Actually, It's More Clinical Than Just a Relapse

Understanding a return to the use of substances as a recurrence of symptoms, leads to compassion

The term "relapse," is an example of language, beliefs and attitudes commonly expressed when discussing substance use disorders (SUDs) that is not informed by medical evidence. *Relapse* has been in use since the 1980s to emphasize behaviors, motivations, and choices rather than focusing on the symptoms, capacity or diagnostic criteria of a substance use disorder (SUD).

"Relapse" is defined as the act of slipping or falling back to a former worse state (Merriam Webster). This definition, commonly understood by many, contributes to the misconception that individuals, due to a lack of caring or a moral failing, consciously choose to return to the use of substances, and that this decision is made from a state of health. This misunderstanding suggests that a person is experiencing a deliberate 'regression' rather than recognizing it is a symptom or expression of the health condition (substance use disorder) itself.

When symptoms return in conditions like diabetes or mood disorders, even after long periods of wellness, others respond with support, not disappointment. It's understood as part of the health condition. But with SUDs, when a return to compulsively seeking substances is referred to as a 'relapse' instead of a *recurrence,* people see this as a failure or choice, rather than a symptom. This double standard is based in stigma, not science.

This false narrative affects how people who use substances are treated and portrayed at the social or public level, in the healthcare system, within in the family unit, and consequently how people with an (SUD) view their own self-worth.

To address these false narratives, CAPSA uses the language of *recurrence* to accurately refer to the signs that indicate the disorder is active. These can include:

- Compulsively seeking and using substances
- Inability to make healthy choices
- Continuing to use substances despite negative consequences

Substance use disorder is not defined by the presence of substances, but by the loss of capacity to make healthy, self-determined choices in one's relationship with them. There are many reasons that these symptoms can occur or return for an individual, which can be psychosocial, neurological, biological, or a combination of these factors. This combination is different for each person. When an SUD returns due to these factors, changing the language from behaviors to symptoms helps create an understanding that:

The return:

- It is part of the condition and comes from the disorder
- It doesn't come from a place of wellness

In this way, it is like other diagnosable conditions, it is not a choice or personal failure.

A recurrence of symptoms of an SUD needs to be rooted in the ongoing diagnosis and support of the disorder, much like how recurrences are understood in other physical and mental health conditions.

How do false beliefs and stigmatizing language lead to real harms?

For a person with an SUD:

When people use words like 'relapse' that focuses on behaviour and assumes *they're not willing or don't care enough* or *just need motivation to make better choices*, individuals will question why they can't seem to find the willpower to change or think that something is wrong with them for not caring enough to make those changes. When these harmful beliefs, held by others and a result of stigma, become internalized, people can begin to feel disconnected from family and community and care. This isolates people and has a direct impact on a person's health.

False ideas that focus on the need for motivation, willingness and making *good* choices, are not grounded in the evidence of substance use disorders. They perpetuate the damaging belief that someone must feel pain or be desperate to make different choices. A concept known as the "rock bottom" myth. This narrative is especially harmful because it suggests that a person must hit an extreme level of suffering before they are open to or offered help. As a result, many people delay reaching out for support, until they are at risk of death.

For Family Members and Caregivers of Individuals with SUD:

When a family member believes the false narratives surrounding choice, motivation and caring, they may impose ultimatums or consequences, hoping to facilitate change. These approaches are not helpful as they do not consider the diagnostic criteria of an SUD, nor the capacity of the individual at that moment. When family members act on these beliefs, the way they speak to and treat their family member, perpetuates both social and self-stigma and lead to the harms described above

One of the criteria of an SUD is:

Continuing to use substances despite negative consequences.

For Service Providers:

When service providers hold false beliefs about wellness, improvement, or 'success,' their compassion can become conditional. If a person does not get 'better' or experiences recurrence, caregivers may feel frustrated or disillusioned, especially if they see their role as fixing, saving, or producing specific outcomes. Over time, this can lead to diminished quality of care for the individual and the emotional withdrawal of the caregiver. In some cases, caregivers begin to place criteria around their support, linking being worthy of support to the absence of recurrence or to the person's ability to stay well. When these expectations aren't met, care may be withheld or, in some cases, individuals may even be rejected from services.

This frustration is often mislabeled as 'compassion fatigue.' However, there is no evidence or assessment showing that being compassionate harms caregivers. What is commonly referred to as compassion fatigue is more accurately a reflection of undeveloped skills, internalized pressure to control outcomes, and the emotional strain of navigating a system that rarely acknowledges these dynamics. It is not compassion that is exhausting, it is the demand to manage someone else's journey, and the resulting sense of failure when that control is impossible. Left unexamined, this dynamic reinforces stigma, especially around recurrence, and ultimately works against the principles of care itself.

In The Health System:

Since substance use and health became part of the healthcare system, public perception, misinformation, and bias have heavily influenced policies and practices in harmful ways. Terms like *"relapse"* have reinforced moralistic interpretations of health, leading to punitive approaches such as abstinence-based requirements, exclusion from services after symptom return, and service models that define success through narrow, singular pathways to wellness.

When individuals do not meet these narrow standards, they are often labeled as 'non-compliant,' and removed from services, rather than supported as people navigating a legitimate health need.

What Can You Do?

For people with a substance use disorder:

- Understand recurrence as part of the condition, not a moral failure or lack of motivation
- Seek compassionate support when it is needed, to strengthen capacity for change
- Connect with peer communities that follow an inclusive approach

For Families and Caregivers:

- Learn about substance use disorders and recurrence as a symptom of a medical condition, not a choice
- Offer support without ultimatums or punishments
- Use person-first language, don't label (e.g., "person with a substance use disorder" instead of "addict")
- Model compassionate boundaries that focus on health and wellness, capacity building and wellness for everyone

For Service Providers:

- To help individuals build capacity; focus on care and support, not just treatment timelines and outcomes
- Challenge your beliefs about recurrence and take the next step by discussing recurrence with colleagues
- Adopt a compassionate care approach that holds hope for a person's wellness, without expectation or demand

For Systems Leaders:

- Ensure capacity building services remain accessible regardless of recurrence
- Shift success metrics to focus on self-determined health goals
- Integrate compassionate care and co-leadership principles into program design

Understanding recurrence in substance use disorder as a symptom of the disorder itself, rather than a result of poor behavior, lack of motivation, or personal choice, is essential to improving health outcomes and reducing stigma. Reframing the conversation away from blame and toward a clinical, dignity-based understanding encourages the use of person-first language, emphasizes care over outcomes, and supports individuals without ultimatums. Replacing terms like "relapse" with "recurrence of symptoms" reinforces a compassionate, health-centered approach that prioritizes wellness over punishment. For meaningful change, policies must reflect this perspective, ensuring that individuals receive the support and understanding they deserve throughout their substance use health journey.

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Who We Are

CAPSA is a national organization that dismantles systemic stigma and promotes health across a spectrum of substance use—from non-use to substance use disorder. Our team of health professionals, educators, and researchers combines technical expertise with lived and living experiences to deliver relevant and evidence-based health programs.