Relapse on the Road to Recovery: Learning the Lessons of Failure on the Way to Successful Behavior Change

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Abstract

Among individuals seeking to change health-related behaviors, relapse is a common experience. Whether it occurs very soon after initiating a change attempt or after several years of sustained changed behavior, it can be discouraging for patients and clinicians alike. Although there is a tendency in healthcare to try to ignore failure, we posit that moving on too quickly results in missed opportunities to learn critical lessons that may promote successful change in the future. In this paper, we use addictive behavior as a lens through which to explore the phenomenon of relapse. We review key insights from the Transtheoretical Model (TTM), including the importance of debriefing failure to promote successive approximation learning while recycling through stages of change. We also offer practical, evidence-based strategies for working effectively with relapse in clinical practice, which we suggest creates a more integrated, client-centered, and personalized approach to care.

Keywords Relapse · Recovery · Failure · Stages of Behavior Change

Clinical Vignettes

James: Adversity, Context, and Giving Up

James is a 50-year-old man whom you have been seeing in therapy for the past year. He developed depression after a back injury forced him to stop working in the warehouse where he'd been employed for 15 years. He reported feeling "bored and useless" and struggling with the lack of structure in his days. Early on in your work together, you learned that James had started smoking marijuana throughout the day to manage his pain, "mellow him out, and cope with his wife nagging him about finances." Over the course of several sessions, you worked to assist James in identifying that his marijuana use may be worsening his mood and interfering with his goal of getting another job. Several times after these conversations he stopped for few days at a time but then resumed use saying, "I can quit any time I want, I just don't think I really want to." However, he recently agreed to try again and this time was able to stay marijuana-free for about 6 weeks. James reported his mood was notably better and his pain wasn't any worse. Last week, he even interviewed for a job he was very excited about and expressed gratitude at knowing he would be able to pass a drug test. Then, this week, he came to your office reporting he found out he did not get the job and had resumed smoking daily for the past several days. He said, "If things are going to be bad anyway, I might as well have something that makes me feel a little better."

Brian: Preparing for Trouble

Brian is a 27-year-old man you've been working with for 4 weeks. He presented reporting increased anxiety and conflict with his long-term boyfriend. In his history he noted "partying" involving binge drinking weekly since early adolescence. After a DUI a couple years ago, he stopped drinking for a while, but once he was no longer on probation he started again (though he no longer drove intoxicated). He became concerned about his alcohol use this year when he noticed an increase in his drinking by himself after work to "decompress" from his stressful job, so he stopped again about 6 months ago. Since quitting, he has been avoiding events where he knows there will be alcohol so he won't be tempted to drink. Although his boyfriend supports Brian's efforts to stop drinking alone, he would like Brian to still attend social events. Months ago, they planned a trip to Mexico with friends, which is coming up in a couple weeks. While Brian is concerned about attending because he knows there will be a lot of drinking, he tells you he "has to go" because it's already paid for and his friends and boyfriend will be disappointed if he doesn't.

Mary: Shame, Blame, and the Need for Compassion

Mary, a 65-year-old woman, presented for therapy for grief related to the loss of her husband George to COVID-19 about 2 months ago. Several years ago, after the sudden death of her son, she began gambling frequently at a local casino to take her mind off things. After she incurred significant debt, her husband assisted her in registering for a voluntary exclusion program to prevent her from entering casinos in the state. She also pursued grief counseling at that time and found it helpful. In a recent session, she admitted to you that after her husband's death she felt she had lost her reason to quit and began gambling online to cope with her sadness, loneliness, and social isolation. She stated, "I know it's a slippery slope for me and I need to stop, but I just can't seem to make myself. I'm so ashamed. I'm so afraid my kids will find out. They would be so disappointed in me. So would George."

Key Background

Understanding Relapse or Failure to Sustain a Behavior Change

Each of the three vignettes above focuses on a clinical manifestation of relapse or the potential for relapse. Because relapse is often experienced in the context of addictive behaviors (they are often referred to as "relapsing disorders"), we use substance use and gambling to illustrate key concepts throughout this paper. However, when conceptualized broadly as failure to sustain a behavior change, relapse is ubiquitous. Importantly, relapse can occur at various time points in the change process. For some, a change attempt may last only a few hours or days prior to relapse; for others, relapse may happen after a significant period of maintained change. Regardless of when in the change process relapse occurs, individuals often experience setbacks in their efforts to modify a myriad of behaviors to manage chronic health conditions and improve quality of life (McLellan et al., 2000). These may include medication adherence, physical activity, dietary changes, a relaxation practice, or any of a whole host of other behaviors. Thus, whether or not they work with clients with substance use or other addictive behaviors, all behavioral health providers will encounter relapse in their clinical practice, likely with some frequency. We therefore invite readers to consider times their own clients have struggled with sustaining behavior change and apply these concepts to the challenges their clients most frequently encounter.

