RELAPSE PREVENTION THERAPY
AN INTEGRATED APPROACH TO THE TREATMENT OF ALCOHOL DISORDERS AND COMORBID ANXIETY

A review of literature on anxiety, alcoholism and relapse prevention therapy
Recommendations for clinical psychology groups conducted as part of an inpatient alcohol rehabilitation programme in the Western Cape

BRETT CHARLES RUFUS

Assignment presented in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology at the University of Stellenbosch

Supervisor: Mr. C.R. Petty

November 2004

DECLARATION

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

Two recent local studies of relapse among individuals who had attended inpatient alcohol rehabilitation programmes in the Western Cape found relapse rates of up to 60%. A high incidence of comorbid anxiety, low self-efficacy and avoidant coping style were principal reasons cited for relapse.

The following literary review was undertaken in an effort at better understanding current findings on the comorbid relationship between alcohol abuse/dependency and anxiety, and on dysfunctional coping styles and relapse. It also reviews current literature and theory concerning the treatment of alcoholics using the Relapse Prevention (RP) model of therapy. Based on these findings, recommendations are made for the application of RP to the clinical psychology groups run for alcohol abusing/dependent inpatients at Neuro Clinic D, Stikland Hospital, Western Cape.

Relapse Prevention Therapy was selected because of its integrated approach to addressing both substance abuse and the inadequate coping styles that often render people vulnerable to anxiety, depression and relapse. It was also chosen because of the more constructive, less punitive approach it takes to substance dependence/abuse and the issue of lapses and relapse.

The recommendations made in this review should not, in any way, be seen as criticism of the existing programme at Neuro Clinic D. They are, essentially, the individual reflections of the author based on the four months he spent conducting clinical psychology groups in the unit and the findings of two local studies that looked at some of the reasons for relapse following treatment in this and other local facilities.

The specific focus on the groups run by clinical psychologists should also not be seen as ignoring the important and valuable work done by other professionals in the unit; notably those in psychiatry, nursing, social work, occupational therapy and pastoral care. On the contrary, information gathered by these professionals is vital to the team effort of rehabilitation, and the identification of psycho-social stressors and cognitive patterns that place people at risk of relapse.

OPSOMMING

Twee onlangse plaaslike studies van terugval onder pasiënte wat binnepasiënt-alkoholrehabilitasieprogramme in die Weskaap bygewoon het, het terugvalkoerse van tot 60% gerapporteer. 'n Hoë voorkoms van komorbiede angs, lae sin van self-vermoë en 'n vermydende streshanteringstyl was die hoofredes aangevoer vir die terugval.

Die volgende literatuur-oorsig is onderneem in 'n poging tot 'n beter begrip van huidige bevindinge oor die komorbiede verhouding tussen alkoholmisbruik/afhanklikheid en angs, en oor wanfunksionele streshanteringstyle en terugval. Die oorsig beskou ook huidige literatuur en teorie aangaande die behandeling van alkoholiste deur middel van die Relapse Prevention (RP) model (Terugvalvoorkomingsmodel) van terapie. Op grond van hierdie bevindinge word aanbevelings gemaak vir die toepassing van RP op die kliniese-sielkundegroepe aangebied vir alkoholmisbruikende/afhanklike binnepasiënte by Neurokliniek D, Stiklandhospitaal, Weskaap.
RP is gekies op grond van sy geïntegreerde benadering tot beide substansmisbruik en die onvoldoende streshanteringstyle wat dikwels mense kwesbaar maak vir angs, depressie en terugval. Die model is ook gekies as gevolg van die meer konstruktiewe, minder strafgerigte benadering tot substansafhanklikheid/misbruik en tot val en terugval.

Die aanbevelings in hierdie oorsig moet in geen opsig beskou word as kritiek op die bestaande programme in Neurokliniek D nie. Hulle is, in wese, die individuele gevolgtrekkings van die skrywer gebaseer op sy vier maande ondervinding met sielkundegroepe in die eenheid en op die bevindinge van twee plaaslike studies wat ondersoek ingestel het na sommige van die redes vir terugval na behandeling in hierdie en ander plaaslike fasiliteite.
Die spesifieke fokus op die groepe wat deur kliniese sielkundiges bestuur word moet ook nie gesien word as 'n geringskatting van die belangrike werk van ander professionele mense in die eenheid nie, in die besonder dié in psigiatrie, verpleging, maatskaplike werk, arbeidsterapie and pastorale sorg. In teendeel, inligting ingesamel deur hierdie mense is lewensbelangrik vir die spanpoging van rehabilitasie, en vir die identifisering van psigo-sosiale stressors en kognitiewe patrone wat pasiënte vatbaar maak vir terugval.

The format of this assignment is in accordance with the requirements of the Department of Psychology

ACKNOWLEDGEMENTS

I wish to express sincere appreciation to the following people:

- **The medical and nursing staff from Neuro Clinic D, Stikland Hospital**
- **The occupational therapy and social work staff attached to Neuro Clinic D**
- **Colleagues and supervisors in the department of psychology, Stikland Hospital**
- **The patients of Neuro Clinic D with whom I had the privilege of working**
- **Chris Petty for his supervision and guidance**
- **My parents and friends, for their encouragement and interest**
- **Michiel Heyns, for his ongoing support and final edit**

INTRODUCTION

The first part of this paper introduces the rationale for this review. The findings of two recent studies on relapse among groups of individuals who had attended inpatient rehabilitation programmes at centres in the Western Cape are discussed and form the motivation for the study. This is followed by a review of the literature on anxiety and coping styles, two of the principle factors cited in the aforementioned studies as contributing to relapse. A review of the theory of relapse and relapse prevention as posited by Relapse Prevention Therapy (RPT) follows, and the paper closes with a discussion on the implementation and the effectiveness of RPT.

Alcoholism is a major psychological, social and economic problem in South Africa, with the country having one of the highest rates of alcoholism internationally (Gerber, 1995; Van der Burgh, 1992). It is estimated that South Africans consumed more than six billion litres of alcoholic beverage in the twelve months from 1 July 1995 to 30 June 1996 (Parry & Bennetts, 1998). This places South Africa approximately eighth out of 53 countries in terms of per capita consumption (Produktschap voor Gedistilleerde Dranken, 1996). The economic burden on society resulting from alcohol use in South Africa is estimated at between 2% and 6% of Gross National Product (GNP) which, according to 1996 figures, would amount to between 10.6 billion and 31.8 billion rands per year (comparison with World Health Organization figures, 1993). It is likely, though, that this figure is even higher.

On the more micro level, studies in South Africa suggest that approximately 25% of hospital admissions are directly or indirectly related to alcohol use (Albertyn & McCann, 1993). Almost 80% of all assault patients presenting at the Trauma Unit at Tygerberg Hospital are either under the influence of alcohol or injured because of alcohol-related violence (Steyn, 1996). Almost 50% of non-natural deaths in the Cape Town Metropolis during 1995 were found to be associated with alcohol use (Lerer et al., 1996). Statistics from the National Trauma Research Programme (NTRP) for 1990 also show that 67,4% of domestic violence in the Cape Town Metropolis was estimated to be alcohol-related (Stydom et al., 1994). Excessive drinking is also significantly linked to child abuse and neglect (Creighton, 1984). Perhaps most disturbing, however, are the findings of a study in Cape Town in 1984/5 in which there was an overall incidence of Foetal Alcohol Syndrome (FAS) of one per 281 live births (Palmer, 1985).

Alcohol is also by far the most widely abused substance among those admitted for treatment at rehabilitation facilities in Cape Town and Durban, accounting for approximately 80% and 68% of admissions, respectively (July 1996 to December 1997) (SACENDU, 1998). Despite the ongoing efforts to provide effective treatment, successful outcomes remain fairly elusive (Van der Burgh, 1992). Nationally, both in- and outpatient rehabilitation programmes have been characterized by poor adherence to treatment and high drop-out and relapse rates (Gerber, 1995). Davis (2003) found relapse rates as high as 60% in her local study. With the high cost of providing these treatment programmes, as well as the high individual and economic costs associated with alcohol abuse (absence from work, hospitalization, accidents, abuse, etc.), it is important that treatment programmes are broad-based and strive to equip patients with the kind of knowledge and skills that will reduce the likelihood of relapsing or, if they do relapse, of returning to full-blown abuse of alcohol. In order to do this, programmes need to screen for psychological and social factors that may impede both inpatient recovery and the maintenance of abstinence, post-treatment. The rationale behind the interest in alcohol abuse and psychopathology is the hope that the identification and treatment of coexisting problems in an alcohol-dependent patient will improve prognosis and provide a further basis on which to match patients to treatment (Griffin et al., 1987). Patients who are diagnosed as having a comorbid psychological condition can then receive appropriate treatment directed towards this condition as well as the alcohol problem (Allan, 1995). Failure to detect and treat other conditions can deprive patients of potentially helpful treatments in a disorder which in some instances can carry a poor prognosis (Weissman & Myers, 1980).

BACKGROUND TO THE REVIEW

Two recent, local studies of detoxified alcoholic patients attending in-patient programmes at rehabilitation facilities in the Western Cape have drawn attention to the role of inadequate coping styles and the presence of comorbid anxiety in those who have lapsed.

In the first of these studies, conducted in the mid-1990s, approximately 72% of a group of 53 recently detoxified patients, recruited from three inpatient alcohol rehabilitation centres in the Western Cape (De Novo, Ramot and Hesketh King Centre), experienced above average levels of anxiety (Campbell, 1996). A significant positive correlation was also found between those with an avoidant coping strategy and elevated levels of both anxiety and depression. Campbell (1996) found that approximately 53% of participants in her study made high use of avoidant coping strategies, and that

such strategies seemed to exacerbate depressive and anxious symptomatology. Use of a problem-solving coping strategy, on the other hand, appeared to help lessen such symptomatology. Campbell (1996) concluded that the most important implication of her study for local alcohol treatment programmes was the need for training in more effective coping skills.

