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The relative importance of risk factors leading to relapse among individuals recovering from substance abuse

Norma America Likens

THE RELATIVE IMPORTANCE OF RISK FACTORS LEADING TO RELAPSE AMONG INDIVIDUALS RECOVERING FROM SUBSTANCE ABUSE

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

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by

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Approved by:

[redacted]

Dr. Laurie Smith, Faculty Supervisor
Social Work

12-3-10
Date

[redacted]

Stacy Smith, Executive Director
Inland Valley Recovery Services

[redacted]

Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

The research literature on addiction has found many risk factors that lead to a relapse but not enough is understood about their relative importance. Researchers report that individuals can know what causes their relapses. In this study 154 people who had relapsed in the past were asked to choose from a list of twenty-three items the ones they believed caused their most recent relapse.

Responses were calculated and presented in rank order of frequency to establish their relative importance. Comparisons were also been made of the responses of men and women as well as those of (non Hispanic) whites and Hispanics.

The most frequent reasons for relapse were spending time with old friends, going around old places, no longer attending 12 step meetings, not spending time with sponsor, isolation, not talking with sponsor, not working with sponsor, not attending church, and not spending time with recovery friends. Men more often than women cited their actions, such as spending time with old friends and not staying connected to after care programs and meetings. Women more frequently chose factors that expressed their feelings, such as isolation, not involved in therapy and

sleep problems. Analysis by ethnicity did not reveal differences.

Participants were also asked an open-ended question. "What do you think is the most important reason for your most recent relapse?" The most frequent answers were the influence of peers and relationship partners, emotional problems & losses, and not being committed to a recovery program. Women were more likely than men to cite factors that involve their feelings such as the influence of peers/partners, emotional problems & losses, relationship & family problems, and the loss of loved ones including child custody.

The findings of this project and related research on addiction should be incorporated into the training of all social workers. Being able to identify the most important relapse predictors can help social workers recognize when their clients are at risk of relapse or to recognize it when it occurs.

This project has some limitations. It is recommended that subsequent research be conducted to see if the results of this project can be replicated under randomly controlled conditions with a larger sample drawn with more geographic, socioeconomic, and racial/ethnic diversity.

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DEDICATION

I would like to first of all thank my God who gives me the guidance to continue and succeed through the difficult times I encounter over the last past years. I dedicate this thesis to my girl Victoria Elizabeth Likens who inspires me to always fight for the better life we both can have. She is the little miracle in my life that god gave to me and who gives me strength when I am weak. Victoria's belief on me has made me a strong, woman, mother, and confident individual who has accomplished an important goal today. During the course of my study she has sacrificed countless hours of my absence at home, giving me support, and understanding without which my graduation would not have been possible. I hope you are proud of my accomplishments, as I am proud of having such a loving daughter, thanks for all you bring in my life. I love you baby.

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CHAPTER ONE

INTRODUCTION

Problem Statement

Every day social workers encounter families in crisis. Problems may be expressed as domestic violence and the abuse, neglect and endangerment of children. A fact that is easy to miss, however, is that such behaviors may have been aggravated by the destructive influence of drugs and alcohol. Diagnosing these and other problems can be especially difficult when one or more in the family is about to relapse or has recently done so.

Social workers need tools to help them establish the root causes of the dysfunction they encounter taking place in the families of their clients. For example, it is not effective to assign a mother to parent training if she has recently relapsed. Courses in anger management are not the most appropriate treatment for a father who has resumed using alcohol and drugs. Social workers would benefit if they could reliably recognize and assess the causes of the relapses that occur in their client families.

Relapse is complex. It is both the event of drinking or using drugs following a period of sobriety as well as the process in which a person's attitudes develop and then that person engages in behaviors are that are likely to lead to a return to substance abuse (Daly, 1989).

Substance abuse experts have identified numerous risk factors for relapse (Gorski & Miller, 1977; Gorski & Kelly, 1996), but not enough is known about which factors on the list of danger signs are most important. That is what this study is about.

Purpose of the Study

The purpose of this project is to help social workers by determining the relative importance of relapse warning signs that have been identified by the addiction treatment professionals. This was done by interviewing individuals in recovery who in the past have experienced relapse. The data were gathered by means of a self-administered questionnaire. This information will be useful to social workers as they work with their clients.

Respondents were asked to choose from a list the of warning signs the ones they believe contributed to their most recent relapse while omitting the ones they did not

think were important. Their responses were tabulated and presented in the order of frequency. Comparisons were also made of the responses of Men vs. Women and Whites vs. Hispanics.[1] Relevant statistical tests were performed to assess the statistical significance of the comparisons.

Significance of the Project for Social Work

Substance abuse is one of the greatest problems facing social workers today, a major factor that impacts the work they perform for their clients. It doesn't matter if you are assigned to child welfare, work in a hospital, or specialize in mental health, if you are a social worker substance abuse is a problem that you encounter every day. According to the web site of the Substance Abuse & Mental Health Services Administration 22 million Americans abuse or are dependent on drugs, alcohol, or both.

Substance abuse is at the core of much of the work done by social workers. Social workers must protect children from abusive parents and shield battered women

[1] For the purposes of this study the term White refers to non-Hispanic whites.

from violence. Often substance abuse exacerbates these problems. Substance abuse can lead to behaviors that put people in jail, which undermines family structure. Sometimes social workers are called upon to work with the criminal justice system and help assess whether people will be sent to jail or lose custody of their children. Social workers also encourage alcoholics and addicts to enroll in treatment.

One of the most important aspects of addiction treatment is relapse. Addiction treatment professionals know that it's not getting addicts sober that's hard, it's keeping them that way. Relapse prevention involves teaching the client to be able to self-assess various stuck points, cravings, and stress related issues in an effort to head off relapse. For social workers recognizing the warning signs of relapse, whether pending or realized, could help them work more effectively with the families in their caseloads.

Treatment specialists know that to stop attending 12 Step Alcoholics Anonymous or to start hanging out with old drinking & using buddies can lead to relapse. There are many other danger signs as well.

This study intends to provide guidance to social workers about which warning signs are most hazardous to the recovering addict. Being able to identify the factors that lead to relapse would be useful for trying to avoid the situations, behaviors, and thoughts that lead to relapse. This information will also help social workers recognize that relapse has taken place and speed up appropriate efforts at intervention.

