

Relapse Capital: Rethinking Substance Use Relapse Within a Recovery Capital Framework

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Abstract

Background: Relapse remains a central yet contested concept within addiction science, practice, and policy discourse. Traditionally conceptualized as treatment failure requiring prevention and correction, relapse continues to be framed primarily through deficit-oriented clinical models. However, recovery-oriented addiction research increasingly highlights the non-linear nature of recovery trajectories and the diverse meanings that individuals attribute to their relapse experiences within longer processes of change. In response, I propose a re-conceptualization of relapse within a strength-based and recovery-oriented framework. **Method:** Drawing on recovery capital theory alongside empirical findings from previous qualitative research in which I explored repeated relapse among both people in recovery and addiction therapists, this paper introduces *relapse capital* as a theoretical extension of recovery capital. **Results:** Relapse capital is conceptualized as a multidimensional phenomenon that may simultaneously erode and generate personal, social, and structural recovery resources. Situating relapse within relational, contextual, and developmental recovery processes allows for a more nuanced understanding that acknowledges both risks and potential learning. Although this perspective challenges deficit-focused interpretations it remains attentive to the clinical, social, and structural harms associated with substance use recurrence. **Conclusions:** Integrating relapse capital into addiction science, pedagogy and practice may foster more compassionate and contextually grounded understandings of relapse. The framework has potential implications for research, clinical practice, service development, and policy by encouraging responses that support sustained engagement, reduce stigma, and recognize relapse as a dynamic force rather than an outcome.

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Introduction

Relapse into problematic substance use, often defined as a return to substance use following treatment, occupies a complex and often uneasy position within addiction science. It is widely recognized as common, and, in many cases, expected, within addiction trajectories, and has even been incorporated into definitions of addiction (e.g., as a chronic relapsing condition). Treatment outcome research estimates that approximately 40–60% of individuals treated for substance use disorders experience relapse at some point, although rates vary depending on substance type, treatment context, and duration of follow-up (National Institute on Drug Abuse [NIDA], 2020; McLellan et al., 2000). Evidence consistently indicates that relapse risk is highest during early recovery, particularly within the first months and year following treatment. Over time, as resources to achieve and maintain recovery (i.e., Recovery Capital; Cano et al., 2017; Cloud & Granfield, 2008) develop and stabilize, this risk generally declines, underscoring the importance of sustained support rather than short-term intervention alone. In response to these realities, much clinical work has focused on relapse prevention. Cognitive-behavioral approaches as well as mindfulness relapse prevention strategies have emphasized coping strategies, risk management, and the strengthening of self-efficacy (Bowen et al., 2021; Imran, 2023; Witkiewitz et al., 2005; Marlatt & Gordon, 1985). These models have made significant contributions to addiction treatment by helping individuals identify high-risk situations and develop practical strategies to support behavioral change. For many individuals, such approaches have been crucial in sustaining recovery. Nevertheless, relapse within these frameworks is often positioned primarily as something to avoid, manage, or correct, all of which implicitly signals disruption to recovery progress.

At the same time, recovery science increasingly emphasizes that recovery rarely unfolds in a linear or uniform manner (Kelly & Stauffer, 2025). Longitudinal studies suggest that recovery is dynamic, relational, and shaped by broader social and structural contexts. The REC-PATH (Recovery Pathways) study, a large multi-country investigation of recovery trajectories, demonstrates that recovery often involves fluctuating engagement with treatment, evolving social networks, and shifting personal priorities over time (Best et al., 2018). Earlier work on addiction and treatment careers similarly describes extended cycles of remission, relapse, and renewed recovery efforts unfolding over many years (Dennis et al., 2005). From this perspective, relapse appears less as an isolated failure and more as part of longer-term recovery trajectories embedded within changing relationships, environments, and life circumstances. Importantly, the meaning of relapse may differ depending on where individuals are situated within these trajectories. For some, relapse may be destabilizing and associated with significant risk; for others, it may represent a difficult but formative moment prompting reflection or renewed engagement with support. As Laudet and White (2008) have long concluded, greater recovery capital prospectively predicts sustained recovery and reduced vulnerability to relapse, all of which further highlights the importance of relational and structural resources in sustaining recovery.

Despite these advances, dominant public, clinical, and policy narratives continue to frame relapse primarily in deficit terms. My recent work exploring how addiction therapists experience their clients repeatedly relapsing (Klein et al., 2024) showed that relapse is frequently interpreted as loss of progress, insufficient motivation, or failure to maintain coping strategies. This reflects wider discourses within addiction science in which relapse is often conceptualised as treatment failure or non-compliance rather than as part of a longer-term and non-linear recovery process (see White et al., 2005; Marlatt & Donovan, 2005).