Because many studies of relapse come out of the substance use disorder (SUD) literature, a brief review of them is instructive. In the 1970s and '80 s researchers began to look at survival curves and demonstrated that, over time, individuals who stopped using tobacco, heroin, or cocaine returned to use at similar rates. The first few weeks of a quit attempt among a cohort demonstrated that a significant percentage did not sustain abstinence: about 60% returned to use by 3 months and only about 20–30% sustained the change (abstinence) over the entire year (Hunt et al., 1971). Studies of the average number of quit attempts needed for success vary greatly, and they indicate a range of estimates from five or six to 20 or 30 serious attempts to change. Thus, while some people do achieve lasting change with one serious attempt, for many people repeated attempts are needed for success (Kelly et al., 2019). Only a fraction of the individuals who make an attempt at any one time maintain the change long term, typically defined as 6 to 12 months in many studies.

If relapse or the failure to successfully sustain a behavior change is so ubiquitous, it is important to understand its function in the process of change. In creating the Transtheoretical Model of Intentional Behavior Change (TTM), Prochaska et al. (1992) proposed that the process of intentional behavior change could be best understood by using a stages of change perspective. They proposed five stages or steps that lead to successful change, including Precontemplation, Contemplation, Preparation, Action, and Maintenance. These stages represent states, not traits, and each is associated with critical motivational and behavior change tasks that are part of the process: generating interest and concern about the need to change (Precontemplation), making a decision and overcoming ambivalence (Contemplation), planning for and committing to making a change (Preparation), initiating the change and making the plan work (Action), and finally maintaining that change over time until it becomes part of our behavioral repertoire (Maintenance). In other words, behavior change does not begin with taking action; there are important pre-Action tasks that contribute to the success of the change. This is how individuals change on their own as well as with assistance or treatment (DiClemente, 2006). In multiple studies, readiness or stage status has correlated with substantive differences in attitudes, intentions, decisional considerations, and behavioral activities (Carbonari & DiClemente, 2000; Krebs et al., 2018; Prochaska et al., 1992). In these same studies, stages and readiness also predicted behavior change outcomes.

Given how frequently relapse occurs, TTM developers considered whether it may represent its own stage of change. However, they observed that individuals who reported relapsing represented a diverse group, with some vowing not to try again and others considering or planning a next attempt; thus, relapse was not appropriately conceptualized as its own stage. These observations led to the insight that

the process of change represented a cyclical rather than linear process for most people and that relapse triggered *recycling* through earlier and later stages of change (Prochaska et al., 1992). That is, where one person may relapse and return to Precontemplation, another may relapse and return to Contemplation or even directly to Preparation ready to make another attempt. Or the same person may return to Precontemplation after one relapse but, because of learning that occurred after that relapse, return to a later stage such as Preparation after a future relapse. Hence, as clients recycle through the stages, learning occurs. They complete the tasks of each stage more fully and, through successive approximations, gradually approach sustained behavior change (DiClemente, 2018). We further discuss this reconceptualization below.

Defining Relapse

A significant problem in the addiction relapse literature is that there is no standard definition of what constitutes a relapse (Moe et al., 2021). Does one or several instances of drinking or drug use after a period of abstinence constitute a relapse or just a slip or lapse on the road to recovery? Is a return to the previous level of behavior necessary for relapse? Perhaps part of the reason for the lack of consensus is that outcomes of any change attempt are variable. Indeed, many individuals who are not completely abstinent do decrease their quantity and frequency of substance use. Thus, if any outcome other than sustained abstinence is considered relapse, then we fail to account for any non-abstinent improvements (Dawson et al., 2007; Project MATCH Research Group, 1997). This dilemma is not limited to substances. What is a relapse for diet or exercise or glucose monitoring: several non-diet conforming meals, a week without physical activity, or several days of non-adherence to glucose monitoring or medication?

Relapse can only be interpreted in the context of the behavior change goal and must be viewed from the perspective of the individual making the change. Clinically, we have seen providers who have diagnosed a relapse (e.g., return to some smoking after a couple days of abstinence) when the client declared success (e.g., cutting down relative to the number of cigarettes smoked prior to the change attempt). So, we have begun to take the perspective that relapse occurs when the individual gives up on their change goal, no matter the quantity and frequency of use and no matter whether it occurs early in Action or after a prolonged period of sustained change in Maintenance. If someone is continuing to try to change, even if there is a good deal of slippage in achieving the goal, this individual is best thought of as continuing in Action and Maintenance stages. Once they abandon the change attempt, they recycle to earlier pre-Action

stages of change. Conceptualizing relapse in this way can help us avoid arbitrary definitions of number of drinks or instances of drug use as the sole defining characteristics of relapse and instead stay focused on the broader process of change (DiClemente & Crisafulli, 2017; Maisto et al., 2016). This is important because once an individual defines themself as having relapsed by simplistic metrics of use, they often experience feelings of failure, lose hope, and give up on the possibility of change, perhaps even reentering Precontemplation believing they cannot change.

This is not to say that we should ignore slippage and other difficulties individuals may have in beginning meaningful change and establishing a new pattern of behavior, which is the task of the Action stage. Because it takes time to achieve stability with the changed behavior, the TTM considers Action to last the first 3–6 months of a change attempt. This time typically presents many challenges, and a single reoccurrence or brief lapses to prior patterns of behavior without abandonment of the change goal are common during this time. Slips and lapses during the Maintenance stage may also occur, indicating difficulty sustaining longer-term change or an unanticipated event that creates some disruption in maintaining the change. Although not relapse in our view, these slips or lapses are also instructive for individuals to anticipate, learn from, and problem solve and should be included in any discussion of relapse and relapse prevention.