The information that will be provided by this study is intended to increase the effectiveness of social workers and addiction treatment professionals on a daily basis as they try to help their clients cope with the complex family issues brought on by relapse. Potentially every phase of the generalist social worker intervention process will be informed by this study: beginning, assessing, planning, implementing, evaluating, and terminating.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter reviews key literature on relapse. It sets relapse into the context of psychological theory. It describes the two main conceptual approaches that have been used in research. It reviews several articles that discuss the two influential models of Marlatt and Gordon, and Gorski. Other relevant literature is presented. Gaps in the literature are discussed which provide a basis for this study.

Theories Guiding Conceptualization

Much research has been done on the causes of relapse and the interventions intended to prevent relapse. According to a review article by Saunders and Houghton (1996) relapse is not just a specific event at which time a person breaks sobriety and returns to using and drinking. Relapse also includes changes in the ways a person's attitudes develop and then their behaving in ways that are likely to lead to a return to substance abuse.

Two broad approaches have been used in this research (Velicer, Diclemente, Rossi, & Prochaska, 1990). One is based on self-efficacy. Self-efficacy is a person's belief that they have the ability to behave in a certain manner in order to attain a desired goal. In this context self-efficacy is a person's belief that they have the ability to perform tasks including maintaining sobriety. The idea is that improving self-efficacy helps people do better especially if they also have sufficient incentives to stay clean and sober.

The other approach identifies situations in which individuals are likely to relapse. This approach involves looking for categories of risk including personal situations, social situations, and physical craving. Velicer and colleagues (1990) conclude that an approach that combines relapse situations and self-efficacy gave the best results.

There are two main models that combine these approaches that are used extensively by investigators who study and treat relapse to addictive behavior: the Relapse Prevention (RP) model of Martlatt and Gordon, and the CENAPS model of Terrence Gorski. Their work appears

in many books and articles, some of which are cited in the Reference section of this project.

Marlatt and Gordon's Relapse Prevention Model

Marlatt and Gordon's book *Relapse Prevention* (1985) is one of the classic references in the entire field of relapse prevention and treatment. This book and the many articles written by Marlatt and Gordon and their colleagues are summarized in an article by Larimer, Palmer, and Martlatt (1999).

Their article describes the causes of relapse and the various treatment measures that can be taken to prevent or limit relapse after treatment has been completed. They explain various triggers that commonly lead to relapse as well as strategies that may help patients avoid and cope with situations that stir up the desire to resume substance abuse. The article also presents studies that offer support for the validity of their Relapse Prevention model.

Marlatt and Gordon (1985) believe that high-risk situations, coping skills, and outcome expectations can contribute to relapse. They also identify lifestyle choices, urges, and cravings that can play a part in

relapse. Their relapse prevention model consists of strategies that can be used to help the counselor and client deal with each step of the relapse process. These include identifying specific high-risk situations for each client, improve, education about alcohol & drug's effects, and managing lapses. These strategies also include helping clients learn techniques to deal with relapse warning signs. The authors note that several studies have provided support for their Relapse Prevention model. Based on this approach, numerous treatment components have been developed to help recovering alcoholics cope with high-risk situations.

Gorski's Model of Relapse Prevention Planning

In another classic article Gorski (1989) describes his model of relapse prevention planning. His approach combines the principles of Alcoholics Anonymous (AA) with professional counseling and therapy to help clients who are prone to relapse.

Gorski (2000) characterizes his model as the third wave of chemical addiction treatment. The first is the Twelve Steps of Alcohol Anonymous (AA). The second combines AA with a professional treatment setting now

known as the Minnesota Model. Gorski's CMRPT, the third wave, integrates the first two with biological science and advanced therapy principles to produce a model for both primary recovery and relapse prevention.

In that same article Gorski asserts that chemical addiction is primarily a disease. In his view long-term abuse of alcohol and drugs causes brain dysfunction that disorganizes a person's personality and leads to social problems and difficulties at work.

Gorski's goes on to say that in total abstinence plus personality and lifestyle changes are required for full recovery. People raised in dysfunctional families develop character defects that interfere with their ability to recover. Addiction is a disease that afflicts those who have a tendency toward relapse. Relapse can end in emotional collapse, suicide, and self-medication with alcohol or other drugs.

According to Gorski (2000) recovery takes place in six stages: First, transition, where clients realize they have problems and need to stop drinking and using drugs. Second, stabilization, a detoxification phase in which individuals recover from withdrawal and stabilize their lives. Third, early recovery, where clients are taught to

replace destructive thoughts, feelings, and behaviors with new ones that focus on sobriety. Fourth, middle recovery where clients change their unhealthy lifestyles. Fifth, late recovery, where clients work on the family-of-origin issues that undermine their recovery. Sixth, maintenance, where clients stay active in a program that stresses personal growth and development. Relapse can occur during any of these stages.

Gorski's model is similar to the Cognitive Behavioral Relapse Prevention model of Marlatt and Gordon. The major difference is that Gorski's model integrates abstinence-based treatment and has greater compatibility with 12-step programs than the Marlatt and Gordon model.

Gorski stresses that relapse is a medical issue. Relapse is viewed as part of the disease and should be dealt with non-judgmentally. The relapse is processed so it can become a learning experience for the client.

Gorski and Kelly (1996) identify eleven warning signs for an impending relapse: Each of them has multiple parts. Gorski and Kelly encourage counselors and clients to work together to help clients learn how to recognize the warning signs.

Other Relevant Literature

Walton, Blow, and Booth (2001) review a literature that supports the idea that a single relapse prevention approach does not take into account differences in needs of women and minorities. Women in treatment may have less social support than men and not as many supportive friendship networks compared with women who do not have substance abuse problems. Women may have a greater need than men for social support. They also note that compared with men women tend to enter treatment in greater psychological distress, have lower self-esteem, and suffer more depression. Women also experience greater physical and sexual abuse histories than men do. These findings are supported in other research (Back, Contini, Brady, 2006).

Walton, Blow, and Booth (2001) also report studies concluding that marriage is a help for men as they are leaving treatment, with married men having better relapse outcomes. However, the impact of marriage on treatment outcome on women is less clear. Some studies have shown that marriage helps women avoid relapse but other studies find that marriage predicts the opposite. Marriage may not be helpful for women because women's spouses are more

likely to have alcohol or drug problems. Studies indicate that women alcoholics also are more likely than men to drink in response to problems in their marriages. Together, these findings suggest that relapse prevention services for women may need to give more emphasis to social support.

