A Focus Group Analysis of Relapse Prevention Strategies for Persons With Substance Use and Mental Disorders

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Objective: **The authors conducted a qualitative, thematic analysis of focus group data to determine the strategies and supports persons with dual diagnoses rely on in their relapse prevention efforts.** ***Methods:*** **Data from four focus group sessions conducted at a large psychosocial rehabilitation center were analyzed for recurrent responses about what was most helpful in maintaining remission and grouped into major categories and subcategories. Each focus group comprised four to nine consumers who had been in remission from substance use for at least six months. A total of 27 consumers participated in the focus groups.** ***Results:*** **The data indicate that maintaining stable housing, relying on "positive" social support, engaging in prayer or relying on a "higher power," participating in a meaningful activity, and thinking differently about life are important strategies for consumers in their attempts to stay clean. Just as frequently mentioned in the groups were conscious attempts to eat regularly, get sufficient sleep, and look presentable.** ***Conclusion:*** **Although this study was exploratory in nature, it identified areas for further qualitative study of strategies for relapse prevention among persons with dual diagnoses. (*Psychiatric Services* 56:1288–1291, 2005)**

Relapse prevention interventions, designed to improve an individual's ability to recognize and effectively manage common internal and external triggers leading to resumption of substance use, are well developed in the substance abuse field (1,2). Recent effectiveness studies have shown fewer relapses among persons who receive such interventions, as well as less intense relapses compared with previous relapses (3,4).

However, in the field of co-occurring disorders, interventions for persons who are in the relapse prevention stage of treatment are not well developed, in part because relapse has not been fully conceptualized. The fact that relapse needs to be better understood and interventions developed is evident in reviewing treatment outcome studies. Several cross-sectional studies show high rates of remission (5,6). Longitudinal studies show that overall rates of substance use disorders among persons with psychiatric illness do not change much over time, because the number of relapses and new cases balances with the number of remissions (7).

Nascent research on determinants of relapse among persons with dual disorders suggests that these individuals face challenges that have not been addressed by interventions developed in the substance abuse field. Precipitants of relapse may not be different in type but in kind. Persons who have both disorders are more likely to face housing instability and suffer daily assaults of poverty and stigma, which makes avoiding putatively common triggers, or at least learning to deal with them, more difficult.

Indeed, an early study of persons with dual disorders usefully compared perceptions of high-risk situations between alcohol abusers with a severe mental illness and drug abusers with a severe mental illness yet was limited by its reliance on measures developed for use in the general population of substance abusers (8). As a result, the study did not capture the nuances of the situations faced by persons who experience highly unstable living situations. For example, the study could not detect what a later study reported—namely, that cognitive deficits, poor judgment about whom to trust, and social isolation makes individuals with dual disorders more vulnerable to drug dealers, and drug dealers actively prey on this group for these reasons (9). A follow-up study was conducted to better identify high-risk situations that are unique to persons with dual disorders (10). That study showed that participants consistently mentioned 33 high-risk situations. These situations were grouped into

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ten categories, ranging from becoming symptomatic to receiving money to experiencing loss.

The purpose of the study reported here was to serve as a complement to existing qualitative research by identifying strategies, supports, and skills used by consumers who have successfully maintained sobriety for at least six months. Toward that end, this study addressed the question, What do people who are in the later stages of recovery do to successfully manage high-risk internal and external triggers? We attempted to answer this question by examining qualitative data collected from focus group discussions with consumers. Identifying successful strategies of persons with dual diagnoses is integral to developing a relapse prevention intervention.