In the second study, conducted in 2002/3, 59.6% of a group of 57 people, who had completed a rehabilitation programme at Neuro Clinic D, Stikland Hospital 12-15 months earlier, were found to have lapsed, and reported that they were not as strong as they would have liked to be in dealing with their drinking problem (Davis, 2003). Problematic situations which, according to Davis, set the context for a return to drinking appeared to fall into areas of family and social relationships, unemployment and stress. Those who had lapsed reported drinking after a particularly stressful event in one of these areas. Most respondents reported drinking as a means of escaping the fears and anxieties associated with the particular problematic situation (Davis, 2003). In addition to highlighting the role of an avoidant coping style, these findings are in line with Lazarus' (1993) view that anxiety is a manifestation of stress. According to cognitive theory, avoidance (which may be seen as dysfunctional coping) is also a key component of anxiety that reinforces and entrenches it. Davis (2003) concluded that there was a need for local treatment programmes to challenge patients' negative beliefs regarding their ability to cope on their own, and to teach them more functional ways of coping.

With the above in mind, it seems important that psychological interventions should seek, simultaneously, to address both substance abuse and those aspects of lifestyle and coping that contribute to continued vulnerability to substance abuse. This requires a degree of flexibility and a willingness to tailor treatment to meet the specific social, economic and cultural demands of the patients.

For the purpose of this review, attention has been given to the much debated relationship between anxiety disorders and alcohol abuse disorders – the incidence, comorbidity, and causal relationship as well as the impact on treatment outcome and abstinence. Attention is also given to encouraging the use of Relapse Prevention Therapy (RPT) as the treatment of choice for use by clinical psychologists working with inpatients at Neuro Clinic D rehabilitation unit, Stikland Hospital.

Relapse Prevention Therapy (RPT) is a cognitive and behavioural treatment approach providing a broad-based intervention that seeks to address alcohol dependence/abuse and confounding variables such as anxiety, lifestyle and coping mechanisms. According to Beck (1976) and Beck, et al. (1979) cognitive therapy is a system of psychotherapy that attempts to reduce excessive emotional reactions (e.g., anxiety) and self-defeating behaviour (i.e., lifestyle and coping) by modifying the faulty or erroneous thinking and maladaptive beliefs that underlie these reactions.

As applied to substance abuse, the cognitive approach helps individuals come to grips with the problems leading to emotional distress and to gain a broader perspective on their reliance on drugs for pleasure and/or relief from discomfort. In addition, specific cognitive strategies help to reduce their urges and, at the same time, establish a stronger system of internal controls. A major aim of cognitive therapy of substance abuse is to help the patient in two ways: (1) to reduce the intensity and frequency of the urges by undermining the underlying beliefs and (2) to teach the patient specific techniques for controlling or managing their urges (Beck, Wright, Newman, & Liese, 1993) – that is, to reduce the pressure and increase a sense of control.

In line with this, RPT combines behavioural and cognitive interventions in an overall approach that emphasizes self-management and rejects labelling clients as "alcoholics" or "drug addicts" (Parks & Marlatt, 2000).

An important feature of RPT is that it is a behavioural self-control programme designed to teach individuals who are trying to maintain changes in their behaviour how to anticipate and cope with the problem of relapse, and in so doing strengthen their perception of self-efficacy (Parks & Marlatt, 2000) and coping. Such a perception is also a key feature in anxiety disorders, individuals often avoiding or dealing ineffectually with stressful situations because they believe that a situation is unmanageable and their ability to cope is inadequate.

ANXIETY AND ALCOHOL USE DISORDERS

The debate around the incidence of anxiety in alcohol abuse disorders and of alcohol abuse in anxiety disorders is an ongoing one, with no definitive understanding of the pathogenesis of this relationship. That they are often comorbid is not in dispute. What is uncertain, though, is the exact nature of this relationship.

Numerous studies have repeatedly found a high incidence of depression and anxiety among treatment-seeking subjects with alcohol-related disorders. According to Driessen et al. (2001), rates of 15-38% for major depression, 11-17% for dysthymia, 6-33% for phobias, 3-52% for generalized anxiety disorders, and 2-21% for panic disorders have been reported. Smail et al. (1984) earlier found that 39% and 41% of sixty alcoholics met criteria for social phobia and agoraphobia, respectively. Numerous other studies, notably those by Hesselbrock et al. (1985), Black et al. (1987), Powell et al. (1987), Ross et al. (1988), Herz et al. (1990) and Tomasson and Vaglum (1995) have reported similar findings on the presence of anxiety in alcohol disorders.

In a later study by Chambless et al. (1997), 40% of a sample of 75 inpatient alcoholics received a lifetime diagnosis of one or more anxiety disorder. Once anxiety and alcoholism had been determined, 59% indicated that they used alcohol to cope with their anxiety disorder. Empirical data indicated, however, that perhaps only 17% of an inpatient alcoholic sample used alcohol, in part, to self medicate for anxiety. Diagnosis and treatment of anxiety disorders among this population may, therefore, prove critical to the goal of relapse prevention.

There appear to be at least three prominent schools of thought on the relationship between alcohol disorders and anxiety disorders. The first of these maintains that having an anxiety disorder promotes the development of an alcohol disorder, and that a reduction in anxiety will, therefore, bring about a reduction in the desire for, or participation in alcohol abuse. This view, which is expressed in the form of a simple *stress reduction hypothesis* (alcohol as self-medication), states that some people use alcohol to cope with stress (Cappell & Greeley, 1987; Sher, 1987), that is to say, that stress and anxiety precede the development of alcohol use disorders. In support of this view are the findings that alcohol use tends to reduce panic attacks (Kushner et al., 1996), simple phobic responses (Lindman et al, 1980) and performance anxiety (Abrams et al, 2001). Medical trials have also found that alcoholics with comorbid anxiety drink less as well as feeling less anxious when taking anxiolytic medication (Sloan et al., 2003).

In further support of the idea that anxiety disorders precede the onset of alcoholism, a study of primary anxiety disorders and the development of subsequent alcohol use disorders in adolescents and adults by Zimmermann et al. (2003) refers to cross-sectional findings in community surveys of adults which suggest that adolescent anxiety disorders are strong predictors of the subsequent onset of alcohol use, abuse and dependence. An analysis of retrospective age-of-onset reports suggests that the anxiety disorders often start at an earlier age than the alcohol disorders (Weiss & Rosenberg, 1985;

Swendsen et al., 1998; Sareen et al., 2001). They are also predictors of the subsequent onset and course of alcohol disorders (Kessler et al., 2003). In one of the earliest studies, Bowen et al. (1984) found that the mean age of development of alcoholism was 25.3 years, while the mean age of development of phobias was 16.3 years, suggesting that phobias tended to develop approximately 9 years before the development of alcoholism. Subsequent research has, however, also drawn attention to the interesting question of whether different anxiety disorders do not have different effects on alcohol outcomes (Kushner et al. 1990; Clark & Sayette, 1992; Page & Andrews, 1996).

In their study, Zimmerman et al. (2003) found this to be the case. Panic and social phobia were identified as predictors of subsequent alcohol problems among adolescents and young adults, while other anxiety disorders did not appear to significantly predict any of the outcomes. It is important to note that these results were obtained in models that controlled for the confounding effects of other anxiety disorders, mood disorders, illegal drug use disorders, antisocial behaviour and demographic variables. It may, therefore, in the long run be more productive to identify and concentrate on specific phobic anxiety states like agoraphobia and social phobia at the same time as offering treatment for alcohol abuse disorders (Stockwell & Bolderston, 1987). However, according to another study conducted by Crum and Pratt (2001), it is not enough to label social phobia as a significant predictor because different levels of social phobia have variable outcomes, and they are not always the most obvious ones. In their study, Crum and Pratt (2001) found that sub-clinical social phobia was associated with high risks of heavy drinking and alcohol abuse or dependence across a median 12.6 years of follow-up. In contrast, they found no appreciable association of clinical social phobia with incidence of heavy drinking or alcohol abuse/dependence. They conclude that this may indicate that individuals who are not specifically avoiding fearful situations may be at greater risk of using alcohol more frequently and may develop problem drinking behaviour over time. Clinically diagnosed social phobics, on the other hand, may avoid exposure to anxiety-provoking social situations and may therefore be less likely to use alcohol to deal with such situations. It is vital, therefore, that clinical assessments not only look for clinical levels of social anxiety, but that they also consider sub-clinical levels of social fears as potential risk factors (Crum & Pratt, 2001). Intake assessments at rehabilitation facilities ought, therefore, to be sensitive both to different types of anxiety and to varying degrees of difficulty within types in order to more accurately screen for risk factors.

In contrast to the above findings (specifically the stress- reduction hypothesis), however, Cooke and Allan (1984), in a sample of 230 women from the general population, found no association between the experience of stressful life events and the consumption of alcohol.

An additional shortcoming of the stress-reduction hypothesis is that it does not explain why a large number of people with a diagnosis of an anxiety disorder do not develop alcohol abuse disorders. It also ignores findings that alcoholics become progressively more anxious, agitated and dysphoric during chronic intoxication (Mendelson & Mello, 1979). In a critical review of research on alcohol problems and anxiety disorders, Allan (1995) challenges the stress-reduction hypothesis with the assertion that the anxiolytic properties of alcohol have been extensively studied in animals and in non-clinical populations and have produced a wealth of contradictory findings (Wilson, 1988; Young et al., 1990). Stockwell and Bolderston (1987) suggest that there is evidence that drinking in fact increases rather than decreases psychological distress.

In line with the above, there are also those researchers who argue that having an alcohol disorder may, in fact, promote the development of, or an increase in anxiety disorders. According to this view, many heavy drinkers develop a wide range of physical, social and interpersonal problems, any of which may lead them to be realistically anxious and depressed about their situation (Schuckit & Monteiro, 1988).