In another study Walton, Blow, Bingham, and Chermack find that "being single" and having

> less income predicted alcohol use directly, whereas greater resource needs and involvement in substance-using leisure activities, being of minority status, and being single predicted drug use directly. Income, gender, problem severity, marital status, and race also predicted alcohol and drug use indirectly. (2003, p. 630)

According to Breslin, Zack, and McCain (2001) people with psychological problems in addition (dual diagnosis) are more likely to relapse than individuals who do not have such disorders. Substance abuse can be a way to get rid of unpleasant feelings and urges.

Gaps in the Literature

Though the relapse prevention models of both Marlatt and Gordon, and Gorski are widely accepted as the basis for understanding relapse, not enough has been done to make them operational for social workers and addiction treatment specialists.

Gorski and Miller (1982) made a list of thirty-seven warning signs to predict relapse though some researchers believe not enough has been to assess their reliability (Miller and Harris (2000). They did a study to test whether the thirty-seven warning signs proposed by Gorski could be combined into a single measure, which they call AWARE, and whether such an AWARE score could accurately predict subsequent relapses. They found that relapse rates for individuals with the highest AWARE scores were 33 to 46 percentage points higher than they were for individuals the lowest AWARE scores, after controlling for prior drinking status. The authors concluded that their scale of Gorski's warning signs appear to be a reliable and valid predictor of alcohol relapses.

Need for This Study

The literature on relapse is extensive but much of it is too complex for use in social work. The AWARE scoring questionnaire, for example, is a helpful tool because it can reduce relapse warning to a single number. But the approach has its own problems. The questionnaire used in AWARE asks individuals to report on their emotional state. It requires individuals to be aware of their feelings and that they be open to sharing them with others. This approach also makes no use of observable behaviors and virtually ignores the influence of social interactions. Most problematic, it is not at all clear how AWARE scores could ethically be obtained by social workers and addiction treatment counselors. Generalist social workers need information that they can use to recognize the warning signs of relapse.

This master's project helps address such shortcomings in a straightforward way. Specifically, this study simply ranks the importance of twenty-three factors that research has found to contribute to relapse. These are mainly about behaviors rather than states of mind. The approach of this study was to ask individuals who are

recovering from substance abuse to indicate which of the risk factors contributed to their last relapse.

This study also looked for differences in the responses of Men and Women, and the responses of (non Hispanic) Whites and Hispanics.

The practical purpose of this project is to help social workers become more effective in managing their case loads by giving them straightforward information they can use to recognize the warning signs of relapse among their clients.

Summary

Researchers studying relapse for addictive behavior have concentrated mainly on two different conceptual models. One uses a framework based on self-efficacy expectations. The other looks at typologies of high risk situations that lead to relapse. Researchers have found that combining the two approaches provides the best results.

The two main models are the Relapse Prevention Model of Marlatt and Gordon, and the CENAPS Model of Gorski. The major difference is that Gorski's model integrates

abstinence-based treatment and has greater compatibility with 12-step programs than the Marlatt and Gordon model.

The present study is conducted in the Marlatt and Gordon, and Gorski tradition. It is designed to add to the research on relapse by asking people to identify the warning signs that they believe contributed to their last relapse. In addition to analyzing the full set of respondents, it compares the responses of Men & Women and Whites & Hispanics. It is intended to help social workers and addiction counselors recognize the warning signs that their clients are at risk of relapse or that it has happened.

CHAPTER THREE

METHODS

Introduction

This chapter presents the study design. It describes the way subjects were selected and qualified for inclusion, the questionnaire, its administration, and the method of analysis.

Study Design

Twenty-three items were chosen from factors that experts say are warning signs for relapse (Gorski 1996). For example, I stopped regularly attending 12 Step meetings, or, my boyfriend was using and wanted me to do so as well. These items were put into a questionnaire written especially for this study (Appendix A).

The research question was to determine the relative importance of these relapse-warning signs by finding out which were chosen most often and which less often. This design intentionally asked questions of everyone in the same way. This works especially well with pre-determined items in a questionnaire. It also is conducive to large sample sizes. In this sense, the methodology is more like that commonly employed in psychology than the detailed

case study or interview study approach often used in sociology or anthropology. The difference is both a matter of taste and appropriateness for the research question under consideration.

The dependent variable in this study is relapse because everyone in the sample had experienced relapse. This is how they qualified to participate in the study. The independent variables are all the risk factors that experts say lead to relapse.

The questionnaire was pre-tested on fifteen subjects to identify and repair any problems. No problems were noted so the questionnaire did not need to be changed.

The questionnaire was completed by individuals who were in recovery but who had relapsed one or more times in the past. Participants were asked to identify factors that preceded their relapse, drawn from the list of twenty-three warning signs.

Sampling

The questionnaire was administered at ABC Recovery Center in Indio and Inland Valley Recovery Center in Upland. This provided ready access to qualified respondents. The questionnaire was self administered so

it would be possible to get a large sample. The goal was to obtain at least 100 usable questionnaires. A limitation is that was a nonrandom sample. In addition people at these two recovery centers might not have been representative of the entire population of people who have relapsed. Therefore the present study can best be considered a preliminary study of the approach being used.

Data Collection and Instruments

Data were collected by means of a self-administered questionnaire written especially for this study (Appendix A). It was completed by individuals who were in recovery but who had relapsed one or more times in the past. Participants were asked to identify factors that preceded their relapse, drawn from a list of twenty-three warning signs that addiction treatment research has identified as important.

Procedures

Individuals who were attending meetings at ABC Recovery Center and Inland Valley Recovery Center were invited to participate. The leader of the meetings asked for volunteers who have experienced relapse after having

gone through recovery. Those who qualified were invited to complete the questionnaire. The leaders did not report that anyone refused to participate. A few people who completed the questionnaire indicated that they had not ever relapsed, and their questionnaire was not included in the analysis.

The questionnaire (Appendix B) asked individuals to check the risk factors that they believe applied during the ninety-day period before their last relapse. It was important that respondents not check items they did not remember as having been important. Items identified often are considered more important than those identified infrequently. It also asked an open-ended question: what do you think is the most important reason for your most recent relapse?

An analysis of the data was done to determine which of the twenty-three risk factors the respondents identified most frequently. This methodology was meant to identify the warning signs that respondents remember having contributed to their relapse. The open-ended responses were coded and compared with the rankings of the twenty-three risk factors.

The questionnaire collected baseline demographic information about the respondents gender, age, employment status, marital/relationship status, residence status (lived alone; with spouse/partner; with parents; etc.), income, and education.