Methods

Participants

Participants included 27 consumers in the later stages of substance abuse treatment (12 women and 15 men) who were recruited from Thresholds, a large psychosocial rehabilitation organization in Chicago. The research was approved by the organization's institutional review board. All consumers provided written informed consent. The consumers' mean±SD age was 43.85±8.77 years; 21 consumers (77 percent) were African American, and six (22 percent) were European-American. Seventeen (62 percent had never been married, and seven (25 percent) were separated or divorced; one person was currently living with a partner. The mean number of years of education was 11.73±2.17. Fourteen consumers (52 percent) were working at the time of the focus group, 16 (59 percent) had worked on and off (mean number of days=747.76±989.66), and 11 (37 percent) had not worked since being in treatment. All were housed. Twenty participants (74 percent) had a schizophrenia spectrum disorder, and six (22 percent) had a major affective disorder. Nine (33 percent) had a diagnosis of substance abuse, and 18 (66 percent) had a diagnosis of substance dependence. Most participants reported having started using drugs or drinking when they were young teenagers. The average amount of time free of alcohol or drug use since treatment ("clean time") across the four focus groups, based on self-reports, was 2.90±2.19 years.

Measures

Data were collected from chart reviews and four focus group discussions between July 2003 and March 2004. Charts were reviewed and a deidentified database created by a Thresholds' data management staff. Focus group sessions were audiotaped, and the tapes were later transcribed for analysis. Krueger's (11) guidelines for focus groups were followed, with some modifications so that the groups resembled the groups that the study participants were used to attending. Each focus group included no more than nine participants. The duration of each focus group session was no more than 75 minutes, and the format was fairly structured. Most focus group questions were designed to elicit strategies that participants were aware of and could imagine themselves using. However, one question, which asked participants to compare how they spent their days when they were using substances with how they spend their days now, tried to elicit "strategies" that people were less aware of relying on. Focus group sessions began with general questions about staying clean and then became more narrowly focused on social support, housing, and treatment, such as "How do important people in your life—friends, family, significant others—help you to stay clean, if at all"?

Procedures

Eligible participants from four programs were invited by their case managers to participate in the focus groups. Individuals were eligible to participate if they were in stages 6, 7, or 8 on the Stage of Treatment Scale (SATS), a scale that has good consensus and convergent validity (12). Clinical staff use the SATS to assess a consumer's motivational state by focusing on overt behaviors in relation to treatment. A rating of 6, 7, or 8 means that consumers are engaged in efforts to reduce substance use with a provider and have not met the criteria for abuse or dependence in at least six months.

Participants attended one of four focus group sessions. The groups ranged in size from four to nine persons and were each led by an experienced clinical staff member and a member of the research staff, both of whom were unknown to the participants. Questions were pilot-tested on two consumers who were representative of the focus group participants. Two questions that received either a one- or a two-word response or a response that would have been more appropriate for a different question were revised after these interviews.

Data analysis

Descriptive statistics were used to analyze the quantitative demographic and diagnostic information obtained from chart reviews. The focus group questions served as a provisional starting list of a priori codes by which to analyze the data. These questions emerged from theoretical studies in both the psychiatric rehabilitation field and the substance abuse field. The studies hypothesize that staying clean involves active, ongoing "work," that it involves the negotiation of both internal and external triggers, and that both treatment and nontreatment factors can help individuals maintain change (1,13). Accordingly, the goal of the focus groups was to identify the conditions, skills, strategies, and attitudes that consumers most relied on to stay clean. Instances of explicit and implicit mention of a particular kind of support, skill, or way of thinking on the part of consumers were coded.

Subcategories and two major categories emerged inductively from the focus group data, including "motivating thoughts" and "personal care issues." These categories were provisional and were settled on only after a process of constant comparison in which each statement was checked against similar data and against a more inclusive category determined to best describe the individual statements as a class (12). A major coding category was added if a group of statements (mentioned more than three times in each focus group) did not fit into a category on the starting list and was discussed in detail by at least two persons in each group. Transcripts were read separately by two

raters—the lead researcher and a clinical staff member. The clinical staff member moderated several focus groups. The two raters examined, jointly discussed, and reached consensus on the subcategories and two major categories to be added.

