

DEMYSTIFYING RELAPSE: A Recurrence of Symptoms

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INTRODUCTION

“Relapse” is the medical term for the deterioration in health or the recurrence of symptoms after a period of remission of disease. For people recovering from a substance use disorder (SUD), sometimes referred to as alcohol or other drug addiction, relapse is common. It is a multifaceted issue, intricately linked to a myriad of physiological, psychological and societal factors. Although similar in complexity to many other chronic conditions, such as diabetes or asthma, which have recurring periods of symptoms, SUD relapse is conceptualized very differently and is distinctly more stigmatized.

While societal pressures can motivate health behavior change, the stigma around recurrence can also act as a barrier, hindering a person’s motivation to reengage with treatment and community support to further entrench individuals in the cycle of addiction.

This disparity underscores the need for a broader societal shift in our understanding of SUD, which has been [classified as a disease by the American Medical Association](#) since 1987, with alcoholism classified as such since 1954. Similar to conditions like autism, which is viewed on a spectrum, SUD exists on a continuum of severity and chronicity. There is massive variation in impact, involvement, characteristics and behaviors, all of which affect the pervasiveness of symptoms and a person’s likelihood of relapse. For individuals with severe SUD, chronic care models can be used to develop more accurate expectations of individual treatment and recovery paths, paving the way for more compassionate and effective interventions.

This issue brief, the first in our “Demystifying Relapse” series, was developed to clarify what SUD relapse truly means and to chart a more effective path forward for treating the recurrence of symptoms. Now is the time for us to address this issue; relapse has become increasingly fatal because of the adulteration of the U.S. illicit drug supply. Unrealistic expectations associated with treatment, intensified by deep-seated stigma surrounding, hinder our understanding and study of SUD symptom recurrences. Worse, these challenges obstruct our capacity to evolve health care systems to effectively support individuals during critical moments in their recovery journeys.

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THE CHALLENGES



Stigma as a barrier

SUD is one of the [most stigmatized conditions in the world](#), and a recurrence in symptoms can compound this stigma, carrying the weight of a failure within a failure, overshadowing the understanding that SUD is a complex, chronic condition akin to other medical illnesses. Stigma often places blame for relapse on a lack of willpower or moral shortcoming of the individual.

These attitudes come from within as well as from outside the SUD community and treatment systems, and together they obscure the unique nature and challenges of an individual's particular recovery journey. In certain cases, societal pressures can serve as a motivating force, yet in other situations, the stigma associated with relapse presents a significant obstacle to re-entering treatment. This stigma can impede an individual's willingness to reengage with treatment options and seek community support.



A different standard

Effective treatment for chronic diseases reduces the severity and frequency of symptoms to restore function but does not aim to permanently eliminate the underlying condition. Said another way, the goal of treatment is not to be a cure, but instead to be a method for managing a condition, whether that is SUD or diabetes.

SUD, like diabetes or hypertension, involves a complex interplay of biological predispositions and personal choices, such as exercising or eating healthily for diabetes management. However, the societal response to these conditions varies significantly. For instance, a person with diabetes who indulges in a cheeseburger faces no punitive consequences, while someone with SUD who has a return to substance use might face severe repercussions, including loss of housing or treatment.

When diabetes or asthma symptoms worsen, society tends to empathize, understanding the complex nature of these chronic conditions without blaming the patient, provider or treatment. In contrast, a recurrence of symptoms in SUD is often met with questions of treatment efficacy rather than empathetic understanding.

Similar rates of substance use-related relapse to other chronic conditions — [around 40%-60%](#) — highlights the need for a shift in how society perceives and responds to substance use-related relapses. Recurrences in SUD could be conceptualized not as failures, but rather as valuable opportunities for intervention and reengagement. This approach would allow for the progressive modification of treatment plans and the effective management of complex disease progression.



Belief in treatment effectiveness

For many other chronic medical conditions, a reduction in the frequency and severity of symptoms is judged as treatment success. In the case of diabetes, neither the patient nor the doctors treating them are blamed when the diabetes becomes “uncontrolled” after a period of remission. For a recurrence of SUD symptoms, however, relapse can perpetuate the false narrative that SUD treatments do not “work,” undervaluing its actual effectiveness.

[2020 research by the World Health Organization and the United Nations Office of Drug Control and Crime](#) found that an individual’s perceptions of the helpfulness of treatment for alcohol use disorder affect treatment retention rates. Additional studies have found that people who express positive feelings about the treatments they receive [have reduced substance use, reduced psychological distress, longer treatment retention and improved quality of life.](#)

The double standard for SUD treatment reduces its potential impact in very real ways. Misconceptions that SUD treatment doesn’t work only make the treatments that are available less effective.