Protection of Human Subjects

Anonymity was not an issue for this study because everyone who attends meetings at ABC Recovery Center and Inland Valley Recovery Center has openly acknowledged a substance abuse problem and is working on a program of recovery.

Consent to participate in research was obtained from each person prior to handing them the questionnaire. As can be seen in the Informed Consent statement (Appendix C) everyone was informed in writing that their responses would be kept confidential and they would not be asked to state their name. They were assured that participation was completely voluntary and they could feel free to stop at any time even after you have started to fill out the questionnaire. They were told that there were no risks in answering this survey and that if any question made them

feel uncomfortable to please feel free to skip that question.

The questionnaire was self-administered. Completed questionnaires were dropped into a sealed box to assure confidentially.

Data Analysis

For each item, the responses were totaled and then converted into the percentage of respondents who marked it.

The project analysis then had to answer the following question: Is a number like 59% really that different from 49%? Are they statistically different or are they about the same and the order was just by chance?

To answer this question the Z score was calculated to see if the items were different at a given confidence level. For example, suppose that 103 people responded to the survey. Assume: Item 10 was checked by 100/103 or 97% of respondents. Item 4 was checked by 90/103 or 90% of respondents. The standard deviation of item 10 is square root of (0.97) (0.03). The standard deviation is hence 0.168. The standard error of the estimate is 0.31/(square root of 103) = 1.66%. Following the same approach, the

standard error of the estimate for item 4 is 3.27%. Item 10 and item 4 are separated by 10/103 = 9.7% = 0.097. The Z score = $0.097/ (\sqrt{(0.166^2 + (0.327)^2)}) = 2.647$, which would be a large enough Z score to say that item 4 and item 10 are different at the .01 confidence level.

In the same way for any item the mean frequency score for Men was compared with the mean frequency score for Women. Similarly the mean frequency score for (non Hispanic) Whites was compared with the mean frequency score for Hispanics.

Respondents were asked an open-ended question: "What do you think is the most important reason for your most recent relapse?" These were sorted by gender and by racial/ethnic groups and analyzed qualitatively. The results were compared with the tabulated risk factor frequency ratings obtained from the questionnaire.

Summary

This chapter presented the study design of the project. It discussed the way subjects were selected and qualified for inclusion, the questionnaire, its administration, and the method of analysis.

Data were gathered by means of a self-administered anonymous questionnaire completed by individuals who were in sobriety but who in the past had relapsed at least once. Subjects were chosen at ABC Recovery Center and Inland Valley Treatment Center. Data were tabulated and converted to percentage responses. Relevant statistical tests of significance were performed. Responses to the open-end question were prepared (Appendix C) and coded for analysis.

CHAPTER FOUR

RESULTS

Introduction

This chapter begins with descriptive statistics of the characteristics of the sample group. This is followed by a presentation and analysis of the responses of the participants including the entire sample, comparison of Men & Women, and comparison of (non Hispanic) Whites & Hispanics. Relevant tests of statistical significance are discussed. The chapter concludes with a presentation of the responses to the open-ended question with a qualitative analysis. This is followed by a short chapter summary.

Presentation of the Findings

As previously described, a self-administered survey was completed by clean & sober individuals in recovery who have previously relapsed at least one time. These people were invited to participate while they were taking part in various 12 Step programs at ABC Recovery Center (Indio) and Inland Valley Recover Center (Upland).

Demographics of the Respondents

Table 1 summarizes demographics of the respondents. In all 154 people completed the questionnaire, 72 men and 82 women. Their average age is 35. On average they have experienced six relapses and have been clean & sober for two years. Currently 32 of them report being enrolled in a treatment program and 119 indicate they are not. 54% of the respondents are White and 33% are Hispanic. Almost a third of the respondents have not completed high school, an additional 29% are high school graduates, and 10% have some college experience. Almost half are single not living with their parents, 33% have no income, and 36% have an annual income less than $29,000.

Table 1. Demographics of the Respondents

Variable	Number	%
GENDER		
Male	72	47%
Female	82	53%
AVERAGE AGE	35	-
ETHNICITY		
African American	17	11%
Asian	2	1%
Hispanic	51	33%
White	83	54%
Native American	1	1%
EDUCATION		
Some High School	47	31%
High School Graduate	44	29%
Some College	45	29%
2 year AA	7	5%
4 year BA, BS	3	2%
Masters	3	2%
Doctor/Professional Degree	2	1%
No Answer	3	2%
STATUS		
Single with parents	18	12%
Single not with parents	73	47%
Married/cohabitating	26	17%
Divorced	21	14%
Separated	16	10%
INCOME		
None	51	33%
Under $1,000	14	9%
10-29,000	42	27%
30-49,000	27	18%
50-69,000	7	5%
70-89,000	3	2%
90,000 and up	10	6%
RECOVERY STATUS		
How Many Relapses? Average	6	-
How Many Years Clean? Average	2	-
Currently In A Treatment Program?		
Yes	32	21%
No	119	77%
No Answer	3	2%

Table 2 compares the racial and ethnic composition of the respondents with comparable population data for San Bernardino County, Riverside County, California, and the United States. The study sample proportions are roughly comparable to local and state populations. Whites and African Americans are somewhat more represented in this study sample compared with Hispanics and Asians who are somewhat less represented.

Table 2. Sample Population Compared with County, State, and National Populations

	(Percent of Total)				
	Study Sample	San Bernardino County	Riverside County	California	U.S.
African American	11.0	9.0	6.7	6.7	12.3
Asian	1.3	3.5	5.5	12.5	3.6
Hispanic	33.1	39.0	42.3	36.3	12.5
White	53.9	44.0	42.3	42.3	62.7
Native American	0.6	2.0	1.4	1.2	.9
Other	none	2.5	1.8	1.0	8.0

Main Findings

Respondents were asked to choose from a list of twenty-three items the factors they believe contributed to their most recent relapse. Table 3 presents the

results in rank order of frequency chosen by the respondents.

The most frequently cited reasons for having relapsed are: "spending time with old friends" (68%); "went around old places" (62%); "stopped 12 step meetings" (61%); "not spending time with sponsor" (60%); "isolation" (59%); "not talking with sponsor" (58%); "not working with sponsor" (58%);"not attending church" (56%); "not spending time with recovery friends" (55%); "arguments and fights" (53%); and "not involved in therapy" (52%).