Results

Avoiding people, places, and things

"Avoiding people, places, and things" was the first response of many focus group participants to the most general question asked: "What most helps you to stay clean?" When prompted, many participants expanded and talked about the importance of long-term drug-free housing and of staying away from familiar neighborhoods and people that trigger the desire to use drugs:

"At the shelter, I only had to stick my head out the door to use. It's best to change where you live, even if you can't keep it." "I just stayed away from the people that I used to get high with. I wouldn't go outside. I just stayed in the house." "Being here (in a residential treatment program) gives me a foundation. I was in a halfway house and I couldn't stay clean there."

One person used the metaphor of a fortress, attributing strength less to himself than to the barriers of the residence itself: "It's black and white. I lived in a ghetto-type neighborhood—chaos. Here, if I want to go out, there's three different doors I need to walk out of to get me to my destination, to get drugs."

In terms of avoiding specific people, one participant said, "My biggest thing was to leave the people, places, and things. . . . Anyway I tried to quit before. I started getting my weight back, gained a few pounds. Then I wanted to go back to my old neighborhood, you know you want to show off how good you look. My friends there said 'I miss you man.' After a while I loaned them money and they were giving me heroin."

Others indicated that, after a number of failures in high-risk situations, they made a commitment to staying away from drug-using friends and acquaintances: "Don't stay around people that use. If I would see them I would tell them I'm no longer using that stuff, that I don't want any. Like, 'say no to drugs,' that's what I would do." Another participant said, "I just stay away from those people I used to party with."

Clinical and nonclinical support

Being able to stay away from people and places depends on, as one person put it, "being around good people." Another said, "I go to AA [Alcoholics Anonymous] meetings, NA [Narcotics Anonymous] meetings, networking, building a relationship with people outside the building that's in the program who have some clean time who know the [AA] material, who know the literature. All that really helps me because, like I said before, I wanted to do it by myself and I kept trying to do it by myself and I kept failing and failing."

Another participant said, "I've got involved with support help groups outside the community. For example, AA and NA and I attend those meetings. Talk to my sponsor."

The role of family was also mentioned: "The one person who helps me stay clean is my mother 'cause she writes me about twice a week and she sends me gifts and she writes me and she encourages me." "My mother always reminds me of what it's like when I'm smoking and how it makes me sick."

Friends were also important: "I was very lonely. I lived alone. . . . I'm around positive people now. My life has changed." "Sober friends who are positive, sober and positive people. If you surround yourself with good relationships, positive people."

Some participants mentioned religion, or a "higher power": "I give glory to my higher power. I'd say God has been my main support mechanism in my recovery, my prayers, my meditation." "First thing I do is that I realize I'm powerless. . . . I've begun to pray real hard a lot since I've been here." "Church is a support group, and the word of God." "Sometimes I turn to the Bible."

The focus groups also discussed the importance of having understanding staff: "When I was in a Christian shelter, I got treated so toughly it just didn't matter to me anymore." "Being supplied with love and kindness—I think everyone needs that no matter what—even if you're using." "Service providers treated me like I was special, they never put me down, always try to build me up." "Encouraging therapist—he made me feel good about myself. He told me I had a lot of potential."

Meaningful activities

Meaningful activities was another common theme: "You have to build up a new sense of pride—have to get involved in something you enjoy—church, school, reading, a job. I feel a new sense of pride." The importance of having a job is evident in one consumer's description of what it is like when he is not working: "My job plays a tremendous part also, keeps me stable, keeps me focused. Gives me something to do, not sitting around doing nothing watching TV all day. Not just being bored. It gives me something to do, and I really look forward to going to work, and it helps me just being around my coworkers, people. It keeps me strong." Another participant said, "I'm trying to stay focused, mainly on my job."

For some participants, school was an area of focus: "I'm going to school, it keeps me occupied." "I was going to school. I was working out. I was playing basketball."