This view fails, however, to explain why many alcoholics do not have a coexisting diagnosis of an anxiety disorder. It also runs the risk of falsely diagnosing anxiety in those who abuse alcohol or are alcohol dependent. Schuckit and Monteiro (1988), for instance, caution against diagnosing anxiety in alcoholic inpatients soon after admission because the acute withdrawal syndrome, lasting up to 4 or 5 days, includes tremors, feelings of tension and anxiety, restlessness and sleep disturbance. These types of symptoms may be indistinguishable by patients and interviewers from an anxiety disorder (Kushner et al., 1990). This is an important consideration when conducting intake assessments with substance-abusing patients and points to the need for some form of continuous evaluation throughout the rehabilitation programme.

Continuing this line, Driessen et al. (2001) refer to a number of studies that reported a substantial decrease of anxiety and depression within the early detoxification period, i.e. in the first 4 weeks after cessation of drinking, including placebo patients (West & Gocka, 1996; Brown et al, 1991; Schuckit et al., 1990). For this reason, assessment within at least the first 7 days of abstinence may produce elevated scores of anxiety. Weiss et al. (1992) have suggested that only symptoms occurring during a clearly defined abstinent period should be used to arrive at a clinical diagnosis of anxiety. With this in mind, Alan (1995) contends that the most consistent finding from studies which use valid and reliable clinical assessment procedures in abstinent subjects is that approximately 10% of subjects fulfil the criteria for an anxiety disorder (Murray et al., 1984; Schuckit, 1985; Allan, 1991; Brown et al., 1991).

Chambless et al. (1987), however, suggested that 23-44% of inpatient alcoholics had one or more anxiety disorder. Despite these discrepancies, these figures demonstrate a fairly high incidence of anxiety disorders among alcoholics, and underscore the importance of dealing with both disorders simultaneously. It is here that clinical psychologists can play a valuable role in the course of rehabilitation therapy at Neuro Clinic D, Stikland Hospital. Almost daily contact with patients over a four week period places psychologists in a position to monitor levels of state and trait anxiety and to respond appropriately to the changes. It also places them in a position to be able to elicit and challenge those cognitive distortions and dysfunctional coping styles that are an integral part of anxiety.

A third theory on the relationship between alcohol abuse disorders and anxiety is that a third variable, namely genetic or environmental factors, may promote the development of both an alcohol use disorder and an anxiety disorder (Nunes et al., 1995; Pohorecky, 1991).

The middle ground in these arguments is held by those, like Kushner et al. (1999a), who, using a prospective study that addressed the longitudinal association of alcohol use disorders and anxiety disorders, concluded that alcohol use disorders (especially alcohol dependence) and anxiety disorders demonstrate a reciprocal causal relationship over time, with anxiety disorders leading to alcohol dependence and vice versa. These writers found that patients with an anxiety disorder at years 1 or 4 of their clinical assessments were four times as likely to suffer a new onset of alcohol dependence in year 7. Conversely, they found that alcohol dependence at years 1 or 4 increased by three to five times the risk for a new onset of anxiety disorders in year 7. In short, and in agreement with other studies, Kushner et al. (1999a) found there to be a two- to threefold increase in risk for either an alcohol disorder or an anxiety disorder given the presence of the comorbid condition.
In explaining this, Kushner et al. (1990) and Kushner et al. (1999b) suggest that short-term anxiolytic alcohol effects may combine with longer-term anxiogenic alcohol effects to produce a vicious cycle of upwardly spiralling alcohol use and anxiety symptoms. This 'feed-forward', vicious-cycle view of comorbidity development suggests that the risk for developing the comorbid condition is increased by means of the same interactive process, regardless of which condition began first.

While the pathogenesis of comorbid disorders and alcoholism remains largely in question, stress disorders in alcoholics and anxiety disorders in female alcoholics have been found to influence the course and severity of alcoholism (Schneider et al., 2001). It is also 'reasonably clear' that alcohol-

dependent individuals who meet diagnostic criteria for one or more comorbid psychiatric disorders (of which depression and anxiety individually, and comorbid depression and anxiety feature most prominently) differ from those without comorbidity in many clinically relevant ways (Schneider et al., 2001).

As contradictory as the findings of various studies may seem, in a study by Schneider et al. (2001), 42.3% of all patients were diagnosed as having an anxiety disorder. This is not inconsistent with the findings of studies that have used the most stringent criteria for diagnosing, and where 23-44% of inpatient alcoholics were found to have one or more anxiety disorder (Bowen et al., 1984; Hesselbrock et al., 1985; Powell et al., 1982; Weiss & Rosenberg, 1985). Schneider et al. (2001) also found that patients with a PTSD disorder had the highest daily alcohol consumption and that PTSD was substantially associated with the course and severity of alcoholism. One would expect, then, that failure to diagnose and adequately consider the comorbidity of a psychiatric disorder as prevalent as anxiety would have a negative impact on therapeutic outcomes. In addition, failure to treat comorbid anxiety disorders, such as PTSD, could result in patients experiencing a re-emergence or intensification of the PTSD symptoms following sobriety and cause them to again turn to alcohol for temporary symptom relief (Schneider et al., 2001).

COPING STYLE

Coping, in general, refers to the cognitive and behavioural efforts used to master, tolerate, and reduce demands that tax or exceed a person's resources (Cohen & Lazarus, 1979).

According to Franken et al. (2001), the function of a healthy coping strategy encompasses the adequate management of life stress and negative emotional states.

Although evidence for an aetiological relation between maladaptive coping and substance abuse is ambiguous, it is believed that an adaptive, active coping style can relieve current and anticipatory stress and psychopathological symptoms.

Looking at social phobia in terms of coping, Beck and Emery (1985) propose that people with social phobia are hypersensitive to the possibility of negative evaluation and believe that they lack the personal resources (e.g., physical attractiveness, social skills) to guard against devaluation and rejection in interpersonal situations. According to this model, social phobics are preoccupied with

negative self-evaluation that can arouse intense anxiety in everyday situations and can interfere with their processing of social cues, leading to objective performance deterioration (Tran & Haaga, 2002). Many cope by 'fleeing' from their social fears, using cognitive (e.g., distraction) and behavioural (e.g., drinking) avoidance strategies in such situations. For some social phobics, alcohol use is a safety behaviour that prevents them from disconfirming their unrealistic fear of social impairment without alcohol and can make their behavioural impairment more likely by reducing the cognitive resources available for social interactions (Tran & Haaga, 2002). Alcohol consumption in these people is further maintained by their high outcome expectancies about alcohol's positive effects (e.g., reduction of social anxiety) and their low outcome expectancies about alcohol's negative consequences (e.g. behavioural impairment).

This being the case, it seems important that treatment should be not only educational and motivational in nature, but also practical in equipping patients to change their avoidant coping style into one that is more solution- or problem orientated. That is to say, treatment should equip patients to alter their avoidant cognitive and behavioural strategies in those situations where they are most vulnerable to lapsing.

Alcohol abuse research further shows that lack of effective coping responses and high positive expectancies of tension reduction contribute to alcohol abuse (Tran & Haaga, 2002).

In a study of the effects of anxiety and mood disorders on the coping styles of detoxified substance-abuse patients, Franken et al. (2001) found that the presence of psychiatric pathology is related to coping style. The presence of a mood disorder was also found to be associated with an extended 'palliative' coping style. Importantly, the presence of an anxiety disorder in detoxified substance abusers was found to be associated with less-active and more-passive coping styles. In clinical terms, substance-abuse patients with an anxiety disorder showed decreased problem-directed behaviour and exhibited increased rumination concerning the problem situation compared to non-anxious substance abuse patients (Franken et al., 2001). Interestingly, however, deficit coping styles were not found to be related to the severity of the substance abuse problem.

In their assessment of coping styles in pre- versus post-detoxifications subjects (those with and without anxiety disorders) Franken et al. (2001) concluded that there was a general change in the direction of more adequate coping styles between these states of toxification, but that this may be influenced by pre-detoxification variables such as the direct influence of psychoactive substances and withdrawal symptoms. A change of coping styles towards more adequate behaviour was, however,

found during six months of treatment. The coping styles of socialization, passive reaction, and palliative reaction improved during treatment towards a more-adequate coping style. This seems to take place within three months of treatment and remains unchanged after six months of treatment. Significantly, though, results suggested that anxiety-disorder patients benefited less from the treatment provided and that more intensive treatment may be required to improve coping styles. In line with the aim of this study, Franken et al. (2001) concluded that more attention should be focused on the treatment of anxiety disorders during substance-abuse treatment in order to improve coping style. This is particularly important because an improvement in coping style may be beneficial to the psychological well-being of the substance- abuse patient and the prevention of relapse. This is a view that is strongly emphasized by the Relapse Prevention (RP) model of G. Alan Marlatt (Larimer, Palmer & Marlatt, 1999), and which would, given the results of the Campbell (1996) and Davis (2003) studies, seem to warrant further investigation and implementation in local programmes.

RELAPSE

There are many possible explanations for relapse. Among these are individual characteristics such as inadequate motivation, resistance to therapy, defensiveness, and an inability to relate to the goals and tasks of the programme. There are also variables such as inadequate techniques, theory and relationship skills on the part of the therapist (Prochaska et al., 1992).

According to Franken et al. (2001), it is well known that the presence of psychiatric problems increases the likelihood of substance-abuse relapse and increased probability of treatment dropout (Carroll et al., 1993). LaBounty et al. (1992), in a study of relapse among alcoholics with phobia and panic symptoms, found that, compared to a control group, significantly more anxious subjects reported lapsing to cope with depression. Previous research has also shown a concordance between anxiety disorders and depression (Lesser et al., 1988). Lapsing among this group is probably not all that surprising, given that depression is characterized by, among other things, reduced attention and energy levels, and increased irritability and frustration, resulting in reduced problem-solving and increased avoidance. LaBounty et al. (1992) also found that a greater number of anxious subjects reported lapsing to cope with fear than did their matched controls.