The least frequently chosen items involved health: "diagnosed illness" (14%; "medical not see doctor" (21%; "not taking medications" (21%); "sleeping problems" (32%); didn't eat well (35%); and "didn't exercise" (39%). These scores do not mean that such problems are not important to people who have them, of course, but that most of the people in the sample either didn't have them or didn't consider them to be important contributors to their relapse.

Table 3. Factors Contributing to Relapse

All 154 Respondents' Responses	Responses	% of Responses
Spending time with old friends	104	68%
Went around old places	95	62%
I stopped 12 step meetings	94	61%
Not spending time with sponsor	92	60%
Isolation	91	59%
Not talking with sponsor	90	58%
Not working with sponsor	89	58%
Not attending church	86	56%
Not spending time with recovery friends	84	55%
Arguments and fights	81	53%
Not involved in therapy	80	52%
Not involved in after care program	75	49%
Not doing volunteer work	76	49%
Not employed or attending school	71	46%
Experienced crisis	69	45%
Seldom participated in 12 Step social events	68	44%
Not attending alumni events/meetings	61	40%
Didn't exercise	60	39%
Didn't eat well	55	36%
Sleeping problems	50	32%
Not taking medications	33	21%
Medical not see doctor	32	21%
Diagnosed illness	21	14%

For any two of the percentage items to be statistically different from one another at the .05 confidence level, there needs to be about a 10% point difference between them. A 7% point difference is enough to make two values statistically significant at the .10 level. Therefore the top seven items in Table 4 are statistically the same at the .05 confidence level. [2]

There is no clear boundary between factors that are important and factors that are not important. The most frequently chosen risk indicator was "spending time with old friends" (68%). This is not statistically different at the .05 level from "not working with a sponsor (58%) and the items in between them in frequency.

However "not working with a sponsor" (58%) is not statistically different from "not doing volunteer work" (49%) and all the items in between them. Similarly "not doing volunteer work" (49%) is not statistically different from "didn't exercise" (39%) and all the items in between them.

[2] The values can change slightly depending on what the mean value is for the variable of interest. For example, when comparing the numbers 50% to 40% the significance is a bit different than when comparing 90% with 80%.

On the other hand, some items are clearly more important to the respondents than others in contributing to their relapses. At the .05 confidence level "spending time with old friends" (68%) is more important than "didn't eat well" (36%) because their scores are more than 10 percentage points different.

Table 3 confirms the usefulness of the items used in the questionnaire for this study. All but six of the twenty-three risk factors used in this project were identified by at least forty percent of the respondents as having contributed to their most relapse.

Comparisons of Men and Women

Table 4 and Table 5 compare the responses of men and women. The response of men and women is statistically different at the .05 level for "not involved in aftercare" (men 63%, women 47%). They are different at the .10 level for six other items. Women more often than men cite "isolation" (66% women, 51% men) "not involved in therapy" (62% women, 54% men) and "sleeping problems" (39% women, 25% men). Men more often than women choose "spending time with old friends" (71% men, 52% women) and

"went around old places" (69% men, 55% women), and "not attending alumni events & meetings" (47% men, 33% women).

It can be seen that men more often than women cited their actions, such as "spending time with old friends" and "not staying connected to after care programs and meetings." Women more frequently chose factors that expressed their feelings, such as "isolation," "not involved in therapy" and "sleep problems".

The overall patterns of men's and women's responses are quite similar. Though the order differs a little, the first ten items in the responses of women as shown in Table 6 are the same ten items that appear at the top of the list for men and women combined in Table 4. Similarly, these same first ten items of men and women together as they are presented in Table 4 appear in the top fourteen rankings of men as shown in Table 5.

Table 4. Factors Contributing to Relapse Ranked by Men's Responses

Men (n = 72) vs. Women (n = 82)	Men No.	Men %	Women No.	Women %
Spending time with old friends**	51	71%	43	52%
Went around old places**	50	69%	45	55%
Not spending time with sponsor	45	63%	47	57%
Not involved in after care program*	45	63%	30	37%
Not talking with sponsor	43	60%	47	57%
I stopped 12 step meetings	42	58%	52	63%
Not time with recovery friends	42	58%	42	51%
Not attending church	41	57%	45	55%
Not working with sponsor	39	54%	50	61%
Not involved in therapy	39	54%	41	62%
Not doing volunteer work	38	53%	38	46%
Isolation**	37	51%	54	66%
Arguments and fights	36	50%	45	55%
Not employed or attending school	34	47%	37	45%
Seldom attend 12 step social events	34	47&	34	41%
Not attend alumni events/meetings**	34	47%	27	33%
Experienced crisis	29	40%	40	49%
Didn't eat well	25	35%	30	37%
Didn't exercise	24	33%	36	44%
Sleeping problems**	18	25%	32	39%
Medical not see doctor	15	21%	17	21%
Not taking medications	14	19%	19	23%
Diagnosed illness**	6	8%	15	18%

* Different at the .05 level of significance.
**Different at the .10 level of significance.

Table 5. Factors Contributing to Relapse Ranked by Women's Responses

Women (n = 82) vs. Men (n = 72)	Women No.	%	Men No.	%
Isolation**	54	66%	37	51%
I stopped 12 step meetings	52	63%	42	58%
Not working with sponsor	50	61%	39	54%
Not talking with sponsor	47	57%	43	60%
Not spending time with sponsor	47	57%	45	63%
Went around old places**	45	55%	50	69%
Not attending church	45	55%	41	57%
Arguments and fights	45	55%	36	50%
Spending time with old friends**	43	52%	51	71%
Not spend time with recovery friends	42	51%	42	58%
Experienced crisis	40	49%	29	40%
Not doing volunteer work	38	46%	38	53%
Not employed or attending school	37	45%	34	47%
Didn't exercise	36	44%	24	33%
Not involved in therapy	41	41%	39	54%
Seldom attend 12 step social events	34	41%	34	47%
Sleeping problems**	32	39%	18	25%
Not involved in after care program*	30	37%	45	63%
Didn't eat well	30	37%	25	35%
Not attend alumni events/meetings**	27	33%	34	47%
Medical not see doctor	17	21%	15	21%
Not taking medications	17	21%	14	19%
Diagnosed illness**	15	18%	6	8%

* Different at the .05 level of significance.
**Different at the .10 level of significance.

Comparisons of Whites and Hispanics

Because the sample contained a fairly large representation of Hispanics and (non Hispanic) Whites, these groups were also compared. They are presented in Table 6.