Other activities were also important: "Keeping busy and not getting bored—'cause you don't want to start thinking about using." "I find I'm doing things I enjoy doing. I listen to music. I watch the baseball game. I participate in different events." "I try to stay as active as possible, go to a lot of meetings, do a lot of service work."

Personal care and lifestyle balance issues

Many participants talked about the importance of self-care: "I keep clean and sober by keeping myself a lot cleaner . . . because when I'd been using in the past I wouldn't take a bath. Now, instead of buying drugs I buy body wash." "I try to keep myself clean, make a meal for myself, and go to bed at a reasonable hour. I buy body wash and things to clean my apartment, stay clean." Another mentioned "thinking about food and en-

joying good food. I starved myself when I was outside. Now I have good food." One participant said, "I eat right, and I get plenty of sleep, sometimes I force myself to sleep."

Thinking differently, developing insight, and developing goals

Although not a strategy per se, developing goals and gaining insight into previously opaque behavior appears to help individuals to stay clean: "Before I came here I hated myself, I hated people, even people who tried to help me . . . today I'm learning that I am somebody with potential . . . and everyone is not bad people." "I'm getting to realize that there is more to the alcohol problem than just the alcohol and the way that I think and how I handle responsibilities." "I now enjoy being sober. The first three years I was sober I didn't like it, I was making excuses but I was sober just to be sober. Now I have goals."

Discussion

Qualitative studies, in general, can be critical in the early stages of inquiry, because they can lay out the boundaries of a problem, provide individual perspectives on a psychosocially defined phenomenon, and refine research questions.

Focus group data suggest that consumers have an easier time staying clean if they live in neighborhoods and residences with other individuals who do not use substances, or at least are able to stay away from a using environment for longer than a month, a typical duration for many programs. Social support and engagement in a meaningful activity, such as work or school, are also important. The importance of a drug- or alcohol-free home suggests that although refusal and coping skills are important, people may need a period during which such skills are not called on so they can develop the commitment and readiness to use them. In addition, the data suggest that social support is critical to staying clean. This support can take many forms—clinical support, self-help and peer groups, nonusing and "positive" friends, and a "higher power."

A potential limitation of this study is that participants' varying durations of being clean might have meant that they relied on retrospective recall. However, given the nature of substance use disorders—that is, the fact that they wax and wane—it is safe to assume that persons who have maintained sobriety for more than two years still rely on strategies for doing so. In fact, many participants, in responding to a question that encouraged them to talk about what their life is like now, mentioned specific times during the year, or even times during the day, that remain difficult for them.

Questions remain. For example, do self-care activities serve as buffers to stress that, as described in the substance abuse literature, allow people to maintain a lifestyle balance, and how might the middle-class concept of lifestyle balance apply to this population (1)? Or, are these activities bound up with a hard-won sense of control so that remission depends, to some extent, on maintaining control in these other areas? Are they important as parts of a daily routine, the adoption of which manages triggers of substance use? What is the role of religion in relapse prevention efforts?

Finally, the fact that many participants talked in an AA idiom in response to the most open-ended of the questions—"What has been most helpful to you in staying clean?"—requires further study. The frequent mention of giving oneself over to a higher power suggests that many consumers see themselves, some of the time, as not being in control of their remission. Is this perceived sense of being powerless reconcilable with a psychosocial relapse prevention intervention that tries to increase self-efficacy? A second issue is germane to any set of beliefs ubiquitous in popular culture. Over time, do these beliefs become clichés, diminishing reflection or the possibility for alternative, potentially useful perspectives? One part of a relapse prevention intervention might usefully explore how consumers understand and use AA so as to maximize the philosophy's potential.

Conclusions

In sum, the data from this study warrant that more in-depth qualitative research be conducted to explore the roles of self-care, religion, and Alcoholics Anonymous in preventing relapse of substance abuse among persons with dual disorders. The data provide a rough outline of some consumers' means for staying clean and a glimpse into their understanding of the recovery process. ♦

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