A recent study by Willinger et al. (2002) reported a relapse rate of 85.5% among recently detoxified alcohol-dependent patients. This was similar to a recent 6-month UK study conducted by Chick et al. (2000), but higher than other studies. Nevertheless, figures for relapse in detoxified patients appear to be in the region of 70%, which is in line with what the two local studies, by Campbell (1996) and Davis (2003) reported.

The debate about the reasons for relapse is, in many ways, tied to the debate about the pathogenesis of comorbid alcohol dependence/abuse and anxiety. To what extent does untreated, or under-treated anxiety contribute to lapses and relapses? Should treatment for anxiety disorders be included in the treatment of those who have comorbid anxiety and alcohol abuse disorders? Evidence seems to suggest that this is preferable and potentially more effective than treatment that is narrowly focused on addressing only the alcohol dependence/abuse problem (Wells et al., 1994; Dimeff & Marlatt, 1995).

Driessen et al. (2001) studied the associations between comorbid anxiety and depressive disorders in treated alcoholics, the course of current anxiety and depression during the early and late-post-detoxification periods, and drinking behaviours after discharge. They found that severe anxiety persisting after 3 weeks of abstinence, comorbid depressive and/or anxiety disorders, and combinations of these with moderate or severe current anxiety and depressive states represented the greatest risk of relapse and therefore may indicate a treatment need. They also found an overall decrease of dimensionally assessed psychopathology in alcoholics during the detoxification period. Interestingly, it was trait anxiety and depression, but not state anxiety that showed a substantial decrease in the (early) post-detoxification period. This was not, however, true of patients with lifetime comorbid anxiety disorders (which were also current disorders in 71% of the afflicted subjects). Willinger et al. (2002) echo the finding that high trait anxiety is of significant predictive value for relapse to uncontrolled drinking in both males and females. They also found that persisting severe anxiety symptoms may lead to an increased risk of relapse. This, according to Driessen et al. (2001), coincides with the concept of trait anxiety, which represents a tendency of the subject to estimate new or unknown stimuli as threatening. It seems important, therefore, that clinical assessments investigate the presence of elevated levels of trait anxiety more thoroughly and give consideration to this in treatment. As Driessen et al. (2001) found, 69% of patients with additional anxiety disorders, and 77% of those with anxiety plus depressive disorders, reported lapses or relapses during the follow-up period of their study. This information is also important because additional

anxiety and/or depressive disorders (but not alcoholism itself) have been identified as major risk factors for suicidal ideas and behaviours (Driessen et al., 1998).

TREATMENT

In concluding their study of coping responses and alcohol outcome expectancies in both alcohol abusing and non-abusing social phobics (as just one form of anxiety disorder), Tran and Haaga (2002) suggest that socially phobic (sub-clinical and clinical) alcohol abusers may benefit from cognitive-behavioural therapy that aims at reducing positive alcohol expectancies and increasing coping skills in alcohol and non-alcohol situations. They continue by recommending that a useful avenue for developing treatment for comorbid social phobia and alcohol abuse is to integrate cognitive and behavioural therapies that have proven effective for treating social phobia (Heimberg & Juster, 1994; Turner et al., 1994) and alcohol abuse (Larimer et al., 1999; Monti et al., 1989). This is because cognitive-behavioural interventions emphasize the interdependence of the socially anxious person's dysfunctional belief system and patterns of behavioural avoidance. LaBounty et al. (1992) earlier suggested that the most prudent course is to assume that relapse rates among substance abusers with anxiety problems might be reduced if the anxiety symptoms, particularly those of agoraphobia and social phobia, were addressed during treatment and, where necessary, referrals made after treatment – that is to say, that it is important to tackle both disorders during treatment. This is because treatment of an anxiety disorder can rarely, if ever, be expected to cure alcoholism (Nunes et al., 1995), in the same way that a treatment approach that deals solely with the substance-abuse disorder will seldom fully eliminate anxiety.

There appears to be a need, therefore, to institute simultaneous treatment aimed at establishing and maintaining sobriety through a multi-focus approach that also addresses comorbid psychological and social difficulties. According to Moos et al. (2000) both alcohol problems and post-treatment drinking are closely related to a larger spectrum of social adjustment dimensions. Some treatment modalities with the greatest evidence of efficacy focus not exclusively or even primarily on drinking but aim to improve the patient's psychological well-being and bring about a change in lifestyle by improving relationships, increasing self-esteem and self-efficacy and social support networks (Miller & Sanchez-Craig, 1996; Visser & Flett, 1998; Maisto et al., 2002).

RELAPSE PREVENTION THERAPY

Before discussing and motivating for the use of Relapse Prevention Therapy (RPT) by psychologists working in Neuro Clinic D, Stikland Hospital, it is important to place this approach to therapy in relation to other models of addiction and treatment.

In their two-factor attributional analysis of helping and coping, Brickman et al. (1982) examined four principal models and posed two central questions: (1) is the addict/alcoholic responsible for the development of the problem and (2) is the addict/alcoholic responsible for changing the problem? The four models reviewed include the *moral model*, the *disease model*, the *spiritual (12-step - AA) model*, and the *compensatory model*:

The *moral model* assumes that the individual is responsible both for the development of the addiction and for changing or failing to change the addictive behaviour. Failure to change, or relapse, is said to be the result of a lack of will-power, or 'moral fiber' (Dimeff & Marlatt, 1995).

The *disease model* views addictive behaviour as a manifestation of an underlying disease process that is rooted in the individual's genetic or physiological make-up. The addict is often told that there is no cure for the disease, that it is progressive in nature, and that abstinence is the only way to 'manage' the disease. According to Dimeff and Marlatt (1995), this approach may alleviate blame, but the addict forever fears the resurgence of the uncontrollable disease.

The *spiritual or enlightenment model* considers the addict personally responsible to some extent for the emergence of the addiction. It also requires that the individual give up personal control in order to change. In this model, clearly defined in the 12-step tradition (Alcoholics Anonymous) the addict is viewed as a self-centred individual who has often placed his or her own selfish needs first, often resulting in the hurt of others. Recovery is achieved by making amends to those harmed by selfish aims and greed, and by turning one's life (including personal control) over to a higher power. In this model, relapse stems from an alienation from one's higher power or group.

The *compensatory model* (CM) believes that the individual 'compensates' for a problem not of his or her own making by assuming active responsibility and self-mastery in the change process. Relapse is viewed as a mistake or error in learning. This approach recognizes the influence of multiple factors in the aetiology of addictions (Marlatt, 1996). It also recognizes the client's willpower and influence in the process of change. While recognizing the multiple determinants of aetiology, CM views the client as the rightful change agent and works to build self-efficacy.

The relapse prevention (RP) approach to understanding and treating addictive behaviours favours the compensatory model.

Relapse Prevention Therapy is a multifaceted treatment modality, formulated by Alan Marlatt in the 1970s, and is based on the observation that relapse was the most frequent outcome of any treatment for substance abuse. Marlatt studied the sequence of events or situations that precipitated relapse and concluded that three categories accounted for nearly three-quarters of the relapses: negative emotional states, social pressure, and interpersonal conflict (Correctional services of Canada, 2004). This research formed the basis for a major part of the relapse prevention (RP) model; namely, the identification of situations that are likely to place a person at risk of relapse, and the development of skills to avoid those situations or to deal with them by other than substance abuse. Integrating principles from social-cognitive theory (Bandura, 1986), health psychology, and psycho-educational therapeutic approaches, RP focuses on strategy building in three distinct areas: (1) anticipating and preventing relapses, (2) coping humanely and effectively with a relapse to minimize its negative consequences and maximize learning from the experience, and (3) reducing global health risks and replacing lifestyle imbalance with balance and moderation (Dimeff & Marlatt, 1995). The RP model also conceptualizes addiction as stemming from a collection of maladaptive habit patterns rather than from purely physiological responses to substance abuse (Marlatt & Gordon, 1985).

According to Dimeff and Marlatt (1995), using skills training as a cornerstone, RP teaches clients how to anticipate, identify, and manage high-risk situations while also making security preparations for their future by striving for broader lifestyle balance. Another important aspect of the RP approach, and one that clearly distinguishes it from other models of treatment, is its concern with how individuals react to relapse. Relapse prevention stresses that individuals should end a relapse quickly and minimize the damage it causes, and that they should consider the slip as an unfortunate but isolated incident rather than an indication that they are incapable of recovering. Far from being punitive, therefore, RP teaches substance abusers that lapses and relapses are mistakes (not ultimate failure) and, more importantly, opportunities for additional learning (Dimeff & Marlatt, 1995).

In this way, patients are encouraged to take stock and try again, rather than give-up and resign themselves to self-defeating ideas of having failed or being weak or 'bad'.

Relapse Prevention is, therefore, a treatment approach that is based on the following four assumptions:

1. Different processes govern the cessation and maintenance stages of behaviour change
2. Relapse prevention is most successful when the client confidently acts as his or her own therapist following treatment. The client is viewed as fully equipped with the necessary behavioural 'tools' to use when signs of trouble appear
3. Relapse risks are complex and involve individual, situational, physiological and socio-cultural factors
4. Relapse and the process of recovery is an ongoing process, and not an end-point or terminal episode to be equated with treatment failure

According to Larimer et al. (1999), Relapse Prevention (RP) is an important component of alcoholism treatment because it suggests that both *immediate determinants* (e.g., high-risk situations – usually involving varying levels of anxiety, coping skills, outcome expectancies, and the abstinence violation effect) and *covert antecedents* (e.g., lifestyle factors and urges and cravings) can contribute to relapse.