Relapse Concepts and Models

As described above, the concept of relapse came into focus with research on survival curves looking at long-term outcomes after an attempt to change substance use. Increased understanding of just how difficult it is to maintain change led to a focus on how to prevent relapse and promote sustained change. Over the past 20 years, there has been a shift in emphasis from just maintaining abstinence to a broader perspective on recovery, which the Substance Abuse and Mental Health Services Administration (SAMHSA) now defines as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012, p. 3). Most models that try to explain maintenance and relapse acknowledge the need to change lifestyles, context, and multiple behaviors but have different views of the nature and cause of relapse.

Alcoholics Anonymous has promoted the idea that total abstinence is the measure of successful change and attributes relapse to the failure of the individual to work the twelve steps, get a sponsor, and attend support meetings. They also began to use the chronic disease concept to describe why reoccurrence happens. This approach certainly has been very helpful to many with SUDs, countering the dangers of some

individuals' overconfidence that they can use in moderation when that may not be a viable goal for them.

Many researchers and clinicians also use the relapsing disease concept to describe addictions. However, their perspective is based on advances in understanding the neuroscience of addiction, especially the view that brain changes from ongoing use of substances creates low stress tolerance and vulnerability. Often this perspective advocates the use of medication to decrease risk of relapse by offsetting substance-induced neuroadaptation and supporting increased self-regulation and greater ability to manage stress (Koob & Volkow, 2016).

In their seminal work on relapse prevention, Marlatt and Gordon (1985) created a biopsychosocial model using cognitive behavioral principles to focus on the relapse event. They characterized relapse as a failure to cope with cognitive distortions and cues, which created vulnerability by undermining the confidence or self-efficacy expectations to sustain abstinence. Although cues and coping do seem to play a role in relapse, a large National Institutes of Health study funded to replicate the relapse cue taxonomy of Marlatt and Gordon indicated that relapse is not a simple matter of types of cues; rather, resources and general coping activities were critical elements in explaining relapse (Connors et al., 1996). A more current view is that relapse is a multidimensional unfolding process that involves the individual and transactions with their environmental context (Witkiewitz & Marlatt, 2007).

Learning models also use a biopsychosocial approach focused on a multidimensional process wherein relapse functions as an instance of successive approximation learning (Bandura, 1986). The TTM uses this perspective, describing relapse as an event that triggers the recycling process. Individuals often need the repetition of multiple change attempts to learn how to adequately accomplish all the tasks identified in the stages of change (interest and concern, decision making, commitment and planning, and successful implementation) to be able to create and sustain change. Thus, relapse is less a failure and more an opportunity to learn how to make a successful change.

Learning from Failure

There is a relevant and growing literature exploring the role of failure in science and life that offers some important insights into the role of relapse. Firestein's (2016) book entitled *Failure* argued that failure is critical for success and is the lifeblood of scientific experimentation and discovery. He pointed out that "scientists hop from failure to failure, happy with the interim results because they work so well and often are pretty close to the real thing" (p. 12) and that even our best hitters in baseball are only successful 30% of the time. So, failures are a critical part of many processes, whether the scientific method, sports, or recovery.

Other writers have also extolled the importance of failure and learning from our mistakes. Matthew Syed (2015) in his book entitled *Black Box Thinking: Why Most People Never Learn from Their Mistakes—But Some Do* described how medical systems and most people want to see failure as an aberration and something that one should not dwell on, something to move forward from and not look back. Indeed, medical professionals often consider a failure as a one-off event and not a symptom of a flaw in the approach, provider, procedure, support, or system.

However, the airline industry takes a different view that may prove instructive. When there is a problematic event with a flight, the subsequent investigation uses airplane black boxes and an extensive examination of the events in both the immediate and distal context. This approach includes examining individuals, interactions, communications, and technology to explore reasons for failure and using data from recordings and conversations to inform conclusions. Investigators also attempt to reenact the entire event to find what went wrong so they can suggest solutions. They then disseminate those findings widely to industry employees, decreasing the likelihood that this type of failure will occur again. This is what makes flying the safest form of travel.

As Schulz (2010) noted in her book, *Being Wrong*, "For every species, then, error is a mechanism of survival and change" (p. 336). Many individuals either suffering from SUDs and psychiatric conditions or trying to make health behavior changes attend multiple programs or otherwise make many attempts before they achieve success. In our clinical experience in treatment facilities, it seems that providers and programs do not always examine the change histories of clients and the attempts that were not successful. Moreover, it is not clear whether providers commonly acknowledge the importance of error and debriefing relapse. Although many programs have a relapse prevention component, often it is focused on one single relapse event and not what went wrong with the change process more broadly. It seems like there is a lot to learn from the work outlined above to inspire and instruct on how to address the failure to successfully launch and sustain behavior change in our clinical work.

