

# The relapse prevention model psychology essay



**ASSIGN  
BUSTER**

Mary E. Larimer, Ph. D., et al provided an overview of the relapse prevention model proposed by Marlatt and Gordon. The model provides a detailed classification of the situations and the factors that can contribute and precipitate to relapse episode. The following factors and situations fall into two categories namely the immediate determinants (e. g., outcome expectancies, high-risk situations, a person's coping skills and abstinence violation effect) and the covert antecedents(e. g., lifestyle imbalances, urge and cravings). The RP model also provided a brief outline about the numerous specific and global treatment strategies which can guide the therapist and the client in the process of preventing relapse. The treatment strategy begins with the initial assessment of the emotional and the environmental characteristics of the situations associated with relapse and the individual drinker's response to these situations and devising strategies to target the weakness in the client's cognitive and behavioural repertoire and thereby reducing the risk of relapse. The RP model proposed in this study is represented as a linear process.

Katie Witkiewitz and G. Alan Marlatt (2004) provided an overview of the efficacy and the effectiveness of the above mention relapse prevention model in the treatment of addictive behaviour. The recent updates on the empirical support for the elements of cognitive behavioural model of relapse and the criticisms about the relapse prevention model were reviewed, based on which a reconceptualised cognitive-behavioural model of relapse was proposed. The reconceptualised model focused on the dynamic interaction of the multiple risk factors and situational determinants. It explains about the

dynamic interaction between the tonic process and the phasic response involved in relapse.

Christian S Hendershot et al., (2011) provided an overview and update of the relapse prevention model on addictive behaviour with a focus on the development over the last few decades (2000-2010). This study included major treatment outcome studies and meta-analyses related to the relapse prevention model. The advances in the study noticed includes the introduction of the reformulated cognitive-behavioural model of relapse, the application of advanced statistical methods to model relapse in large randomized trials, and the development of mindfulness based relapse prevention . From the overall inferences obtained the study proposes that the relapse prevention model remains an influential cognitive-behavioural framework that can inform both theoretical and clinical approaches to understand and facilitate behaviour change.

Irvin, Jennifer E et al.,(1991) conducted a meta-analytic review in which she took 26 published and unpublished studies with 70 hypothesis test with a sample of 9, 504 participants. The result of the study indicated that the relapse prevention model was generally effective particularly for alcohol problems. She also found that the relapse prevention model was most effective when applied to alcohol and poly substance use disorder, combined with the adjunctive use of medication. It was also found that it was effective when evaluated immediately following treatment using uncontrolled pre-post tests.

McCrary(2000) conducted a comprehensive review of sixty two alcohol treatment outcome studies comprising thirteen psychosocial approaches. Among the thirteen psychosocial approaches two approaches -RP and brief intervention- qualified as empirically validated treatments based on established criteria.

Miller and Wilbourne(2002) conducted a review of clinical trials. Their study evaluated the efficacy of forty six different alcohol treatments based on treatment effect size and methodological quality. The treatment which ranked in the top ten places in the review incorporated components of relapse prevention model.

Stephen Roberts et al.,(1994) conducted a study in marijuana dependence in which 161 men and 51 women were randomly assigned to either a relapse prevention(G. A. Marlatt &J. R. Gordon, 1985) or social support group discussion intervention. The study found that the men in the RP condition were more likely than men in the social support group discussion condition to report reduced use without problem at 3 months follow up.

Gray, Alison Stickrod et al(1993) conducted a study among sexually aggressive adolescents and children. The study describes the implementation of relapse prevention model in assessing and treating juvenile sex abusers. The RP model serves three distinct functions in sex offender treatment: 1) It provided an internal, self management dimension which facilitates the clients self control; 2) It provided an external supervisory dimension to monitor the juvenile's behaviour and model

appropriate behaviours; 3) It provides a conceptual framework, which integrates highly specific therapeutic intervention within a unifying theory.

Craig Dowden et al (2003) conducted a meta-analysis on the effectiveness of the relapse prevention model with offenders. This study has done a meta-analysis of forty tests of relapse prevention treatment and revealed moderate mean reduction in recidivism. It also found that some elements of the relapse prevention model like training significant others in the program model and identifying the offense chain, yielded stronger effects than others (aftercare sessions, coping skills).

Miriam bottlender et al (2004) conducted a study to find the impact of craving on alcohol relapse and she found that patients who relapsed during the treatment phase had higher obsessive compulsive craving scale. The study also proposed that the craving measured by the OCDS total score at the end of the treatment was a predictor for relapse in the 12 months after treatment completion. Measurement of craving with OCDS can be a useful tool to predict subsequent drinking during outpatient treatment and to identify individuals at risk for relapse. The study thus proposed that OCDS may predict future drinking status.