According to Marlatt (1996), *immediate determinants of relapse* consist of the following:

High-risk Situations. These frequently serve as major precipitators of initial alcohol use after abstinence. Several types of situations can play a role in relapse episodes (Marlatt, 1996):

a. Negative emotional states, such as anger, anxiety, depression, frustration, and boredom, often referred to as intrapersonal high-risk situations.

b. Situations that involve another person or a group of people, particularly interpersonal conflict. According to Marlatt (1996), intrapersonal negative emotional states and interpersonal conflict situations served as triggers for more than half of all relapse episodes in his 1996 analysis.

c. Social pressure, including both direct verbal or nonverbal persuasion and indirect pressure (e.g., being around other people who are drinking). This accounted for 20 percent of relapse episodes in Marlatt's (1996) study.

d. Positive emotional states (e.g. celebrations), exposure to alcohol-related stimuli or cues.

Coping. A person's coping behaviour in a high-risk situation is seen as a particularly critical determinant of the likely outcome. People who have coped successfully with high-risk situations are assumed to experience a heightened sense of self-efficacy (i.e., a personal perception of mastery over the specific risky situation). Conversely, according to Marlatt (1996), people with low self-efficacy perceive themselves as lacking the motivation or ability to resist drinking in high-risk situations.

Outcome Expectancies. Research has shown that those who drink the most tend to have higher expectations regarding the positive effects of alcohol, and may anticipate only the immediate positive effects while ignoring or discounting the potential negative consequences of excessive drinking (Carey, 1995). Positive expectancies may become particularly obvious in high-risk situations, when the person expects alcohol use to help them with negative emotions or conflict.

The Abstinence Violation Effect. According to Larimer, Palmer & Marlatt (1999), a critical difference exists between the first violation of the abstinence goal with a return to uncontrolled drinking and complete abandonment of the abstinence goal (i.e., a full-blown relapse).

Marlatt and Gordon (1985) described a type of reaction by the drinker to a lapse, the *abstinence violation effect*, which may influence whether a lapse leads to full relapse. People who attribute the lapse to their own personal failure are said to be more likely to experience guilt and negative emotions, with the potential of increased drinking as a further attempt to avoid or escape the feelings of guilt or failure.

Larimer, Palmer & Marlatt (1999) describe *covert antecedents* of high-risk situations in the following way:

These are lifestyle factors, such as overall stress level, as well as cognitive factors that may serve to "set up" a relapse, such as rationalization, denial, and a desire for immediate gratification (i.e., urges and cravings). These factors can increase a person's vulnerability to relapse both by increasing exposure to high-risk situations and by decreasing motivation to resist drinking in these situations. In many cases, according to Larimer et al. (1999), initial lapses occur in high-risk situations that are completely unexpected and for which the drinker is often unprepared. In the course of therapy, though, it may be possible to identify a series of covert choices or decisions, each of them seemingly inconsequential, which in combination set the person up for situations which present a high risk.

Marlatt and Gordon (1985) see an imbalance between external demands (i.e., "shoulds") and internally fulfilling or enjoyable activities (i.e., "wants") in a person's life as the covert antecedent

most strongly related to relapse-risk. A life that is full of demands may lead to elevated levels of stress, which not only can generate negative emotional states, thereby creating high-risk situations, but also intensifies the person's desire for pleasure and supports the rationalization that indulgence is justified.

Also important as covert antecedents of relapse, according to Marlatt and Gordon (1985), are the concepts of *urges* and *cravings*.

Many researchers and clinicians consider urges and cravings to be physiological states, while the RP model proposes that they are precipitated by psychological or environmental stimuli. Marlatt and Gordon (1985) define an urge as a relatively sudden impulse to engage in an act such as alcohol consumption, whereas craving is defined as the subjective desire to experience the effects or consequences of such an act. It is important, therefore, that patients are taught about the cognitive aspect of urges and cravings, as well as how to manage them. The ultimate aim is a greater sense of control and self-efficacy.

The RP model also incorporates numerous specific and global intervention strategies that allow the therapist and client to address each step of the relapse process. In this way, the focus is not only on the substance dependence or abuse, but also the cognitions, interpretations, coping styles and life habits that perpetuate the patient's problem.

In line with the above theory, specific interventions in RP include the following:

(1) identifying specific high-risk situations for each client and enhancing the client's skills for coping with those situations

(2) increasing the client's self-efficacy, through teaching them that cravings and urges are sensations and thoughts that usually diminish over time and that with awareness and resolve they can be effectively managed

(3) eliminating myths regarding alcohol's effects, such as that perpetuated by the stress reduction theory

(4) managing relapses, so that they do not lead to long-lasting lapses and a return to previous levels of addiction and abuse

(5) restructuring the client's perceptions of the relapse process, so that abstinence is not seen as an end state, but rather as an ongoing behavioural goal that can be resumed even after a lapse. In this it seeks to reduce the anxiety around the achievement of abstinence, which arises from the alcoholic's belief that a relapse will result in a full loss of control (Dimeff & Marlatt, 1995).

As a guide to the implementation of this form of therapy, Marlatt recommends that treatment consist of approximately eight sessions and several additional follow-up sessions. This is only a guideline, though, and treatment should be tailored to the specific needs of individuals or groups. Some of these sessions can be spread over two sessions so that each of the fifteen one-hour sessions, attended by inpatients on the 4-week programme at Neuro Clinic D, Stikland Hospital (and similar local facilities), covers different aspects of the programme. Working with groups of up to eight people it may be necessary to spread a session over two sessions.

Dimeff and Marlatt (1995) have recommended the following structure to the RP programme:

Session 1

This involves establishing rapport and providing the client with information about the RP approach to treating addictive behaviour. It also highlights the primary aim: providing the client with tools to use in the maintenance of the desired behaviour (abstinence) and in the event of lapses.

A thorough history of the problem behaviour, as well as the client's motivation, is also assessed in this session.

Clients are then asked, as part of their 'homework', to do an *Autobiographical Sketch* – a brief depiction of any experiences, images and feelings related to the current pattern of drinking that are personally meaningful. In addition, they are asked to *Self-Monitor* – reflect on situations and influences that have a direct influence on their addictive behaviour. This can often help to identify both situations and dysfunctional coping skills that underlie the addictive behaviour.

According to Dimeff and Marlatt (1995), the task of self-monitoring proves useful as both an assessment procedure and intervention strategy. Information obtained can increase the client's awareness of a behaviour or set of behaviours that may have become routine and habitual, and aid in determining the antecedents of the behaviour. This latter purpose can, according to the authors, help the client prepare for future high-risk situations.

Session 2

Important here is to further examine high-risk situations and the client's repertoire of effective coping responses and skill deficits. The autobiographical sketches and self-monitoring given as 'homework' in the previous session should be further explored in this session.

Session 3

Continuing from session 1 and 2, assess coping strategies and high risk situations using one of several structured assessment instruments, such as the therapist-administered *Situational Confidence Questionnaire* (SCQ-39) (Annis et al., 1988; Annis & Davis, 1989), which can help in monitoring gains in the client's self-efficacy during the course of treatment. Included in the assessment during this session is a careful examination of past relapses and of relapse fantasies. This enables the therapist to examine the client's cognitive and affective response to any goal 'violations'.

During this session it is also recommended that *urges* and *cravings* be put into perspective for the client. It is important that clients understand that urges and cravings will arise and subside on their own and that if they can wait out the current without acting in the old, dysfunctional way, the internal pressure will eventually fade.

Clinical psychologists might also give consideration to the administration of an Anxiety Inventory, such as the State-Trait Anxiety Inventory (STAI) or that by Aaron T. Beck. It would be useful, for purposes of monitoring, if this could be done at intake and again at regular intervals throughout treatment.

Session 4

In this session, attention is given to developing more effective coping strategies, with coping being defined as a form of action or response to reduce a danger and/or achieve a goal (Wanigaratne, Wallace, Putin, Keaney & Farmer, 1990). Coping also refers to both specific coping strategies (e.g., skills training, cognitive reframing, etc.) and global lifestyle coping strategies (e.g., balancing one's lifestyle). The latter is the focus of later sessions.

Also in session IV, the therapist discusses the abstinence violation effect (AVE) and what the authors see as the second broad goal of RP: ways to minimize the negative effects of a lapse or relapse, should one occur.

In dealing with the issue of lapses it is important to emphasize the following four points:

(1) a lapse is a specific, unique event in time and space

(2) the lapse can be reattributed to external specific and controllable factors that can be handled by effective coping strategies

(3) a lapse can be turned into a 'prolapse' (a learning experience) instead of a relapse

(4) abstinence or control is always only a moment away

Session 5

Furthering the topic of coping, this session centres on understanding and coping with various cognitive and affective states. It is important to develop the client's awareness of thoughts and feelings, and to see the relationship between cognitions, affect, physiological responses, and behaviour.

Dimeff and Marlatt (1995) suggest that it is useful to centre the above discussion around anxiety because clients often report feeling anxious during the initial phases of maintenance and while experiencing urges and cravings. It is also useful for dealing with anxiety in general. According to the authors, clients often think that heightened anxiety is a sign that they are losing their 'footing' or personal control. The experience of anxiety is often interpreted as a sign that they need to manage their mood or situation by obtaining a 'quick fix'; hence, anxiety serves as a strong cue for drinking.

Session 6

In the sixth session, therapy shifts its focus from the management of specific, day-to-day high-risk situations to more global lifestyle management. The idea here is that the client learns how an unbalanced lifestyle or a persistent disequilibrium between 'shoulds' and 'wants' can pave the way to relapse (Dimeff & Marlatt, 1995). The client is made aware of how lifestyle imbalance can produce a chronic sense of deprivation which may, in-turn trigger urges, cravings, and cognitive distortions that make them more vulnerable to relapse. Clients are also encouraged to seek greater balance in their lives by identifying 'healthy indulgences' that might replace the more destructive one of alcohol. The authors cite daily healthy lifestyle habits or 'positive addictions' such as running, exercising and meditating as contributing to the client's long-term health, while also providing an adaptive coping response for life stressors and relapse situations.