The overall rankings of Hispanics and Whites are quite similar and the item-by-item differences between them are not great. Hispanics slightly more often than Whites cite "not working with sponsor" (67% Hispanic, 59% White), and "arguments and fights" (69% Hispanic, 54% White). Slightly more frequently Whites pick "went around old places (73% White, 63% Hispanic), "isolation" (68% White, 58% Hispanic) and "didn't exercise" (48% White, 38% Hispanic).

However, none of these differences are statistically significant at either the .05 or .10 level and may have occurred simply by chance. There is no support in Table 6 for concluding there are differences in relapse risk factors between Hispanics and (non Hispanic) Whites.

Table 6. Factors Contributing to Relapse Hispanics versus Whites

	Hispanics		Whites	
	No.	%	No.	%
I stopped 12 step meetings	31	65%	51	65%
Not spending time with sponsor	32	67%	76	67%
Not talking with sponsor	33	69%	49	62%
Not working with sponsor	32	67%	47	59%
Not time with recovery friends	28	58%	48	61%
Not involved in after care program	28	58%	43	54%
Not attending alumni events	22	46%	35	44%
Not participate 12 step socials	24	50%	36	46%
Not attending church	31	65%	51	65%
Not involved in therapy	29	60%	43	54%
Not doing volunteer work	24	50%	46	58%
Not employed or attending school	23	48%	43	54%
Spending time with old friends	35	73%	56	71%
Isolation	28	58%	54	68%
Experienced crisis	24	50%	41	52%
Not taking medications	12	25%	19	24%
Didn't eat well	17	35%	31	39%
Didn't exercise	18	38%	38	48%
Sleeping problems	16	33%	27	34%
Medical not see doctor	10	21%	18	23%
Diagnosed illness	8	17%	9	11%
Went around old places	30	63%	58	73%
Arguments and fights	33	69%	43	54%

Responses to Open Ended Question

The questionnaire asked respondents an open-ended question: "What do you think is the most important reason for your most recent relapse?" Data from open-ended questions can serve as a means of interpreting closed-ended questions as well as shedding additional light on the motivations or attitudes behind the closed-ended response patterns. The full responses to the open ended question are presented in Appendix C. Their answers were edited into categories and are presented in Table 7.

The two most common answers to the open end question are: (1) the influence of peers and significant partners who use and drink and (2) not staying connected to the person's recovery program. This is the same answer as the most frequently selected responses to the 23 items of the closed end question summarized in Table 3: (1) spending time with old friends in old places and (2) not participating in recovery programs with sponsors and recovery friends.

The answers provided by respondents in Table 7 closely match the factors included in the closed end

questions of the questionnaire. This confirms that the items under consideration in the present study are valid.

Table 7. Analysis of Responses to Open End Question: "What do You Think is the Most Important Reason for Your Most Recent Relapse?"

(Total Responses and Percent of Responses)

	Total	%	Men	%	Women	%
Influence of peers/partners	41	22%	18	22%	23	21%
Emotional problems/losses	26	14%	9	11%	17	16%
Did not want to quit	23	12%	13	16%	10	9%
Not committed to program	22	12%	9	11%	13	12%
Relationship/family problems	16	8%	2	2%	14	13%
Isolation	12	6%	5	6%	7	6%
Loss of loved one/child custody	8	4%	4	5%	4	4%
Don't know/no answer	7	4%	0	0%	7	6%
Prison influence adjustment	6	3%	5	6%	1	1%
Economic difficulties	6	3%	2	2%	4	4%
Idle time	6	3%	3	4%	3	3%
Addicted	4	2%	2	2%	2	2%
Thought I would be able to use	4	2%	4	5%	0	0%
Lack of self will	4	2%	4	5%	0	0%
Lost spiritual beliefs'/support	3	2%	2	2%	1	1%
Health Problems	2	1%	0	0%	2	2%

The open-end responses in Table 7 also support the observation made earlier women more often than men

mention their feelings. In Table 7 half of women cited the influence of peers/partners (21%), emotional problems/losses (16%) and relationship/family problems (13%) and loss of loved one/child custody (4%). These four items were chosen by only a third of the men.

Table 7 also provides a new insight that was not evident from the closed end list of twenty-three items. Not all of the respondents wanted to stop substance abuse: (1) 12% of the men and 9% of the women report that the main reason they relapsed is that they did not want to stop using and drinking; and (2) 12% of the men and 12% of the women also reported that they were not committed to a program of sobriety. This should not be a surprise. According to the research literature, such feelings are a part of relapse experience (Gorski, 2000; Marlatt & Gordon, 1985).

Coding of the open-end responses by racial/ethnic groups revealed no differences. This may or may not be due to small sample size.

Conclusions

Three conclusions follow from analysis of the open-end responses. First, the items volunteered by the

respondents coincide closely with those identified in the questionnaire. This supports the validity of the questionnaire. Second, there are some differences in the responses of men and women. Third, no obvious differences occur in the responses across these racial/ethnic subgroups.

CHAPTER FIVE

DISCUSSION

Introduction

The chapter begins with a statement of the problem that has been addressed in this project and the purpose of the research that has been undertaken. This is followed by a section that discusses the findings. Then there is a section on the limitations the study along with suggestions for further research. Next there is a section with recommendations for social work practice, policy and research. The final section presents conclusions.

Discussion

A large and often complex body of research has been developed to study addiction and relapse. Fortunately addiction specialists have developed warning signs that relapse is about to occur or has already occurred. This master's project helps clarify that research in two ways.

First, the project has identified the relative importance of twenty-three relapse warning signs. Second, the results confirm that this is a useful list because for seventeen of these warning signs at least forty

percent of the respondents indicated it contributed to their relapse

These two findings are reinforced by the responses to the open-ended question: "What do you think is the most important reason for your most recent relapse?" For the most part the answers coincide with the twenty-three items on the questionnaire.

The findings about the relative importance of the twenty-three warning signs can be reduced further. The study's participants indicated that the factors that most often contributed to their relapse were two clusters of behaviors: (1) reconnecting with past friends and going to old places where they has used in the past; and (2) withdrawing from the people, programs, and resources that supported staying clean and sober.

There were some differences in the responses of men and women. Men more often reported the act of hooking up with old friends and going to places where they had used in the past. Women more often reported their internal state of mind expressed as isolating and losing sleep.

The open-end responses support this observation. Half of the women respondents cited the influence of peers/partners, emotional problems/losses,

relationship/family problems, and loss of loved one through death or lost child custody. These four items were chosen by only a third of the men.

