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Relapse Following Prolonged Addiction Recovery: Time for Answers to Critical Questions

William L. White and Mel Schulstad

Mrs. Marty Mann, the "First Lady of Alcoholics Anonymous" and founder of today's National Council on Alcoholism and Drug Dependence (NCADD), was perhaps the most singular figure in the advocacy movement that laid the foundation for modern addiction treatment. Her tenacious public education and policy advocacy efforts—always buttressed by her personal witness of recovery— brought hope and resources to millions of American citizens suffering from alcoholism. When a definitive biography of Mann was finally published, it revealed a carefully guarded secret: Marty Mann had experienced a brief relapse at the height of her work with NCADD (Brown & Brown, 2001). Few details are known about Mann's relapse episode other than its brevity and its potential link to her use of alcohol-based medicine. Cases of relapse following prolonged sobriety remain shrouded in mystery at personal, professional, and cultural levels.

Addiction treatment and the larger alcohol and other drug (AOD) problems arena in America have undergone dramatic and sometimes sudden shifts in philosophy and policy over the past two centuries. There is, however, a central theme within this history that has remained unchanged. The knowledge upon which the field has evolved is drawn primarily from the study of addiction-related pathologies and clinical interventions aimed at acute biopsychosocial stabilization. As a field, we know a great deal about addiction and the processes of brief professional intervention, but we know very little about the pathways and processes of long-term recovery. T

he present paper, and the series of which it is a part, calls upon the field to extend (if not shift) its organizing center from these pathology and intervention paradigms to a recovery paradigm (Laudet, 2008; Laudet et al., 2009; White, 2006, 2007, 2008,a, b, in press; White & Chaney, 2008; White & Godley, 2007). Millions of individuals and families in sustained recovery from severe AOD problems have learned important lessons about how to navigate the long-term recovery process; yet their voices are absent from the field's research and popular discourse. As a result, individuals and families in recovery face

critical decisions regarding their health, family life, faith, work, and play without a science of long-term recovery to guide these decisions. The time for research and treatment authorities—the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Center for Substance Abuse Treatment as well as state authorities and private foundations—to pursue a recovery-focused research agenda is long overdue.

The authors have been deeply blessed by having spent (between us) more than 75 years in the addictions field in clinical, administrative, research, and teaching roles. Our lives have been filled with close association with thousands of addiction professionals and people in recovery, including people from a wide variety of religious, spiritual, and secular recovery support groups. Due to our elder status, we are often contacted when questions arise outside the window of the field's core knowledge. The shared stories and questions posed in these emails, phone calls, and face-to-face conversations provide a rare and unsettling glimpse into the darker corners of our field—corners seldom illuminated by the field's professional texts, journals, or conferences. One of the most poignant issues brought to us is that of late-stage relapse (LSR)—defined here as lapse/relapse after a prolonged period (more than five years) of seemingly stable recovery.

Existing research suggests that the risk of future lifetime relapse declines to below 15% for those who have achieved 5 years of continuous sobriety (see White, 2008 for a review), but those people who do experience relapse after years of recovery remain a mystery within the worlds of addiction research, addiction treatment, and recovery mutual aid fellowships. An important item within any recovery research agenda is the phenomenon of LSR. Here are some of the unanswered questions we believe are critically important.

Prevalence

- What is the prevalence of relapse across the life cycle of recovery? Are there points of vulnerability identifiable by age or length of sobriety?
- Does the rate of LSR differ by primary drug(s) involved in past dependence?
- Does the rate of LSR following alcohol dependence differ by pattern/type/severity of alcohol dependence?
- Does the rate of LSR differ across religious, spiritual, and secular frameworks of recovery (or across particular recovery mutual aid societies)?
- What are the particular characteristics of recovery support groups associated with the highest and lowest rates of LSR?
- Do LSR prevalence rates and points of vulnerability differ by gender, race/ethnicity, sexual orientation, or presence of co-occurring medical or psychiatric disorders?

Etiology, Course, and Consequences

- Does LSR in young adulthood differ from LSR in midlife or late life?
- Are there critical transition points from recovery initiation/stabilization to recovery maintenance and from recovery maintenance to enhanced quality of life in recovery that constitute periods of increased risk of relapse?
- Is LSR related to disengagement from active involvement in recovery mutual aid societies and other recovery support relationships/activities?
- Is there a relationship between LSR and physical and emotional distress linked to onset or progression of physical illnesses and their treatment? (e.g., medication for acute or chronic pain)?
- Is there a relationship between LSR and changes in intimate and social relationships (e.g., separation, divorce, or death of one's intimate partner; separation from or death of a

friend or sponsor; onset of new intimate or social relationships)?

- Is there a relationship between LSR and major life transitions, (e.g., death of a parent or sibling, children leaving home, "midlife crisis," geographical relocation, menopause, occupational displacement, retirement, diagnosis of terminal illness)? Is there a relationship between LSR and the presence or loss of religious faith? Does religious faith constitute a protective shield against LSR? To what extent is LSR linked to past sources of emotional pain, particular blocks to developmental maturity, or the failure to master particular developmental tasks of long-term recovery?
- What factors, other than the above, are linked to LSR?
- What are the common trajectories of LSR in terms of duration, intensity, consequences, and outcomes?
- What is the speed of progression from lapse (return to use) to relapse (compulsive use and problem development) in LSR? What is the long-term prognosis for recovery following restabilization after LSR? To what extent is the outcome of LSR influenced by the family, professional, and social response to it?
- What is the effect of LSR on the family?
- What are the effects of a sponsor's LSR on his or her sponsee, home group members, and the fellowship's reputation in the local community?
- What are the mortality rates associated with LSR (e.g., death by overdose, trauma, disease, suicide)?
- How does the prominent coverage of LSR among celebrities (but failure to report on the lives of people in long-term recovery who do not relapse) influence cultural views on addiction and recovery?

Intervention and Treatment

- Are models of family-based, systematic encouragement (e.g. CRAFT) effective in re-involving a family member in professional treatment and/or recovery mutual aid following LSR?
- What are shared issues commonly confronted in the treatment of LSR, e.g., isolation, shame, loss of status, depression, suicidal ideation, etc.?
- Does past familiarity with local treatment and recovery support societies constitute an obstacle to re-initiation of recovery following LSR? If so, what strategies can be used to overcome this obstacle?
- How can the client entering treatment following LSR who has extensive knowledge of addiction and recovery be effectively engaged and counseled?
- How do treatment outcomes differ following LSR than for those newly entering recovery following professional treatment? Do those outcomes differ if the person experiencing LSR was working in the addictions field at the time of the relapse?
- What are the factors associated with successful re-initiation of recovery following LSR?

Self-Management

- As one's life is filled or refilled with work, love, children, and activities in the community, how does one continue to integrate recovery into an expanding quality of life?
- How can the LSR risk and experience be best conveyed to enhance the vigilance of others in recovery?

People in late-stage recovery (more than 5 years) and very late-stage recovery (more than 20 years) appear in only a small number of the field's research studies. There

is no science-based cartography of recovery— particularly later stage recovery. Beyond the folk wisdom found in recovery support groups, little is available to guide professional interventions and peer-based supports for individuals and families experiencing LSR. It is time we answered questions related to late-stage relapse and the most effective responses to it.

As a field, we need a new vanguard of addiction scientists who redefine themselves as addiction recovery scientists. We need recovering people to pursue education and professional careers in the field in order to forge a new science of addiction recovery. We need collaborations between scientists and people in recovery to design, conduct, and interpret studies of long-term addiction recovery. We suspect that this movement has already begun. We hope you will be part of it.

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