician
- Attend AA
- Drug testing
- Individual and/or family therapy
- Avoiding past using friends and environments
- Remote access to treatment center case manager

While these activities are fine in the abstract, one big problem is that it is up to your LO to actually follow through and engage in each one. Failure to comply is a leading cause of relapse.

The above are all voluntary activities. Unless your LO signs a complete release to share information, very often you will only know if he/she is not following the plan when there is a relapse.

d. The "Pillars of Recovery – Recovery Capital

Recent studies examined factors supporting long term sobriety after leaving treatment Common factors, often called "Recovery Capital" include:

- Social/Community support
- Family Support
- Stable living environment
- Financial stability
- Access to needed counseling, medical care

Reviewing the ASAM criteria may also be a helpful exercise in identifying deficits in Recovery Capital.

For people with few social supports, identify where they might need structure in their lives such as a halfway house or sober living and develop a self-management plan as part of the recovery plan

- For some people, returning to the home environment may not be possible or desirable.

It is possible to work at a coffee shop, live at an Oxford House, buy a bus pass and membership at the YMCA and have enough money left over to live a modestly comfortable life in recovery. A lot of people from all walks of life have successfully followed this path, as the first stage to living a rewarding, sober life.

e. Assess Levels of Formal or Structural Therapeutic Interventions Needed

One essential question to ask when revising a treatment or relapse plan in regard to building recovery capital is

- *What level of formal or structured intervention is necessary to prepare the patient for the next (reduced) level of structure and intensity and - ultimately self-management?*

Look at needed behavioral changes and additional services or actions (including within the greater family system) to support those changes to achieve this overall goal of building Recovery Capital

Note that in reviewing recovery capital one factor often missing Is the degree of motivation and commitment on the part of the participants**.** This includes not only the PWP, but also family members and their support system. There is a difference between going through the motions in agreeing to participating in implementing a plan and being emotionally committed to the knowledge that the end result of continued use is disability/death

3. Formal Therapeutic Interventions – Adding Resources

Adding Resources to support a positive recovery environment
(Suggestions from the OPG - Oconnorpg.com - for a-d)

a. Case Management and Care Coordination Services

A case manager provides guidance and support services through meetings and frequent phone contact. Services include:
Compilation of medical records, identification of appropriate clinical resources, location of vocational pursuits, creation of case management plan, regular updates to the "team", coordination with treatment team, implementation of drug/alcohol testing and overseeing recovery coaches and other personal assisting in the recovery process

b. Recovery Coaching Services (in home or remote)

Vocational and academic support, mindfulness training, self-help meeting navigation, budgeting and financial planning, nutritional guidance, transportation, social activities and community integration, and medication monitoring.

c. Relapse Supervision

Up to Twenty four-hour in-home services for people in need of supervision due to relapse, unstable living situations or negative influences.

d. In Home Transitional and Life Coaching Skills

Supporting recovery, assisting client in learning to develop healthy habits, and aiding a client in finding a sense of purpose and meaning in life.

e. Family Appoints Professional to Oversee the New Relapse Plan on Their Behalf,

This is a major "therapeutic intervention" in that the family has their own professional who acts on their behalf to help craft the relapse plan, receive updates on compliance and act as the intermediary between their LO and family on issues such as progress, access to money or other resources and receiving drug test reports.

- The family professional or case manager concept is modelled after the highly successful programs for doctors and pilots.

Medical Boards and airlines appoint a case manager to oversee the entire recovery process. See my article: Dual Track Case Management & Monitoring: The Key to Recovery from Addiction and Other Behavioral Disorders

f. Clinically Appropriate Treatment to Improve Therapeutic Alliance

The therapeutic alliance between patient and counselor is key to recovery. Many counselors and treatment staff resent affluent patients – not just the well off and well known but professionals and non-working spouses. Finding empathetic, respectful providers is crucial to a successful plan.

- Specialized resources are often a better fit for higher end patients, **IF** the focus is on meeting their unique clinical needs rather than promoting amenities.

It is not easy locating these resources. OPG keeps up to date on the few facilities providing acceptable treatment for this group.

RELAPSE PART SEVEN THE RELAPSE PLAN, PART TWO

The Relapse Plan, PART TWO

4. Structural Therapeutic Interventions – Changing the Dynamics
- **a. Duration of Treatment**
- **b. Signing Complete Releases of Information**
- **c. Identify and Disable Using Support System**
- **d. Modification of Trust/Family Business Documents – Estate Plans**
- **e. Directing Funds to Spouse/ Children**
- **g. Identify Incentives/Leverage Points**

5. Benefits/Negatives of 12 Step Programs
6. Planning Chart

4. Structural Therapeutic Interventions – Changing the Dynamics

a. Duration of Treatment

The longer your LO is committed to a formal treatment plan, the better the odds of recovery.