Though there were some differences in the response frequencies of Whites and Hispanics none of these comparisons were statistically significant at either the .05 or .10 confidence level. In fact, the overall patterns of responses between these two groups were very much alike. However, the sample size is probably too small to reliable observe such differences if they exist. Coded responses to the open-end question reveal no difference by racial/ethnic categories.

Recommendations for Social Work Practice, Policy and Research

The findings of this study are consistent with the research that has been done on addiction and relapse. The study's value is that these findings can help social workers manage their case loads more effectively by giving them clearer information about the main causes of relapse among their clients.

It is important for social workers to realize that relapse is not simply an event where a sober person begins to drink or use. Relapse is also a process in

which an individual's thinking change and the person's behavior is altered in ways that lead them to break their sobriety. Relapse is a normal part of recovery from substance abuse.

Social workers should know that these observations are supported by the participants of this study. Most of the respondents emphasized the importance of the thoughts and behaviors that moved them toward relapse. These include most importantly the risky behaviors of spending time with old friends in familiar places plus pulling away from the support of their recovery programs. This information can be used to point social workers to the most important warning signs of relapse for clients in their caseloads.

Social workers should also be aware that women and men experience relapse differently. Women are more likely than men to go through stress, depression, and isolation in advance of relapse.

Substance abuse has significant impacts the practice of social work. An emphasis on understanding relapse and relapse prevention needs to be included as a vital part of the knowledge of social workers. It is recommended

that the results of this study be incorporated into the ongoing training for professionals in the field.

Limitations

The data for this study were chosen from a small, non-random sample. The answers of the respondents may not be representative of the larger population of substance abuse relapse individuals. The participants for this study were chosen from two San Bernardino County treatment centers which, as it turns out, specialize in young, low income clients with less than average levels of education. Further study with a broader socioeconomic sample is also needed. Because the respondents were chosen in San Bernardino County there are very few African Americans and Asians.

Individuals enter treatment for a variety of reasons. Some present themselves to ask for help. Others get involved because of the intervention of family, friends, or employers. Some are assigned to treatment by the courts as an alternative to jail. This study did not attempt to analyze the extent to which differences in readiness for recovery might matter.

For all these reasons more research is needed to determine whether the results of this study can be replicated in other studies that investigate a wider geographic, socioeconomic and racial/ethnic population.

Conclusions

This study has attempted to identify the relative importance of factors that are most likely to lead to relapse. Its purpose is to contribute to the knowledge of generalist social workers and other professionals as they face the issues of addiction and relapse.

The kind of information provided by this study could help increase the effectiveness of social workers and addiction treatment professionals on a daily basis as they try to help their clients cope with the complex family issues brought on by relapse.

Being able to identify the factors that lead to relapse will be useful to social workers as they help clients to try to understand and avoid the situations, behaviors, and thoughts that lead to relapse. This information can also help social workers recognize that relapse has taken place and speed up appropriate efforts at intervention.

Understanding relapse could help social workers at every stage of their work. For example, a social worker might begin a new case when called in to deal with reports of domestic violence and child abuse. This social worker could use the findings of this project to assess whether or not relapse from substance abuse is part of what is going on. With this information in hand the social worker could get involved in planning and implementing steps to address the situation. Getting the substance abuser into treatment might be an appropriate strategy. Putting the child into foster care might be necessary. Over time the social worker could use the information in this project to evaluate whether the plan is working. Has the client gone through successful detox, stabilized and begun working a program of sobriety? Can children be returned to their parents? During all these steps knowing how to recognize whether the client has relapsed or shows danger signs of relapsing can be crucial. If sobriety is achieved and seems sustainable the social worker could consider whether or not to become less concerned or even to terminate active involvement.

It is recommended that the findings of this project and related research be incorporated into the training of

all social workers. It is also recommended that further research be conducted to see if the results of this project can be replicated under randomly controlled conditions with a larger sample drawn with more geographic, socioeconomic, and racial/ethnic diversity.

APPENDIX A

QUESTIONNAIRE

QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

The following questions are for statistical purpose only; information will be kept confidential.

1. _____ Male _____ Female
2. _____ Age
3. What one of the following best describes your ethnic background?
   _____ African American
   _____ Asian- Pacific Islander
   _____ Hispanic
   _____ Caucasian
   _____ Native American
   _____ Other (Specify)_____
4. What is your highest level of education?
   _____ Some high school
   _____ High school graduate
   _____ Some College
   _____ 2 year college degree (AA)
   _____ 4 year college degree (BA, BS)
   _____ Master's Degree
   _____ Doctoral Degree/ Professional
5. What is your status?
   _____ Single, living with parents
   _____ Single, not living with parents
   _____ Married/Cohabitating
   _____ Divorced
   _____ Separated
6. In which yearly income range do you place your family?
   _____ No income/unemployed
   _____ Under $1000
   _____ $10,000-$29,000
   _____ $30,000-$49,000
   _____ $50,000-$69,000
   _____ $70,000-$89,000
   _____ $90,000 and up

ABOUT YOUR RELAPSE HISTORY

7. _____ How many times have you relapsed?
8. _____ How long had you been clean and sober at the time of your last relapse?
9. Were you in a treatment program at the time of your relapse?
   _____ Yes _____ No

CAUSES OF YOUR MOST RECENT RELAPSE

Relapses can occur for many reasons. Please check all that you believe contributed to your relapse. Leave blank the items that you do not believe contributed.

"In the ninety day period prior to my most recent relapse..."

_____ I stopped regularly attending 12 Step meetings

_____ I did not talk often with my 12 Step sponsor

_____ I was not working with my sponsor on one of the 12 Steps

_____ I did not spend significant time with friends I had met in recovery

_____ I did not often participate in my treatment center's after care program

_____ I did not often participate in my treatment center's alumni events and meetings

_____ I seldom participated in 12 Step related social events and other activities

_____ I did not often attend church

_____ I did not often participate in group or individual therapy

_____ I was not employed or going to school

_____ I began to spend time with old friends I knew prior to my sobriety

_____ My spouse or love interest was using and wanted me to do so as well

_____ I was spending a lot of time in isolation

_____ I experienced a crisis event such as divorce/separation, illness of a loved one, loss of job, death of a loved one

_____ I went around places where people regularly engaged in the use of alcohol and/or drugs

_____ I had arguments and fights with one or more loved ones

_____ I began to have physical cravings for alcohol and/or drugs

_____ I had been prescribed medications, but I didn't take them regularly

_____ I didn't eat well

_____ I didn't exercise regularly

_____ I had problems sleeping well

_____ I had medical problems but I did not go see a doctor

_____ I was diagnosed with a significant illness

What do you think is the most important reason for your most recent relapse?