Session 7

Here, the authors suggest that the therapist(s) cover more troubleshooting, provide practice in adaptive responses to problematic situations, and review the client's progress, and problem solving, in the event of a relapse. Ask the client to 'draw' a 'road map' to illustrate their individualized plan for relapse prevention. This should include one or more coping responses they would use in each high-risk junction.

Session 8

Review the client's 'road map' to dealing with urges, cravings, high-risk situations, and relapses. Ask them to 'rehearse' for a relapse in the session. This can be preceded by stress-reduction relaxation techniques before the presentation of a vivid 'lapse' situation. This could, according to the authors, also be conducted in vivo or with the forbidden substance in the room.

Additional sessions

These should focus on the continued strengthening of coping responses via modelling and role-plays, preparing the individual for additional high-risk situations, and continuing the management of lifestyle balance and health.

As therapy nears the end of formal inpatient sessions, clients should be encouraged to attend outpatient, post-treatment, sessions where their progress can be monitored and the principles of the treatment reinforced.

At present the outpatient support group at Neuro-D is mainly unstructured, with patients given an opportunity to speak about their experiences, difficulties, etc. While there is certainly a place for this kind of support group, a group that reinforces coping skills (both cognitive and behavioural) would, almost certainly provide greater continuity and support in the patient's ongoing efforts to abstain.

FINDINGS ON THE EFFECTIVENESS OF RELAPSE PREVENTION THERAPY

In spite of its widespread use within the field of addictions treatment, few controlled trials of the efficacy of RPT have been conducted. Those completed have, however, identified RP as an effective treatment that is equal to, and in some important areas more effective than, other treatment modalities.

In the first controlled outcome study of RP, Chaney et al. (1978) randomly assigned forty male, alcohol dependent inpatients to one of three conditions: skills training group (RP), insight-orientated discussion group (DG), and a group where no additional treatment control was administered. In the RP group, inpatients rehearsed adequate coping skills in high-risk situations using modeling, role-playing, and instructional procedures. They were also taught general problem-solving and assertiveness training. In the DG participants were encouraged to verbally explore feelings and motivations that may interfere with their coping skills. All participants also received standard inpatient treatment.

The results of this study are important for a number of reasons. Results not only consistently favoured RP, with drinking rates in this group being significantly lower compared to the other two treatment conditions, but the RP group also experienced less severe lapses for shorter periods compared to the other groups. Where there were lapses, members of the RP group stopped drinking sooner than the other conditions (an average of 5 days compared to 45 days, respectively). Researchers also found that the RP group drank less, experienced fewer days of intoxication and also demonstrated more 'controlled drinking' when compared with the other groups (Dimeff & Marlatt, 1995).

In a controlled study of inpatient alcohol abusers, Koski-Jannes (1992) compared RP to three common treatment modalities: psychodynamic, systems theory, and social learning theory. Results indicated that treatment adherence and satisfaction were greater in the RP condition. While results at one-year revealed significant reductions in drinking rates in all groups, outcomes on specific measures (reduced lengths of inpatient stay and fewer alcohol related arrests) favoured the RP group (Dimeff and Marlatt, 1995). In this and other studies, post-treatment self-efficacy (the degree to which patient's feel in control, are able to handle high-risk situations and maintain abstinence) was the best predictor of outcome.

In one of the most extensive meta-analytic reviews of RP, Irvin et al. (1999) reviewed twenty-six published and unpublished studies with 70 hypothesis tests representing a sample of 9,504 participants. Results indicated that RP was generally effective, particularly for alcohol problems. The authors found that treatment effects were 'strong and reliable' for alcohol use and for polysubstance use disorders, particularly with the adjunctive use of medication. In conclusion, the analysis supported the overall efficacy of RP in reducing substance use and improving psychosocial adjustment.

In an earlier study, that compared the efficacy of Twelve-Step (AA) and Cognitive-Behavioural treatment approaches (the latter being an essential feature of RP therapy), Ouimette et al. (1997) found that individually, and in combination, these programmes were equally effective in reducing substance abuse and improving most other areas of functioning. However, according to Wells et al. (1994), who compared 12-step and relapse prevention psychotherapy groups, 12-step patients showed significantly greater increases in their alcohol use from 12 weeks to the 6-month follow-up than the relapse prevention patients. Relapse prevention therapy appeared to have greater long-term (i.e., greater than six months) positive impact.

An apparent advantage to using relapse prevention (RP) therapy lies in the fact that it is broadly focused and emphasizes the integrated treatment of both substance abuse and comorbid psychiatric problems, such as anxiety. The 12-step philosophy, on the other hand, focuses almost exclusively on substance abuse as the primary problem and discourages the use of psychotropic medications for psychiatric problems (Buxton et al., 1987; Zweben & Smith, 1989). It also appears to be less concerned with addressing the patient's psychosocial stressors. Given that Davis (2003) found family and relationship problems, unemployment and stress to be major factors contributing to relapse in patients who had attended Neuro Clinic D, an integrated approach that deals with both substance abuse and other psychiatric/psychosocial factors would seem to be a more appropriate response to local conditions. Relapse prevention therapy also aims to increase the adaptive coping responses of patients, an area which Campbell (1996) identified as a major cause of relapse in the post-treatment patients she surveyed.

If we then consider that a key feature of anxiety is a perceived inability to cope with stressful situations, RP would seem to offer an effective way of addressing the distorted beliefs and maladaptive behaviour of patients.

Another feature of RP treatment that is particularly relevant to the local clinical population is its consideration of ethnicity, culture, gender and social class when providing training to patients. Those attending rehabilitation at Neuro Clinic D come from divergent racial, linguistic and socio-economic backgrounds, and from communities where levels of service provision and availability differ dramatically. Davis (2003) found that more than half the patients at Neuro Clinic D (66%) were semi-skilled and unskilled labourers, with an average education level of Grade 8. She also found that forty-five percent of the respondents found it difficult to manage the logistical problems involved in attending aftercare groups. Most had neither the transport nor the financial means to be able to attend. Relapse Prevention Therapy is interested in how the internalized effects of race, class, and/or gender prejudice and discrimination interact with efforts to establish and maintain self-efficacy (Dimeff & Marlatt, 1995). RP is also concerned with the possibility that 'learned helplessness' (Maier & Seligman, 1976) and real socioeconomic disadvantages undermine the primary aim of heightening the patient's sense of competence in order to achieve a particular goal (Dimeff & Marlatt, 1995). While consideration is given to this in the programmes run at Neuro Clinic D, with patients being assessed and assisted by a qualified social worker and occupational therapist (both individually and in groups), it seems important that future clinical psychology groups provide a structured programme that integrates this information into the supportive nature of the psychology groups. Together, the

programmes run at Neuro Clinic D aim at modifying attitudes and behaviours, increasing self-awareness, managing stress and conflict, and developing coping skills (Davis, 2003). Relapse prevention (RP), however, provides a structured format within which the clinical psychology groups, specifically, can collectively address substance abuse, comorbid psychiatric features and coping in the context of the socio-economic difficulties experienced by the majority of the patients.

RECOMMENDATIONS

In light of findings by Campbell (1996) and Davis (2003), of a high incidence of anxiety and ineffective coping styles in those individuals who lapsed following treatment for alcohol use disorders, as well as the extensive research on the comorbid relationship between alcohol disorders and anxiety disorders, it is recommended that clinical psychologists consider the following in structuring their rehabilitation groups:

- A thorough intake assessment that includes the use of both anxiety and depression inventories
- Monitoring of state and trait anxiety in inpatients at regular intervals throughout treatment
- The use of a structured treatment approach, such as Relapse Prevention Therapy, that addresses substance abuse as well as teaching patients to identify, challenge and modify dysfunctional cognitions and coping styles
- Regular follow-ups in the form of structured, weekly outpatient support groups
- Follow-ups at 6-months and 12-months in order to monitor treatment effectiveness, and to reinforce the skills-learning process

CONCLUSION

Given the high incidence of alcohol abuse and dependence in South Africa, the high rates of relapse following treatment, and the psycho-social reasons given for both addiction and relapse, it is important that treatment programmes go beyond labelling and simply prescribing abstinence.

If we consider that the principal reasons given for relapse by the respondents in the Davis (2003) study concern a perceived lack of self-efficacy and control in problematic situations clustered around family and social relationships, unemployment and stress, then it is important that treatment equip patients with tools to manage these situations. Psychology groups present the ideal context in which

anxiety and depression can be assessed and monitored. They also present the ideal context in which negative cognitions and maladaptive coping styles can be identified and challenged in a way that equips patients to do the same, post-treatment. Relapse Prevention Therapy (RPT) appears to offer the kind of treatment philosophy, format and flexibility that would enhance clinical psychology's contribution to the rehabilitation programme at Neuro Clinic D. Implementation of this form of therapy would also provide an ideal opportunity for a longitudinal study of its effectiveness with the local clinical population. Of particular interest would be patients' perceptions of self-efficacy and relapse, as well as any shifts in the length of, and intervals between, lapses. It should be borne in mind, though, that RP therapy is associated with what Carroll (1996) calls "delayed emergence effects" – that is, significant effects, compared with other treatment approaches, are often found only at later follow-up points (i.e., 1 year or more after treatment). This delayed effectiveness may result from the fact that it takes time to learn new skills and that, consequently, RP effects become more obvious as patients acquire additional practice (Larimer et al., 1999). Clinical psychologists working in Neuro Clinic D could make a valuable contribution to both the treatment offered and the facility itself (in terms of empirical data and feedback) through the implementation and monitoring of a RP treatment programme in their groups.