Clinical and Ethical Challenges

Stigma and Shame

It is well-documented in the literature that SUDs are highly stigmatized conditions (Earnshaw, 2020), as are many other physical and mental health conditions where behavior change attempts and relapse are common (e.g., depression, HIV, obesity; van Brackel et al., 2019). Common beliefs

about individuals with SUDs and other addictive behaviors include that they are to blame for their condition, dangerous, unpredictable, and incompetent (Earnshaw, 2020). These beliefs often translate into harmful behaviors and policies, such as criminalization of substance use, practices that block employment or housing for people in recovery, or bias among healthcare providers (see Earnshaw, 2020 for review). In working with individuals with addictive behaviors, it is important to be aware of various manifestations of stigma and their potential interplay with relapse.

One possibility is that clients' exposure to stigma, whether from family, friends, or strangers—or in the form of structural inequities—may precipitate negative emotions that in turn contribute to relapse. For instance, a client may notice that despite having changed their behavior, they are still perceived as untrustworthy. Frustration, sadness, disappointment, or unhelpful cognitions like "if everyone's convinced I'm eventually going to use again, I might as well do it" could contribute to abandoning attempts at recovery.

Additionally, when clients do experience relapse, they may be subject to increased stigma (Witte et al., 2019). Many people in their lives may view their re-engagement in addictive behavior as a moral failing or a sign that they will never recover. Moreover, clients themselves may internalize these stigmatizing attitudes (a process referred to in the literature as self-stigma or internalized stigma), which in turn may be associated with shame and decreased self-efficacy to sustain or reinitiate behavior change (Bozdağ & Çuhadar, 2021; Earnshaw, 2020).

Finally, it is worth mentioning that clinicians are not immune to holding stigmatizing attitudes ourselves (van Boekel et al., 2013). These may stem from family and personal interactions with individuals with addictive behaviors or simply from unconsciously absorbing biases within a society where stigma is pervasive. Indeed, individuals with addiction often report experiencing and anticipating stigma in healthcare contexts (Earnshaw, 2020). Although these attitudes may be implicit or subtle, if clients perceive them, or even expect that we may hold them (e.g., based on previous interactions with healthcare providers), they may be more hesitant to disclose substance use and relapse in the therapeutic relationship. Thus, it is essential to be aware of and interrogate our own biases. It may also be helpful to name and directly address any impact of stigma within the therapeutic relationship.

Poor Prognosis

Relapse can be discouraging, not only for individuals using substances but also for the providers who treat them. This often is reflected in our intake procedures and the labels we use to characterize our patients. An individual who has made many recovery attempts and who has a more severe

SUD is often declared to have a poor prognosis, which in turn may become a self-fulfilling prophecy through the creation of expectancies. If the provider does not believe that the client can change because they are labeled as a "frequent flyer" who is not motivated to change, the client may perform according to expectations. That is why in our motivational interviewing trainings we say that if you do not believe a client can change then you should transfer the client. Our clinical prognoses are often wrong.

The case of smoking cessation is illustrative. Mark Twain is quoted as saying "quitting smoking is easy. I've done it a thousand times," and indeed nicotine use disorder is often compared with opioid use disorders in severity and actual difficulty of quitting. Across many different outcome studies, prevalence of success, defined as abstinence from smoking, is at best 30–40% even with nicotine replacement therapy, medications, and significant psychosocial support. For smokers trying to quit on their own, success rates are even lower, estimated at 7–10% over a single year. Yet as a country, the United States has gone from 42% of the population smoking in 1964 to about 15% currently. There are more than 40 million individuals living in the US who previously smoked and are now successfully abstinent, but many have had to make multiple attempts to quit to be successful and many more will be successful in the future if they continue to try. If providers took these multiple attempts as a sign that prognosis was poor and these individuals would never stay quit, this expectancy may have seriously interfered with later quit attempts that ultimately proved successful.

Because relapse can undermine our confidence in the potential for change, it is essential to be aware of and question beliefs that multiple attempts make change impossible or even unlikely. In fact, there is an argument to be made that we should retire the term "relapse" altogether, perhaps instead calling it a reoccurrence, a setback, or recycling on the road to recovery. This is consistent with the current focus of NIDAMED, the physician outreach arm of the National Institute on Drug Abuse, on changing the language we use with SUDs, moving away from terms such as "addict," "junkie," and "substance abuser" and shifting to more person-first language (e.g., "individuals who use substances" or "persons in recovery"). Words matter. We should use them to assist clients in detaching blame, shame, and hopelessness from their inability to sustain a change at any one point in time, helping them (and ourselves) view this not as an indicator of poor prognosis but instead a sign of learning and potential for future change.

Restricting Recycling

A number of years ago there was a Veterans Administration program that offered 28 days of inpatient alcoholism

treatment funded by the government. Individuals would go through treatment and then be referred to outpatient aftercare, which they seldom attended. As one would expect, many would return to the inpatient program through the detox unit shortly after returning home. The program decided that this was a not a good use of resources on a subset of clients, so they made a rule that anyone discharged could not be re-admitted for 2 years. These sorts of policies were not uncommon and most have already been changed. While it is understandable to want to use resources as efficiently as possible, such policies were nevertheless problematic in that they effectively restricted opportunity for recycling. They did not allow patients the chance to promptly apply learning from the recent failed attempt. Instead of restricting we should be promoting recycling.