JanaWrase, et al (2008) conducted a study to find whether alcohol relapse and craving is associated to reduction in amygdala volume. The study comprised of fifty one alcohol dependent subjects and fifty two age and education matched healthy comparison subjects after detoxification. The subjects selected were made to undergo imaging and clinical assessment and they were followed for 6 months and the alcohol intake was recorded.

The imaging results for subjects with alcohol dependents showed significant reduction in amygdala volume and increased craving and alcohol intake after the 6 months follow up.

A. S. Potgieter et al (1999) in his study using the four craving scale OCDS (obsessive compulsive drinking scale), Lubeck craving scale, Alcohol craving questionnaire, Ordinal scale. The four scales were discussed and compared. The four instruments measure different dimensions of craving over different periods. Thus suggesting that there is still a need to conceptualize a standard interpretation of the word craving. The following result suggested a need to measure an emotional- motivational dimension, a cognitive-behavioural dimension, expectancies and effects on positive and negative reinforcement with different instrument or with multidimensional instruments.

Linda M. Martin et al(2008) conducted a study to evaluate the occupational performance, self esteem, and quality of life in substance abuse recovery program that included occupational therapy services addressing life skills. A sum of about 75subjects participated in the study. Intake and discharge assessment were made that used the occupational performance history interview (version 2. 0), the Rosenberg Self-esteem scale, and the quality of life rating scale. Follow up interview was conducted at three and six months. There was marked improvement and significant difference and large effect size were found between intake and discharge scores of all measures. Change in occupational performance was clearly reflected in the recovery process.

Gordon (2003) stated that the relapse prevention program “ should teach new skills to change old habits, as well as advocate a balanced life that substitutes addictive behaviours with positive activities”. Occupational therapy is uniquely equipped to address the need described by Gordon.

Jennifer Creek stated in occupational therapy and mental health that relapse prevention is a approach that fits well with occupational therapy in particular because it focuses on lifestyle and real situations that cause relapse. She also stated that occupational performance area, components and contexts are critical to treatment success.

Kielhofner, 1985 stated in model of human occupation that developing psychological performance components, such as volition and self-esteem, for example, can help an individual cope with environmental triggers to relapse, also known as environmental press.

Christiansen, 1991 in occupational therapy: overcoming human performance deficits stated that the premises behind occupational therapy intervention are that occupational performance deficits contribute to stress in life. He also stated that through improved occupational performance, the client will be able to cope with life’s challenges.

Busuttil (1989) reported that the occupational therapist serve a major therapeutic role in the substance abuse rehabilitation program by enabling the client to improve on work and social skills, develop healthy routines and habits, and engage in personal hobbies and experiences.

Vijoy K. Varma et al(1994) conducted a study to find out the demographic, clinical, personality, and behavioural correlates of age at onset of alcohol dependence. The study included fifty one male clients of alcohol dependence among which 26 were late onset and 25 were early onset alcoholics. The age of late onset subjects ranged from 30 to 52 years and for early onset the age range was 20-52. The early onset alcoholics had a larger proportion of first degree relative with both lifetime use and dependence of alcohol alone. The early onset alcoholics were high sensation seekers and tend to display aggression, violence and general disinhibition when drinking. The late onset alcoholics were anxiety- prone and guilt- ridden. And had less alcohol related problems.

M. Jimenez- Gimenez et al(2008) conducted a study to find the psychophysiological relationship between the alcohol craving scale based on three factor and the startle reflex. Fifty five alcoholic patients of which 29 were abstainers and 26 were relapsers. They were exposed to acoustic startle test after a 3 week of detoxification treatment. The results showed that the abstainers group showed a significant inverse correlation between craving total score in ACS-3F and the motivational value of alcohol cues. Thus the study concluded that the ACS-3F has adequate properties of concurrent validity.

Monica Jeimenez et al(2009) was involved in the construction of a craving scale based on three factors namely loss of control, positive reinforcement, negative reinforcement. The scale consists of 33 items rated on a likert type response scale with four alternatives: never, rarely, frequently and always. The scale formulated was administered to 209 alcohol dependent clients and <https://assignbuster.com/the-relapse-prevention-model-psychology-essay/>



137 controls. The items on the scale were correlated with three other scales namely the severity of alcohol dependence scale(SADS), sensitivity to punishment and sensitivity to reward questionnaire(SOSRQ), Barratt's impulsiveness scale(BIS-10). The scale formulated was found to have adequate reliability, sensitivity and specificity, concurrent and discriminant validity.