REFERENCES

Abrams, K., Kushner, M., Medina, K.L., & Voight, A. (2001). The pharmacologic and expectancy effects of alcohol on social anxiety in individuals with social phobia. *Drug and Alcohol Dependence, 64*, 219-231.

Albertyn, C., & McCann, M. (1993). *Alcohol, employment and fair labour practice*. Cape Town: Juta.

Allan, C.A. (1991). Psychological symptoms, psychiatric disorder and alcohol dependence amongst men and women attending a community based voluntary agency and an Alcohol Treatment Unit. *British Journal of Addiction, 86*, 419-427.

Allan, C.A. (1995). Alcohol problems and anxiety disorders – a critical review. *Alcohol and Alcoholism, 30*(2), 145-151.

Annis, H.M., & Davis, C.S. (1989). Relapse prevention. In R.K. Hester & W.R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (pp. 170-182). New York: Pergamon.

Annis, H.M., & Graham, J.M. (1988). *Situational confidence questionnaire (SCQ) user's guide*. Toronto, Canada: Addiction Research Foundation of Ontario.

Bandura, A. (1986). *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice Hall.

Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: International Universities Press.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression*. New York; Guilford Press.

Beck, A.T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

Beck, A.T., Wright, F.D., Newman, C.F., & Liese, B.S. (1993). *Cognitive therapy for substance abuse*. New York: Guilford Press.

Black, D.W., Winokur, G., & Nasrallah, A. (1987). Treatment and outcome in secondary depression: A naturalistic study of 1087 patients. *Journal of Clinical Psychiatry, 48*, 438-441.

Bowen, R.C., Cipywnyk, D., D'Arcy, C., & Keegan, D. (1984). Alcoholism, anxiety disorders, and agoraphobia. *Alcoholis: Clinical and Experimental Research, 8*, 48-50.

Brickman, P., Rabinowitz, V.C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist, 37*, 368-384.

Brown, S., Irwin, M., & Schuckit, M. (1991). Changes in anxiety among abstinent male alcoholics. *Journal of Studies on Alcohol, 52*, 55-61.

Buxton, M.E., Smith, D.E., & Seymour, R.B. (1987). Spirituality and other points of resistance to the 12-step recovery process. Special issue: Professional treatment and the 12-step process. *Journal of Psychoactive Drugs, 21*, 221-228.

Campbell, M.E. (1996). *Anxiety, depression and coping strategies in recently detoxified alcoholics.* Unpublished Master's Thesis: University of Stellenbosch.

Cappell, H., & Greeley, J. (1987). Alcohol and tension reduction: An update on research and theory. In H.T. Blane and K.E. Leonard (Eds), *Psychological Theories of Drinking and Alcoholism* (pp.14-53). New York: Guilford Press.

Carey, K.B. (1995). Alcohol-related expectancies predict quantity and frequency of heavy drinking among college students. *Psychology of Addictive Behaviors, 9*(4), 236-241.

Carroll, K.M., Power, M.-E.D., Bryant, K.J., & Rounsaville, B.J. (1993). One-year follow-up status of treatment-seeking cocaine abusers: psychopathology and dependence severity as predictors of outcome. *Journal of Nervous & Mental Disease, 181*(2), 71-79.

Carroll, K.M. (1996). Relapse prevention as a psycho-social treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology, 4*, 46-54.

Chambless, D.L., Cherney, J., Caputo, G.C., & Rheinstein, B.J.G. (1987). Anxiety disorders and alcoholism: A study with inpatient alcoholics. *Journal of Anxiety Disorders, 1*, 29-40.

Chaney, E.R., O'Leary, M.R., & Marlatt, G.A. (1978). Skill training with alcoholics. *Journal of Consulting and Clinical Psychology, 46*, 1092-1104.

Chick, J., Howlett, H., Morgan, M.Y., & Ritson, B for the UKMAS Investigators (2000). United Kingdom multicentre acamprosate study (UKMAS): a 6-month prospective study of acamprosate versus placebo in preventing relapse after withdrawal from alcohol. *Alcohol & Alcoholism, 35*, 176-187.

Clark, D.B., & Sayette, M.A. (1992). Anxiety and the development of alcoholism. *American Journal of Addictions, 2*, 59-76.

Cohen, F., & Lazarus, R.S. (1979). Coping with the stress of illness. In G.C. Stone, F. Cohen, & N.E. Adler (Eds.), *Health psychology, a handbook* (pp.217-254). San Francisco, CA: Jossey-Bass.

Cooke, D.J., & Allan, C.A. (1984). Stressful life events and alcohol abuse in women: a general population study. *British Journal of Addiction, 79*, 425-430.

Correctional Service of Canada (2004). *Review of substance abuse treatment modalities: relapse techniques* [Electronic version]. Correctional Services of Canada.

Creighton, S.J. (1984). *Trends in child abuse*. London: NSPCC Publications.

Crum, R.A., & Pratt, L.A. (2001). Risk of heavy drinking and alcohol use disorders in social phobia: a prospective analysis. *American Journal of Psychiatry, 158*, 1693-1700.

Davis, L. (2003). *An impact assessment of a current inpatient alcohol rehabilitation programme in the Western Cape*. Unpublished Master's Assignment: University of Stellenbosch.

Dimeff, L.A., & Marlatt, G.A. (1995). Relapse Prevention. In R.K. Hester and W.R. Miller (Eds.), *Handbook of Alcoholism Treatment Approaches – Effective alternatives* (pp.176-193). Boston: Allyn and Bacon.

Driessen, M., Veltrup, C., Weber, J. et al. (1998). Psychiatric comorbidity, suicidal behaviour and suicidal ideation in alcoholics seeking treatment. *Addiction, 93*, 889-894.

Driessen, M., Meier, S., Hill, A. et al. (2001). The course of anxiety, depression and drinking behaviours after completed detoxification in alcoholics with and without comorbid anxiety and depressive disorders. *Alcohol & Alcoholism, 36*(3), 249-255.

Franken, I.H.A., Hendriks, V.M., Haffmans, P.M.J., & van der Meer, C.W. (2001). Coping styles of substance-abuse patients: effects of anxiety and mood disorders on coping change. *Journal of Clinical Psychology, 57*(3), 299-306.

Gerber, M.A. (1995). *Compliance in the treatment of alcoholism*. Paper presented at the 25th Inter-American Congress of Psychology, San Juan, Puerto Rico.

Griffin, M.L., Weiss, R., Mirin, S., Wilson, H., & Bouchard-Voelk, B. (1987). The use of the Diagnostic Interview Schedule in drug-dependent patients. *American Journal of Drug and Alcohol Abuse, 13*, 281-291.

Heimberg, R.G., & Juster, H.R. (1994). Treatment of social phobia in cognitive-behavioural groups. *Journal of Clinical Psychiatry, 55*, 38-46.

Herz, L.R., Volicer, L., D'Angelo, N. et al., (1990). Additional psychiatric illness by diagnostic interview schedule in male alcoholics. *Comprehensive Psychiatry, 30*, 72-79.

Hesselbrock, M.N., Meyer, R.E., & Keener, J. (1985). Psychopathology in hospitalized alcoholics. *Archives of General Psychiatry, 42*, 1050-1055.

Irvin, J.E., Bowers, C.A., Dunn, M.E., & Wang, M.C. (1999). Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 67*(4), 563-570.

Kessler, R.C., Aguilar-Gaxiola, S., Andrade, L., Bijil, R., Borges, G., Caraveo-Anduaga, J.J., DeWit, D.J., Kolody, B., Merikangas, K.R., Molnar, B.E., Vega, W.A., Walters, E.E., & Wittchen, H.-U. (2003). Cross-national comparisons of comorbidities between substance use disorders and mental disorders: results from the International Consortium in Psychiatric Epidemiology. In W. Bukowski and Z. Sloboda (Eds.), *Handbook for Drug Abuse Prevention Theory - Science and Practice* (pp. 447-472). New York: Plenum Publishing Corp.

Koski-Jannes, A. (1992). *Alcohol addiction and self-regulation: A controlled trial of relapse prevention program for Finnish inpatient alcoholics*. Finland: The Finnish Foundation for Alcohol Studies.

Kushner, M.G., Sher, K.J., & Beitman, B.D. (1990). The relation between alcohol problems and the anxiety disorders. *American Journal of Psychiatry, 147*, 685-695.

Kushner, M.G., Mackenzie, T.B., Fiszdom, J., Valentiner, D.P., Foa, E., & Wangensteen, D. (1996). The effects of alcohol consumption on laboratory induced panic and state anxiety. *Archives of General Psychiatry, 53*, 264-270.

Kushner, M.G., Sher, K.J., & Erickson, M.A. (1999a). Prospective analysis of the relation between DSM-III anxiety disorders and alcohol use disorders. *American Journal of Psychiatry, 156*(5), 723-732.

Kushner, M.G., Abrams, K., & Borchardt, C. (1999b). The relationship between anxiety disorders and alcohol use disorders: a review of major perspectives and findings. *Clinical Psychology Review* (in press in spring 1999).

LaBounty, L.P., Hatsukami, D., Morgan, S.F., & Nelson, L. (1992). Relapse among alcoholics with phobic and panic symptoms. *Addictive Behaviours, 17*, 9-15.

Larimer, M.E., Palmer, R.S., & Marlatt, G.A. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioural model. *Alcohol Research and Health, 23*, 151-160.

Lazarus, R.S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology, 44*, 1-21.

Lerer, L., Matzoupoulous, R., Phillips, R., & Bradshaw, B. (1996). *Violence and injury mortality in the Cape Town Metropole 1995*. Cape Town: Medical Research Council.

Lesser , I.M., Rubin, R.T., Pecknold, J.C., Rifkin, A. et al. (1988). Secondary depression in panic disorder and agoraphobia. *Archives of General Psychiatry, 45*, 437-443.