Of note, this type of policy restricting access to resources or treatment is very different from current efforts by insurance companies that refuse to pay providers when patients have to be readmitted within 30 days. The first restricts the client, whereas the second puts the onus of the return on the provider and, more broadly, on the healthcare system by suggesting that adequate treatment, follow-up, and support should be able prevent this hospital readmission. This is not to side with the insurance industry since these payment policies also can restrict access to care in ways that are problematic. However, we do believe it is helpful when treatment providers share some of this systemic perspective and provide pathways to prevent and address slips, lapses, and relapse, and to promote recycling.

Disparities, Resources, and Recovery

Successful change and recovery from SUDs undoubtedly require personal effort, time, energy, and focus. However, as we have begun to understand health disparities better, it is clear that differences in access and resources make engagement and outcomes more complicated and challenging for some clients than others. Individuals with more economic, psychological, and social capital are often more successful in recovery with fewer attempts. For instance, we know that smoking rates remain highest among individuals with lower socioeconomic status and those who suffer from mental health and substance use disorders (American Lung Association, 2022). This often is not a problem of motivation or ability to change but rather a lack of personal and social resources. The challenge for clinicians then is to understand ways in which systemic disadvantage may predispose relapse and not only to treat individuals but also advocate to find support and resources for our clients. The hope is to help them be successful with fewer rotations through the cycle of change and less suffering along the way.

Considerations for Clinical Practice

Clinicians need to find a balance between normalizing the fact that multiple change efforts are often needed, while also avoiding the belief that relapse is inevitable or predetermined. Most importantly, they need to hold the hopeful perspective that change is possible over the long term. As one woman who was well into successful SUD recovery said when asked her advice to others with addiction: "stick and stay the course." Persistence and patience are needed to navigate the process and to successfully launch a new pattern of behavior. This is true for the changer as well as the clinician trying to help the person change.

In addition to this persistence, ensuring that integration of learning occurs with each change attempt is essential. It has been said that one definition of insanity is doing the same thing over and over again hoping for a different result. Successful recycling is not just more of the same. Instead, it involves gleaning the important lessons from our mistakes and failures, being able to do better the next time, or as a colleague once put it "working smarter, not just harder." The cycle of successful change should look more like a spiral staircase advancing upward to success rather than an endless circle (DiClemente, 2006; Prochaska et al., 1992). This is the pathway that represents turning a failed attempt to change into a successfully sustained new pattern of behavior. Whether we are talking about helping clients initiate a health protection behavior or to modify or stop risky or destructive behaviors, "never a failure, always a lesson" needs to be our mantra (Metcalfe, 2017).

To aid readers in working with clients who have relapsed or are at risk of doing so, and in promoting recycling through the stages of change to ultimately sustain the target behavior, we suggest several exercises. Each of these is applied to one of the foregoing clinical vignettes in order to illustrate its implementation.

Black Box Metaphor

As noted above, when airplanes crash, there is a black box that records what went on in the cockpit, as well as critical information from the flight. This device is designed to withstand the crash so that it can be reviewed afterwards to determine what went wrong that led to the incident. We often use this as a metaphor with clients to discuss the circumstances of the relapse and glean information that may be used to assist the client to get back on track with their change goal, and prevent relapse in the future. Although there is no black box, asking clients to self-observe and be mindful of the larger context of when they are tempted to use, slip, lapse, or relapse would hopefully create an internal black box.

We would start by asking James whether he is familiar with the fact that airplanes have black boxes. If so, we would have him tell us what he knows about their purpose; if not, we would describe it. Then we would let him know that we sometimes use this concept to think with clients about times when they have made a decision contrary to a previously expressed change goal. We would then talk with him about the various factors and chain of events that led to his choosing to begin using marijuana again. Specifically, we would explore thoughts, feelings, and contextual circumstances. We might also use this opportunity to introduce the concept of "apparently irrelevant decisions" (Marlatt & Gordon, 1985), encouraging James to identify more subtle or distal factors where there was a choice point that could lead to greater exposure, temptation, or opportunity to engage in the addictive behavior. Often it is useful to map out these details in writing.

For instance, James initially might identify disappointment and frustration at not getting the job as the sole triggers for using, ignoring his thoughts that include: things would never get any better for him, missing his work in the warehouse, anticipating criticism from his wife, and increased focus on the unfairness of his back injury and continued pain. With further prompting to review the black box, he may identify the factors above, as well as not having supportive friends to talk with and other flaws in his plan for change. He may also recall thinking that because he didn't get the job it no longer mattered whether he could pass a drug test. Perhaps even with these thoughts and feelings he did not actually have the intention to use marijuana but rather made an "apparently irrelevant decision" to drive a route home that took him by his dealer's house instead of the slightly longer route he'd previously been using to avoid temptation. He may have told himself that this was simply because he was in a hurry and it made sense given the circumstances, but it ended in him calling his dealer later that day and ultimately resuming marijuana use.

