Relapse Prevention: Future Directions

Stephen M. Hudson\textsuperscript{1,2} and Tony Ward\textsuperscript{1}

\textit{There are several significant problems with both Marlatt's and Pithers' relapse prevention (RP) models. It is argued in this paper that there are good empirical, theoretical, and practical reasons for viewing the offense and relapse process as functionally equivalent. The core construct in both these traditionally different models is the problem behavior process. The application of a framework based on the problem behavior process has significant theoretical and clinical advantages and can overcome the major difficulties associated with Marlatt's and Pithers' RP models.}

\textbf{KEY WORDS:} abstinence violation effect; cognitive/behavioral therapy; relapse prevention; sexual offender treatment.

\textbf{INTRODUCTION}

Our review of the relapse prevention (RP) and Pithers' modification of this framework identified four major areas of difficulty. In this paper we briefly traverse these issues and argue that they may be overcome by focusing on the core process underlying both the offending and relapse process. We suggest that viewing the offense and relapse process as functionally equivalent solves some of the difficulties. We then outline our model of the offending process and suggest that it can provide a framework to guide future research and clinical practice.

\textbf{PROBLEMS WITH THE RELAPSE PREVENTION MODEL}

Some of our concerns with the RP model are fundamental to Marlatt's model and are simply inherited by Pithers in his adaptation for sex offend-
ers (Ward & Hudson, 1996b). Others are associated with the limited range of Marlatt’s components which are utilized by Pithers and the modifications driven by ethical concerns.

First, the theoretical diversity in both models leads to confusion and redundancy. This applies primarily to the RP model but is shared by Pithers’ model. We have suggested that there are other ways of conceptualizing the mechanisms (e.g., the abstinence violation effect) that are simpler and more reflective of current theory in the area of social cognition (e.g., Ward, Hudson, & Marshall, 1994).

Second, Marlatt’s model does not cover all the possibilities involved in reoffending. His three routes to high-risk situations emphasize skill deficits as the major mediators and fail to cover situations where individuals consciously decide to use drugs or engage in an addictive behavior (see Allsop & Saunders, 1989). Third, this lack of scope is exacerbated by Pithers’ exclusive use of the covert route, at the expense of other, clinically evident, pathways. In addition, this means that Pithers’ model shares the problems of unconscious thinking and desires, and it implies the unlikely prospect of offenders covertly planning to experience negative affective states (Ward & Hudson, 1996b). Finally, moving the lapse and relapse points back in the offense chain has created significant conceptual and practical problems, for example, the inherent incompatibility between the problem of immediate gratification and the abstinence violation effect as transitional mediators.

**OFFENDING VERSUS RELAPSE**

Traditionally relapse is thought to follow a period of treatment or being symptom free. This equates relapse with treatment failure and implies a dichotomous, or disease perspective of treatment outcome (Marlatt & Gordon, 1985). Marlatt and Gordon propose an alternate definition in which relapse is viewed in the context of an ongoing life management process rather than an end state. Relapse is seen as backsliding, or returning to baseline levels of the behavior.

In the sexual offending literature there is an implicit assumption (e.g., Ryan, 1996; Ward & Hudson, 1996a) that treatment is a prerequisite for relapse: untreated sex offenders simply offend; they do not relapse. However, some men may be quite unaffected by treatment and it seems odd to suggest that such individuals “relapse” when they may never have intended to stop offending. Conversely, there are clearly some men who, even in the absence of treatment, are aware of the wrongness of their actions and who avoid self-evaluation through a variety of strategies (Ward, Hud-