- One year minimum. Two years after a relapse or if our LO has co-occurring conditions

Commonly, families terminate services far too early. They fail to follow the science:

- DSM V: Early Remission begins three months after last use, Sustained remission at twelve months.

Family authorizers become tired of consulting with professionals before communicating with their LO. It interferes with their power, control and historic role of deciding what's best for their family. Many reject suggestions about changing their behavior to support their LO's recovery.

b. Signing Complete Releases of Information

Addictions thrive in secrecy. We always insist on LO's signing <u>complete</u> (versus limited) releases of information from all providers so we are informed as to progress in attaining recovery goals and compliance with treatment plan activities. Note that many providers far prefer communicating with professionals due to the sensitive nature of the information and the fact that family members often misunderstand or misuse the information received.

- You do not need or want to know all the details of your LO's alcohol/drug use and associated behaviors!!!

Let that information stay with your professional, unless it has some bearing on your relationship with your LO. As an aside, your LO's use and behavior is always much more severe than they tell you when seeking help. So, keep that in mind when you want them to attend family reunions/events in the face of expert advice not to do so.

c. Identify and Disable Using Support System

Sometimes this may mean hiring private investigators or security services to get rid of dealers and the using entourage. It can mean buying off relatives or other relationships

that benefit from keeping your LO high. It can mean tearing down a professional, advisory or staff structure that supports the addiction.

- Examples Trustee or Father-in-Law tips off LO that something is up. Dealer living with your LO.

Usually your LO is living a dual life – the one presented to you and the one when drinking or drugging. It is the latter than must be discovered and aggressively dismantled.

d. Modification of Trust/Family Business Documents – Estate Plans

Decant or take any other action necessary to limit access to funds, per my articles on this topic, suggesting model language for trusts and business documents. This language can be used for adopting distribution guidelines. The idea is to make clear that continued funding is contingent on treatment compliance

When young adults control some funds, the threat of being cut out of the estate can be sufficient leverage to elicit a positive response for requests to seek help

e. Directing Funds to Spouse/ Children

When the PWP has the money, it is common for spouses and children to say nothing because they are worried about being cut off. In these situations, parents and other relatives need to bypass the addict and support the spouse and children directly. Same for trustees or business owners who have the power to distribute funds to the next generation.

g. Identify Incentives/Leverage Points

Explicit Leverage refers to provisions in documents or elsewhere conditioning access to money or other resources based on compliance with treatment recommendations

Non-Explicit Leverage

In the absence of such explicit leverage, the family has to turn to non-explicit sources of "encouragement".

- Soft Pressure – Personal
- Externalized (it's not me, it's you) – Opportunistic Pressure
- Action-Based – Creating Consequences

Non-Explicit Leverage is far less effective than document-based leverage because of the inability to maintain pressure for sustained recovery over several months. The addict figures out how to avoid the pressure or decides to ignore it because the consequences are not significant enough to counter the desire to use. (For more detail on leverage, see a future blog or one of my articles on leverage.)

5. Benefits/Negatives of 12 Step Programs

Because so many people in treatment are told to attend 12-Step programs, it may be helpful to understand the basics:

The AA Big Book views addictive behavior as symptom of an underlying spiritual crisis

- To recover, the individual must address the larger issues of spirituality and character development.

This is generally done by working the steps. Content varies, some meetings cover one step per week or read a chapter in the Big Book of AA. Others develop their own content and "rules". Because it is a self-led group, quality is dependent on the leaders, some of whom go way off track on their own ego trips.

It does offer a social network. But the downside is that it is open to exploitation by attendees and sponsors, including dealers attending meetings. Strongly advise women to attend same sex meetings.

- Self-identification is important for successful AA attendance

That can be difficult for those with socio-economic and racial differences from AA participants. A particular problem for the affluent. Never heard so many anti-rich diatribes as in meetings in Aspen.

6. RELAPSE PLAN – PLANNING CHECKLIST

Address Current Use		
Data Review		
Prioritize Underly Cond. etc.		
Identify Add. Assess/Med Info		
Review Services in Exist. Plan		
Review Rec. Capital		
Assess levels of Interventions		
Adding Resources		
Case Manage/Care Coord		
Recovery Coaching		
Relapse Supervision		
In Home/Transit. Coaching		
Professional Oversight		
Clinically appropriate TX		
Struct. Therapeutic Interv.		
Duration of Treatment		
Release of Information		
Disable Using Support System		
Modify Trust – Family Docs.		
Direct funds to spouse/child		
Identify Incentives &-Lev Pts		
Ben. & Negs 12 Step Program		

CONCLUSION- I hope this article helps family members better understand relapse and how to respond to relapse. However, this information is no substitute for qualified counseling help, and I urge readers to find such help by looking at the ASAM directory to locate professionals in their local area.
Bill Messinger, April 2021