It is important to highlight that the purpose of debriefing the chain of events in this level of detail is not to engender shame or self-criticism. Rather, it is to learn what went wrong to promote recycling through the stages of change. His decision to stop and commitment to change seemed contingent on getting a job. His expectations of getting the job may have been unrealistic. His frustration tolerance seems weak. The information gathered may be particularly useful in tasks associated with Preparation, enabling planning strategies to challenge unhelpful thoughts, cope with uncomfortable emotions, and avoid high-risk situations in the future.

Prospective Hindsight

Whereas the black box exercise might be thought of as a "post-mortem" of sorts, the prospective hindsight exercise, by contrast, would be what is referred to in medical settings as a "pre-mortem." This exercise is relevant in situations where a client is at risk of relapse but has not yet abandoned their change goal. As described by Syed (2015), the objective here is to consider what could go wrong with a plan *before* it has been put into action. However, to accomplish this more effectively, we ask clients not to think abstractly about what *might* go wrong but to actually imagine that the relapse has already happened and then ask what went wrong. That is, through imagery, we ask the client to make the failure concrete, thereby changing the way the mind thinks about potential faults in the plan.

This exercise may be particularly useful with a client like Brian who has a high-risk situation upcoming. For instance, we might ask Brian to close his eyes and imagine he was on the plane back from Mexico, having resumed heavy alcohol use while he was there. We would then ask him to tell us, in detail, what went wrong, how it was that he came to use alcohol on his trip even though his goal was to avoid doing so. Depending on the factors identified, we would then work with Brian to develop concrete strategies for managing these vulnerabilities.

So, for example, perhaps through this exercise Brian might imagine that he was able to avoid using alcohol the first couple days of his trip but then overheard his partner talking with a friend about how he missed the fun they used to have. He might note assuming his partner was referring to Brian no longer using alcohol, even though this was not explicitly stated. This thought then perhaps brought on fear that his partner might break up with him, as well as concerns that he would lose his social circle more broadly. Brian then might identify a moment where he was at a club later that night, planning to order soda water with lime when this conversation he'd overheard echoed in his head and he quickly decided that having just one drink wouldn't hurt anything. He found he felt good, more relaxed, and like he was reconnecting with his partner. This in turn led to a few more drinks that night and several nights of heavy drinking over the course of the trip.

By reviewing the relapse as if it had already happened, we would assist Brian in making concrete strategies and addressing some of the most salient risk factors, in this case apparent concerns about whether his partner and friends still found him fun since he had stopped drinking. These considerations seem to be a critical part of his risk reward analysis for making the change. To offset this risk, he might decide to have an open conversation with his partner and/or another friend about these issues in advance of the trip. He also might directly talk with them about fun activities they could engage in that would not involve drinking, such as sightseeing, parasailing, or surfing—or about limiting his time out at clubs at night, perhaps planning an evening out with just his boyfriend or just one or two friends while the

others went clubbing. By determining what factors would be most likely to contribute to relapse and addressing weak points in the change process and his plan ahead of time, the hope is that Brian would be able to prevent relapse from occurring.

Self-Compassion

As previously discussed, self-stigma and shame are very common among individuals with addiction. We commonly see them arise for individuals struggling to change other health behaviors as well, especially in the aftermath of relapse events. Because of the multiple pernicious effects of shame and self-stigma, including potential to precipitate and worsen relapse, it is critical that clinicians have strategies available to address these concerns. In their 2019 paper, Wong et al. theorized and delineated evidence that self-compassion may be a particularly powerful strategy in mitigating self-stigma and shame.

In her seminal work, Neff (2003) conceptualized self-compassion as composed of three essential elements: mindfulness (a nonjudgmental, open state of mind that sees and accepts the present moment reality), common humanity (recognition that all humans are connected, that we all make mistakes, suffer, and at times fail), and self-kindness (treating oneself with warmth and positive regard, including and especially in the face of failure and pain). Exercises designed to promote self-compassion involve nurturing each of these elements and can be particularly useful when clients relapse.

There are many different techniques designed to promote self-compassion, ranging from explicit efforts to speak to oneself as one would a good friend, to writing a letter to parts of ourselves that are in pain, to lovingkindness meditation, to gently placing a hand on the heart to activate the parasympathetic nervous system. We have found that Neff's website, self-compassion.org, which provides many of these evidence-supported exercises for free, can be a particularly useful resource to provide to more technology-savvy clients. We've also found that for some clients who are skeptical of these exercises and related terms (e.g., viewing them as too "soft"), providing brief psychoeducation on the science behind these techniques can be helpful.

In the case of Mary, she explicitly identifies feeling ashamed of her recent return to gambling after years of avoiding this behavior. This shame, in turn, appears to be fueling her decision to keep her relapse a secret from her children, who she feels would be disappointed in her. Unfortunately, this secrecy may prevent her from accessing valuable support they could provide. Additionally, if gambling is partially serving an emotion regulation function, then the negative emotion of shame could contribute to ongoing engagement in this problematic behavior creating a vicious cycle.