_____

_____

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

My name is Norma Likens. I am a graduate student seeking a Masters Degree in Social Work at California State University, San Bernardino. I am conducting research on the importance of factors that contribute to relapse among individuals who are recovering from substance abuse. I would very much appreciate your help in this research.

You can help by completing an anonymous and confidential questionnaire that will be used to generate the information I need for the study. It should take approximately 5-10 minutes to complete the questionnaire. This project is being conducted under the supervision of Dr. Thomas Davis and approved by the Sub-Committee of the Institutional Review Board at Cal State San Bernardino.

Your responses will be confidential and you will not be asked to state your name. Participation is completely voluntary and you may feel free to stop at any time even after you have started to fill out the questionnaire. There are no risks in answering this survey. If any question makes you feel uncomfortable please feel free to skip that question.

The intended benefit of this study will be to help professionals in the field of social work and substance abuse as they work with individuals who are in recovery and their families. Participants in the study will answer questions about the factors that they believe may have contributed to their relapse. Everyone's responses will be combined and presented in a single report. Results of this study will be available upon request at the participating agency where you complete the questionnaire.

Additional questions in regards this study should be directed to Dr. Thomas Davis, Ph D. at California State University, San Bernardino. He can be reached at 909 537-3839 or tomdavis@csusb.edu

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Please mark and detach this page from the questionnaire and place it in the box labeled "Consent."
Once you complete the questionnaire, place it in the box labeled "Questionnaire".

My mark below indicates my willingness to participate in this research study. I understand that I am not required to answer any of the questions, and if I wish, I may refuse to do so. I am at least 18 Yrs of age.

_____ _____

Participant's Mark Date

APPENDIX C

RESPONSES TO OPEN ENDED QUESTION

Responses to
"What Do You Think is the Most Important Reason for Your Most Recent Relapse?"

MALE WHITE

Being in prison with easy access to drugs
Alcohol addiction -improves feelings
Not attending program
Not following program, peer influence
Not accessing program and support
Not willing to abstain to quit
Prison and not committed to quitting
Emotional stress and loss of a friend
Access to drugs and other users
Not accessing program sponsor, peer influence
Peer influence, past friends
Not attending program and too much idle time
Loss of loved ones and emotional stress
Not following program and not accessing sponsor
Unwilling to change and being in prison
Not making good choices
Isolation and peer influence, not following program
Not able to stay sober every day, anxiety about self control
Unable to resolve feeling about the past and guilt
Loss of ability to stay sober and resignation to addiction
Thought able to use occasionally
Not taking medications and peer influence
Isolation, emotional stress, loss of loved ones
Peer influence, past habits
Too much free time
Decided to continue drugs
Lack of self will
Depression, boredom, low self esteem, unemployment, antisocial Behavior
Not committed to program
Family problems
Not following program
Living on the streets, homeless
Loss of family support
Peer influence, girlfriend influence
Self pity
Leaving support group
Peer influence, girlfriend influence
Not following program, peer influence, though able to use occasionally

Divorce, cancer treatment

MALE HISPANIC

Too much free time
Old habits and places
Old places, isolation
Spousal problems, emotional stress, depression, negative thoughts
Not willing to quit
Old friends, old places
Return to society after prison
Did not believe addicted
Isolation, depression
Addiction, enjoyed using
Bored, isolation, enjoyed using
Unwilling to quit using
Peer influence
Loss of spiritual beliefs
Loss of loved one -mother
Unwilling to quit
Not following spiritual beliefs
Girlfriend influence
Not following program

MALE NATIVE AMERICAN

Past peers, not following program, thought able to control use
Depression, low esteem, loss of child, isolation
Unable to focus on recovery, difficulties in life

MALE AFRICAN AMERICAN

Past friends, peer influence
Unwilling to quit
Not following program
Stress
Thought able to control use
Past friends peer influence

FEMALE WHITE

Not following program, peer influence
Unemployment, depression, family problems
Mental health problems
Health problems, need for pain relief
Not following program
Loss of child custody
Depression
Death of family member, not following program tools

Relationship & family problems, self esteem & weight loss issues, returning after prison
Depression, isolation, financial stress, anxiety, need for pain relief
Unwilling to quit
Peer influence from past friends
Do not know
Past peers and places
Returning to past friends and old places
Physical addiction and craving
No answer
Not utilizing the program
Anger and relationship difficulties
Relationship difficulties
Stress, depression, isolation, peer influence
Relationship difficulties and coping skills
Past peers
Family relationship difficulties
No answer
Homeless, socializing with other users
Separation from family
Stress, isolation, anxiety
Loss of child custody
Fear of pain, grief, loss
Unwilling to quit
Unwilling to follow program
Did not follow program, no spiritual support
Not following program, poor family support
Isolation, loneliness, spouse using
Isolation, depression
Lack of support
Unwilling to quit

FEMALE HISPANIC

Past peers and places, difficulty with relationships, not eating or sleeping well
Past peers and places
Not ready to stay sober
Peer influence
Not ready to stay sober
Past peers, depression, unemployed
Isolation
Past peers, peer influence, difficulty with relationships
Not following the program, not accessing support

Relationship stress
Isolation
Too much free time
No answer
No answer
Ill parent, relationship difficulties
Anxiety
Not prepared for recovery, returning to past peers
No answer
Divorce, loss of child custody
Stress, family difficulties
Unable to quit
Continued involvement with drugs
No answer
Family problems, access to drugs and old friends

FEMALE AFRICAN AMERICAN

Not following recovery program
Not ready to stay sober
Depression, not attending program meetings
Not accessing program support and meetings
Past peers and peer influence
Not ready to stay sober
Not following recovery program, unhealthy relationships
Stress and anxiety
Returning to old friends and places
Old friends and habits

FEMALE NATIVE AMERICAN

Isolation
Not attending program meetings

APPENDIX D

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The data and analysis for this project are contained on an SPSS file which has been given to Professor Laurie A. Smith of the School of Social Work, California State University San Bernardino.

Additional questions in regards this study should be directed to Dr. Laurie A, Smith, at California State University, San Bernardino. She can be reached at 909 537-3837 or lasmith@csusb.edu

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