Stigmatizing language

With chronic physical health conditions like cancer, the term “relapse” has been replaced by the more descriptive term “recurrence,” used in the updated [American Society of Addiction Medicine \(ASAM\) Criteria](#), to conveying greater moral neutrality. While the words “relapse” and “slip” are not necessarily stigmatizing, both can have larger colloquial connotations that incorrectly suggest that a recurrence of symptoms sits fully within an individual’s control. Using descriptive but morally neutral terms, such as “resumed use,” “returned to use,” or “experienced a recurrence of symptoms,” removes the erroneous and potentially stigmatizing implications of complete individual control, leaving greater space for the complex interplay between behavior and biology.



Incorrect use of terminology

To properly clarify the concept of “relapse,” it’s important to recognize that the term is often misused. It is frequently incorrectly applied to any instance of substance use that happens after a person is discharged from treatment. In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR), an individual who has been diagnosed with an SUD is in “remission” when none of the criteria for the disorder have been met for at least 90 days. Therefore, when an individual recovering from addiction returns to alcohol or other drug use during the first 90-day period of treatment and recovery, any return to use is not a relapse, because the individual never achieved remission. The return to use is part of the same episode of the disorder.

Additionally, a relapse occurs only when the individual has met criteria for a disorder. Substance use alone does not meet criteria for an SUD. An assessment is necessary to determine if a “relapse” has occurred after remission from a diagnosed disorder.

There is high risk for experiencing a recurrence in symptoms during the first 90 days of recovery because individuals have greater sensitivity to stress and a lower sensitivity to natural rewards such as food or sex. Individuals experience substantial physiological, psychological and social changes during this period, known as early recovery. Residential treatment programs typically last between 14 to 28 days. Individuals discharged from treatment without proper linkages to continuing care, often face multi-month gaps in services despite not even being in remission.



Treatment doesn't end when "treatment" ends

When an individual completes a typical 14-to-28-day residential treatment program, it's only their first step in a multiyear process of recovery from SUD. A single time-limited treatment episode without continuing care and services is often not a sufficient duration for curing a chronic condition. Treatment programs that offer graduation ceremonies and treatment completion certificates may perpetuate a false belief that SUD is cured upon discharge, setting the patient and family up for a feeling of failure — of the individual and the treatment program — if there is a return to use.

Realistic expectations for an initial 14-to-28-day residential treatment episode can be found in [the ASAM Criteria](#), which notes goals of stabilization and reduction in the severity of symptoms across six medical, psychological and environmental dimensions. Recovery and healing are long-term journeys, often extending over several years and even a lifetime, depending on the severity of the condition. When patients depart from residential SUD treatment, they are embarking on their path to recovery, a journey typically marked by phases of symptom remission and recurrence.



Starting from zero

Alcoholics Anonymous (AA) and other twelve-step programs support millions of people in their addiction recovery journey, using sobriety coins or medallions to mark recovery milestones. When a return to use occurs, the count resets to zero. There are pros and cons to this approach. While some find the medallion process particularly rewarding, this approach may fail to acknowledge the continuous progress, or the overall improvements achieved during periods of sobriety.

In SUD treatment and recovery, celebrating patient progress rather than perfection may be important, as perfection is difficult to achieve with chronic conditions. This involves acknowledging steps toward personal recovery goals, building recovery capital and improving overall self-care. It means recognizing the full journey and personal growth of the individual, shifting the focus from "how many days since" to "look how far you've come."

Health care, even more generally, regularly restarts SUD patients from zero after a recurrence of symptoms, by administratively requiring individuals to recount the same extensive questions about their histories as they did in prior treatment episodes. Furthermore, due to the absence of established standards and guidance around subsequent treatment episodes post-relapse, returning patients can be given treatment plans with little to no adjustments to the interventions used previously.



THE OPPORTUNITIES

As we face these challenges, it is crucial we acknowledge that a reduction in the frequency and severity of symptoms is a treatment success, and recurrence is a pivotal opportunity to reengage individuals with services and support systems.

To demystify relapse, we need greater recognition of the variations that exist within relapse. Each return to use is unique, influenced by various factors such as condition severity, duration, substance type(s), amount and circumstance.

Moreover, establishing more accurate expectations regarding the likelihood of symptom recurrence, the goals of short-term treatment programs and the extended duration of recovery (often measured in years, not days), is essential. This heightened understanding can more effectively prepare individuals, families, health care professionals and treatment systems for the recovery process. Additionally, this deeper insight can foster more empathetic societal responses, nurturing a culture of compassion that embraces a holistic perspective of recovery. It acknowledges recovery as a nonlinear, iterative journey, rich with varied goals and experiences.

As long as systemic blame and misunderstandings persist toward those experiencing symptom recurrence and their caregivers, our understanding and research into these recurrences will be impeded. It will limit the evolution of our health care systems to provide optimal support for individuals' health and wellbeing during these critical moments. By recognizing these challenges, we hope to transform them into opportunities for progress for establishing systems of care that genuinely support individuals on their paths to recovery, revolutionizing our understanding and treatment of SUD.



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