Various self-compassion strategies may prove useful with Mary. We would likely start with brief psychoeducation on self-compassion. To promote awareness of common humanity, we might work with Mary to recognize the elements of her suffering that are universal, such as grief and loss, as well as social isolation during the global pandemic that affected her decision-making and commitment. To promote mindfulness, we might encourage initial breath awareness or compassionate body scan exercises to promote present-moment, nonjudgmental awareness. With this increased self-awareness, we then would invite Mary to begin cultivating self-kindness by noticing when her inner monologue is particularly self-critical or exhibits elements of self-stigma, and to practice shifting her tone. To facilitate this shift, she might imagine herself as a child or a good friend. Importantly, we would underscore that developing self-compassion is a process, that strengthening these neural pathways can take time, but that with continued practice they may help her decrease vulnerability to shame-related relapse and improve overall quality of life moving forward. Self-compassion can help in the debriefing of the relapse and enable her to explore issues and barriers to her change process and enable her to address these more effectively.

Conclusions and Lessons Learned

Relapse, or the failure to sustain a behavior change, often happens in the process of changing health and addictive behaviors. It is always challenging for clinicians and clients alike. The goal of this article is to change clinicians' and hopefully their clients' views of the phenomenon of relapse, specifically encouraging them to reevaluate how to understand, define, and address the failure to sustain a behavior change. In actuality, if we can move beyond the desire to avoid the discomfort of examining failure, we can see clearly that any slip, lapse, or abandonment of a change attempt is actually rich with useful information. Examining in detail what led to the failure, while taking care not to blame or stigmatize, can encourage successive approximation learning and recycling through the stages of change. It is also important to note that, while thus far we have spoken mostly about learning from what did *not* work, it is also essential to review, celebrate, and reinforce elements of the change attempt that *did* work well, so that these can be replicated in the future.

Whether trying to follow health recommendations or make other changes to improve quality of life, everyone has had the experience of intentionally trying to modify behavior at some point. Most of us have also had the experience of failing to sustain change despite our best efforts and intentions. Recalling the pain and disappointment of these experiences in our own lives can help us hold compassion for our

clients when they falter on the road to change. Additionally, the extent to which we can practice self-compassion—in relating to our own failures to sustain behavior change as well as our inability to be perfect clinicians whose clients never suffer the pain of relapse—will likely impact our ability to work effectively with clients during these difficult times. The aftermath of failure is hard. In an effort to make clients and ourselves feel better quickly, it can be tempting to ignore or paint over flaws in a change plan, rather than address them directly. However, if we can remove the judgment, hold compassion for ourselves and our clients, and stay grounded in the perspective that there is much to be learned from reviewing failure, we are better able to assist clients in doing the challenging work of changing.

The other lesson we need to learn is that we need to not only examine the event or cues that directly preceded the slip, lapse, or relapse but also look more closely at the process of change overall. Sustained change is built on significant personal concern and interest in changing. Making a change for someone else only creates a shaky foundation. Ambivalence and a weak cost–benefit or risk-reward analysis can build a decision that may be sufficient to start a change but inadequate to sustain it when challenges arise. In addition to weak commitment, planning that is not comprehensive and supported by skills creates potholes that interfere with success during the Action stage. Finally, not being flexible in problem solving our change plans and experiences often leads individuals to abandon the change rather than revise the plan. Behavior change is multidimensional, so in debriefing failure we need to explore all these elements of the process of change and not just the immediate event or context of the relapse.

In sum, in order to adequately address relapse, clinicians and clients will need to shift perspective and practices to more fully embrace the experience of failure and help turn it into success. All stories of successful change include persistence and patience. Trying smarter requires learning from all past attempts to more adequately accomplish tasks in the process of change, including but not limited to learning strategies and skills to navigate the journey to successful change.

Key Clinical Considerations

- Given the ubiquity of relapse or failure to sustain change, not only in addiction but across a wide variety of behaviors, normalize these experiences for yourself and for clients. Help clients understand them as part of the overall process of change, rather than events that warrant blame, shame, or self-stigma.
- Recognize that although the term "relapse" may have some heuristic value, it also has the potential to promote discouragement and decrease hope. Consider alternatives such as "setback," "reoccurrence," or "recycling." Mirror the perspective of the client in referring to their failure to sustain change and recognize that what a clinician considers a relapse may not be defined as such by the client.
- Reframe any failure to sustain behavior change as a learning opportunity. Use a wide change process and client-centered lens to debrief both distal and recent change attempts in detail. Use lessons gleaned to inform future attempts.
- When relapse occurs, assess clients' current stage of change, learn what this and past unsuccessful attempts teach you both, and promote recycling through critical stage tasks to enable "adequate" completion and successful future change.

Declarations

References

American Lung Association. (2022, January 26). *Top 10 Populations Disproportionately Affected by Cigarette Smoking and Tobacco Use*. https://www.lung.org/research/sotc/by-the-numbers/top-10-populations-affected

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall, Inc.

Bozdağ, N., & Çuhadar, D. (2021). Internalized stigma, self-efficacy and treatment motivation in patients with substance use disorders. *Journal of Substance Use*, 27(2), 174-180. https://doi.org/10.1080/14659891.2021.1916846

Carbonari, J. P., & DiClemente, C. C. (2000). Using Transtheoretical model profiles to differentiate levels of alcohol abstinence success. *Journal of Consulting and Clinical Psychology, 68*(5), 810-817.

Connors, G. J., Longabaugh, R., & Miller, W. R. (1996). Looking forward and back to relapse: Implications for research and practice. *Addiction, 91*, S191–S196.

Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2007). Rates and correlates of relapse among individuals in remission from DSM-IV alcohol dependence: A 3-year follow-up. *Alcoholism: Clinical & Experimental Research, 31*(12), 2036-2045. https://doi.org/10.1111/j.1530-0277.2007.00536.x

DiClemente, C. C. (2018). *Addiction and change: How addictions develop and addicted people recover* (2nd ed.). Guilford Press.

DiClemente, C. C. (2006). Natural change and the troublesome use of substances. In W. R. Miller, & K. M. Carroll (Eds.), *Rethinking substance abuse: What the science shows and what we should do about it* (pp. 81-96). Guilford Press.

DiClemente, C. C., & Crisafulli, M. A. (2017). Alcohol relapse and change needs a broader view than counting drinks. *Alcoholism: Clinical and Experimental Research, 41*(2), 266-269. https://doi.org/10.1111/acer.13288

Earnshaw, V. A. (2020). Stigma and substance use disorders: A clinical, research, and advocacy agenda. *American Psychologist, 75*(9), 1300-1311. http://dx.doi.org/https://doi.org/10.1037/amp0000744

Firestein, S. (2016). *Failure: Why science is so successful*. Oxford University Press.

Hunt, W. A., Barnett, L. W., & Branch, L. G. (1971). Relapse rates in addiction programs. *Journal of Clinical Psychology, 27*(4), 455-456. https://doi.org/10.1002/1097-4679(197110)27:4<455::AID-JCLP2270270412>3.0.CO;2-R

Kelly, J. F., Greene, M. C., Bergman, B.G., White, W. L., & Hoeppner, B.B. (2019). How many recovery attempts does it take to successfully resolve an alcohol or drug problem? Estimates and correlates for a national study of recovering U.S. adults. *Alcoholism: Clinical & Experimental Research, 43*(7), 1533-1544. https://doi.org/10.1111/acer.14067

Koob, G. F., & Volkow, N. D. (2016). Neurobiology of addiction: a neurocircuitry analysis. *Lancet Psychiatry, 3*(8), 760-773. https://doi.org/10.1016/S2215-0366(16)00104-8

Krebs, P., Norcross, J. C., Nicholson, J. M., & Prochaska, J. O. (2018). Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology, 74*(11), 1964–1979. https://doi.org/10.1002/jclp.22683

Maisto, S. A., Roos, C. R., Hallgren, K. A., Moskal, D., Wilson, A. D., & Witkiewitz, K. (2016) Do alcohol relapse episodes during treatment predict long-term outcomes?: Investigating the validity of existing definitions of alcohol use disorder relapse. *Alcoholism: Clinical and Experimental Research, 40*(10), 2180-2189. https://doi.org/10.1111/acer.13173

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention*. Guilford Press.

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*(13), 1689-1695. https://doi.org/10.1001/jama.284.13.1689

Metcalfe, J. (2017). Learning from errors. *Annual Review of Psychology, 68*, 465-489. https://doi.org/10.1146/annurev-psych-010416-044022

Moe, F. D., Moltu, C., McKay, J. R., Nesvag, S., & Bjornestad, J. (2021). Is the relapse concept in substance use disorders a 'one size fits all' concept? A systematic review of relapse operationalisations. *Drug and Alcohol Review*. https://doi.org/10.1111/dar.13401

Neff, K. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85-101. https://doi.org/10.1080/15298860309032

Prochaska, J. O., DiClemente, C.C., & Norcross, J. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114. https://doi.org/10.1037//0003-066x.47.9.1102

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes. *Journal of Studies on Alcohol, 58*(1), 7-29. https://doi.org/10.15288/jsa.1997.58.7

Schulz, K. (2010). *Being wrong: Adventures in the margin of error*. Harper Collins Publishing.

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery*. https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Syed, M. (2015). *Black box thinking: Why most people never learn from their mistakes - but some do*. Penguin.

van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence, 131*(1-2), 23-25.

van Brackel, W. H., Cataldo, J., Grover, S., Kohrt, B. A., Nyblade, L., Stockton, M., Wouters, E., & Yang, L. H. (2019). Out of the silos: Identifying cross-cutting features of health-related stigma to advance measurement and intervention. *BMC Medicine, 17*, 13. https://doi.org/10.1186/s12916-018-1245-x.

Witkiewitz, K., & Marlatt, G. A. (2007). Modeling the complexity of post-treatment drinking: It's a rocky road to relapse. *Clinical Psychology Review, 27*(6), 724-738. https://doi.org/10.1016/j.cpr.2007.01.002

Witte, T. H., Wright, A., & Stinson, E. A. (2019). Factors influencing stigma toward individuals who have substance use disorders. *Substance Use & Misuse, 54*(7), 1115-1124. https://doi.org./https://doi.org/10.1080/10826084.2018.1560469

Wong, C. C. Y., Knee, C. R., Neighbors, C., & Zvolensky, M. J. (2019). Hacking stigma by loving yourself: A mediated-moderation model of self-compassion and stigma. *Mindfulness, 10*, 415-433. https://doi.org/10.1007/s12671-018-0984-2

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