Lindman, R., Alexanderson, G., & Lindfors, B. (1980). Anxiety and alcohol: limitation of tension reduction theory in nonalcoholics. Report from the Department of Psychology at ABO Akademi, Monograph Supplement 1. Turku, Finland: ABO Academi University Press.

Maier, S.F., & Seligman, M.E. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General, 105*, 3-46.

Maisto, S.A., Clifford, P.R., Longabaugh, R., & Beattie, M. (2002). The relationship between abstinence for one year following pretreatment assessment and alcohol use and other functioning at two years in individuals presenting for alcohol treatment. *Journal Studies on Alcohol, 63*(4), 397-403.

Marlatt, G.A., & Gordon, J.R. (1980). Determinants of relapse: implications for the maintenance of behaviour change. In P.O. Davidson and S.M. Davidson (Eds), *Behavioral Medicine: Changing Health Lifestyles* (pp.410-452). New York: Brunner/Mazel.

Marlatt, G.A., & Gordon, J.R. (Eds.) (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Marlatt, G.A. (1996). Taxonomy of high-risk situations for alcohol relapse: Evolution and development of a cognitive-behavioural model. *Addiction, 91*(suppl), 37-49.

Medical Research Council (1998). *Monitoring alcohol and drug abuse trends: South African Community Epidemiology Network on Drug Use (SACENDU)*. Proceedings of Report back meeting, 15 October. Tygerberg: Medical Research Council.

Mendelson, J., & Mello, N. (1979). One unanswered question about alcoholism. *British Journal of Addiction, 74*, 11-14.

Miller, W.R., & Sanchez-Craig, M. (1996). How to have a high success rate in treatment: advice for evaluators of alcoholism programs. *Addiction, 91*(6), 779-785.

Monti, P.M., Abrams, D.B., Kadden, R.M., & Cooney, N.L. (1989). *Treating alcohol dependence: A coping skills training guide*. New York: Guilford.

Moos, R.H., Finney, J.W., & Moos, B.S. (2000). Inpatient substance abuse care and the outcomes of subsequent community residential and outpatient care. *Addiction, 95*(6), 833-846.

Murray, R.M., Gurling, H., Bernadt, M., Ewusi-Mensah, I., Saunders, J., & Clifford, C. (1984). Do personality and psychiatric disorders predispose to alcoholism? In G. Edwards & J. Littleton (Eds), *Pharmacological Treatments for Alcoholism*. New York: Croon Helm.

Nunes, E.V., McGrath, P.J., & Quitkin, F.M. (1995). Treating anxiety in patients with alcoholism. *Journal of Clinical Psychiatry, 56*, 3-10.

Ouimette, P.C., Finney, J.W., & Moos, R.H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of Consulting and Clinical Psychology, 66*(2), 230-240.

Page, A.C., & Andrews, G. (1996). Do specific anxiety disorders show specific drug problems? *Australian and New Zealand Journal of Psychiatry, 30*, 410-414.

Palmer, C. (1985). Foetal alcohol effects – incidence and understanding in the Cape. *South African Medical Journal, 68*, 779-780.

Parks, G.A., & Marlatt, G.A. (2000). Relapse prevention therapy: a cognitive-behavioural approach. *The National Psychologist, 9*(5), 1-3.

Parry, C.D.H., & Bennetts, A.L. (1998). *Alcohol policy and public health in South Africa.* Oxford: Oxford University Press.

Pohorecky, L.A. (1991). Stress and alcohol interaction: an update of human research. *Alcoholism: Clinical and Experimental Research, 15*, 438-459.

Powell, B.J., Penick, E.C., Othmer, E., Bingham, S.F., & Rice, A.S. (1982). Prevalence of additional psychiatric syndromes among male alcoholics. *Journal of Clinical Psychiatry, 43*, 404-407.

Powell, B.J., Read, M., Penick, E. et al. (1987). Primary and secondary depression in alcoholic men: an important distinction? *Journal of Clinical Psychiatry, 48*, 98-101.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviors. *American Psychologist, 47*(9), 1102-1114.

Producktschap voor Gedistilleerde Dranken (1996). *World drink trends 1997.* Henley-on-Thames, UK: NTC Publications.

Ross, H.E., Glaser, F.B., & Germanson, T. (1988). The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry, 45*, 1023-1031.

Sareen, J., Chartier, M., Kjernisted, K.D., & Stein, M.B. (2001). Comorbidity of phobic disorders with alcoholism in a Canadian community sample. *Canadian Journal of Psychiatry, 46*, 733-740.

Schneider, U., Altman, A., Baumann, M. et al. (2001). Comorbid anxiety and affective disorder in alcohol-dependent patients seeking treatment: the first multicentre study in Germany. *Alcohol & Alcoholism, 36*(3), 219-223.

Schukit, M.A. (1985). The clinical implications of primary diagnostic groups among alcoholics. *Archives of General Psychiatry, 42*, 1043-1049.

Schuckit, M., & Monteiro, M. (1988). Alcoholism, anxiety and depression. *British Journal of Addiction, 83*, 1370-1380.

Schuckit, M.A., Irwin, M., & Brown, S.A. (1990). The history of anxiety symptoms among 171 primary alcoholics. *Journal of Studies on Alcohol, 51*, 34-41.

Sher, K.J. (1987). Stress response dampening. In H.T. Blane and K.E. Leonard (Eds), *Psychological Theories of Drinking and Alcoholism* (pp.227-271). New York: Guilford Press.

Sloan, T.B., Roache, J.D., & Johnson, B.A. (2003). The role of anxiety in predicting drinking behaviour. *Alcohol and Alcoholism, 38*(4), 360-363.

Smail, P., Stockwell, T., Canter, S., & Hodgson, R. (1984). Alcohol dependence and phobic anxiety states. *British Journal of Addiction, 82*, 971-979.

Steyn, E. (1996). Women and trauma. *Medical Research Council Trauma Review, 4*(2), 1-2.

Stockwell, T., & Bolderston, H. (1987). Alcohol and phobias. *British Journal of Addiction, 82*, 971-979.

Strydom, M., Van der Spuy, J., Abrahams, N., & Peden, M. (1994). Home violence: Some data from the National Trauma Research Programme. *Medical Research Council Trauma Review, 2*(3), 2-5.

Swendsen, J.D., Merikangas, K.R., Canino, G.J., Kessler, R.C., Rubio-Stipec, M., & Angst, J. (1998). The comorbidity of alcoholism with anxiety and depressive disorders in four geographic communities. *Comprehensive Psychiatry, 39*, 176-184.

Tomasson, K., & Vaglum, P. (1995). A nationwide representative sample of treatment-seeking alcoholics: a study of psychiatric comorbidity. *Acta Psychiatrica Scandinavica, 92*, 378-385.

Tran, G.Q., & Haaga, D.A.F. (2002). Coping responses and alcohol outcome expectancies in alcohol abusing and non-abusing social phobics. *Cognitive Therapy and Research, 26*(1), 1-17.

Turner, S.M., Beidel, D.C., Cooley, M.R., & Woody, S.R. (1994). A multicomponent behavioural treatment for social phobia: Social effectiveness therapy. *Behaviour Research and Therapy, 32*, 381-390.

Van der Burgh, C. (1992). *Memorandum: The contribution of the South African National Council on Alcoholism and drug dependence in combating alcohol and drug abuse in South Africa.* Cape Town: South African National Council on Alcoholism and drug dependence.

Visser, M.J., & Flett, M.M. (1998). Die evaluering van 'n behandelingsprogram vir alkoholafhanklikes. *Social Work Practitioner – Researcher, 11*(1), 94-108.

Wanigaratne, S., Wallace, W., Pullin, J., Keaney, F., & Farmer, R. (1990). *Relapse prevention for addictive behaviours: A manual for therapists.* London: Blackwell Scientific Publications.

Weissman, M.M., & Myers, J.K. (1980). Clinical depression in alcoholism. *American Journal of Psychiatry, 137*, 372-373.

Weiss, K.J., & Rosensberg, D.J. (1985). Prevalence of anxiety disorders among alcoholics. *Journal of Clinical Psychiatry, 46*, 3-5.

Weiss, R.D., Mirin, S.M., & Griffin, M.L. (1992). Methodological considerations in the diagnosis of coexisting psychiatric disorders in substance abusers. *British Journal of Addiction, 87*, 179-187.

Wells, E.A., Peterson, P.L., Gainey, R.R., Hawkins, J.D., & Catalano, R.F. (1994). Outpatient treatment for cocaine abuse: A controlled comparison of relapse prevention and twelve-step approaches. *American Journal of Drug and Alcohol Abuse, 20*, 1-17.

West, A., & Gocka, E. (1986). Self-ratings of typical mood and behaviour during recovery from alcohol abuse. *Psychopathology, 19*, 303-308.

Willinger, U., Lenzinger, E., Hornik, K. et al. (2002). Anxiety as a predictor of relapse in detoxified alcohol-dependent patients. *Alcohol & Alcoholism, 37*(6), 609-612.

Wilson, G.T. (1988). Alcohol and anxiety. *Behaviour Research and Therapy, 26*, 369-381.

World Health Organization (WHO) - Regional office for Europe (1993). *European alcohol action plan*. Copenhagen: WHO Regional Office for Europe.

Young, R., Oei, T.P., & Knight, R. (1990). The tension reduction hypothesis revisited: an alcohol expectancy perspective. *British Journal of Addiction, 85*, 31-40.

Zimmerman, P., Wittchen, H.-U., Hofler, M., Pfister, H., Kessler, R.C., & Liebe, R. (2003). Primary anxiety disorders and the development of subsequent alcohol use disorders: a 4-year community study of adolescents and young adults. *Psychological Medicine, 33*, 1211-1222.

Zweben, J.E., & Smith, D.E. (1989). Considerations in using psychotropic medication with dual diagnosis patients in recovery. *Journal of Psychoactive Drugs, 21*, 221-228.