While such concerns reflect genuine clinical risks, including overdose, health deterioration, and social exclusion, deficit-focused framings may also contribute to stigma, shame, and disengagement from services (Kelly & Westerhoff, 2010; Luoma et al., 2007; Wakeman & Rich, 2018). Research has additionally shown that stigmatizing attitudes towards substance use and relapse can negatively affect treatment engagement, help-seeking, and recovery outcomes, particularly among structurally marginalized populations (McGinty & Barry, 2020; Sonbol et al., 2023). However, research with people in recovery after repeated relapses (Klein et al., 2022) has indicated a more complex reality. Relapse is often experienced as painful and destabilizing, yet it may also prompt reflection, renewed commitment, or reconnection with recovery resources. This aligns with qualitative literature suggesting that relapse can function as part of ongoing learning and identity development process rather than solely as evidence of failure (Best & Laudet, 2010; Dennis & Scott, 2007). Similarly, clinicians in Klein et al. (2024) reported that compassionate responses to relapse can strengthen therapeutic alliance, whereas punitive or exclusionary responses may exacerbate harm (White et al., 2005). These tensions raise several important conceptual questions that remain insufficiently addressed within existing literature:

- How should relapse be understood in relation to recovery, and recovery in relation to relapse?
- How can progress toward wellbeing be recognized when relapse continues to occur along the recovery journey?
- If recovery is genuinely non-linear, what forms of response to relapse might continue to support recovery, and under what circumstances might relapse instead erode recovery resources?

These questions are not merely theoretical. They reflect lived tensions experienced by individuals in recovery, clinicians, and service systems alike. Addressing them requires a conceptual framework that is capable of acknowledging both the risks associated with relapse and its potential to facilitate further development without reducing relapse to individual failure.

In this paper, I seek to contribute to this discussion by proposing the concept of *relapse capital* as an extension of recovery capital theory (Cloud & Granfield, 2008; Best & Laudet, 2010). With this concept, I seek to capture the complex ways in which relapse may both diminish and generate recovery resources across personal, relational, and structural domains. Rather than positioning relapse solely as regression, relapse capital, I argue, offers a more nuanced and compassionate lens through which relapse can be understood as part of longer-term recovery trajectories. The remainder of this paper unfolds in three parts. Firstly, I outline evolving conceptualizations of relapse in substance use recovery to identify areas of conceptual tension and overlap. Secondly, I introduce and describe the concept of relapse capital in greater detail. Finally, I consider implications for research, clinical practice, and policy, highlighting how a relapse capital perspective may inform more compassionate and contextually responsive approaches within addiction science and practice.

Evolving Conceptualizations of Relapse in Substance Use Recovery

Efforts to understand relapse in substance use have evolved alongside broader shifts in how addiction and recovery themselves are conceptualized. Early models tended to frame relapse primarily as an individual clinical event, typically defined as a return to substance use following treatment, and interpreted largely through psychological, biomedical, or behavioral

lenses (see Sliedrecht et al., 2022). Over time, however, research has increasingly recognized relapse as embedded within complex personal, relational, and structural contexts. This shift reflects a growing appreciation that recovery cannot be understood solely as the absence of substance use but rather as an ongoing, socially situated process of change. Despite this broadening perspective, the concept of relapse remains contested, with ongoing debates surrounding its definition, measurement, meaning, and clinical implications.

A persistent challenge within relapse research concerns how relapse itself is operationalized. Moe and colleagues (2022) demonstrate that there remains substantial variability in definitions across empirical studies. For instance, a lapse has typically been defined as a brief, isolated return to substance use (or other target behaviour) following a period of abstinence, while a relapse refers to a more sustained return to previous patterns or levels of problematic behaviour (Kaviyani et al, 2023; Larimer et al., 2004). However, some researchers have also used the term relapse to describe any return to substance use, including isolated episodes, thereby blurring the distinction between lapse and relapse (DiClemente & Crisafulli, 2022). Still other approaches incorporate broader indicators such as wellbeing, functioning, or alignment with personal recovery goals. These definitional variations reflect deeper conceptual tensions. It remains unclear whether relapse should be understood primarily as a behavioral outcome, a clinical endpoint, a subjective experience, or a developmental process. Similarly, debates continue regarding whether recovery is best defined through abstinence, improved functioning, social participation, or personal meaning. The diversity of definitions suggests that relapse may not represent a universal construct but rather one shaped by treatment philosophy, social context, and individual recovery narratives. Qualitative research further highlights this complexity. In a recent scoping review, I have highlighted that individuals in recovery often conceptualize relapse differently from clinical

frameworks (Klein, 2021). For some, relapse may involve emotional disconnection, social isolation, or loss of purpose prior to any return to substance use. For others, episodes of substance use may not necessarily signal abandonment of recovery identity. These lived perspectives invite more flexible and compassionate conceptualizations that acknowledge recovery as dynamic rather than binary.

Much foundational relapse theory stems from cognitive-behavioral relapse prevention traditions, particularly the work of Marlatt and colleagues (Marlatt & Gordon, 1984; Marlatt & Witkiewitz, 2005). These models conceptualize relapse as arising when individuals encounter high-risk situations without sufficient coping resources, where craving, emotional distress, perceived self-efficacy, and environmental triggers interact dynamically. Importantly, relapse prevention approaches encouraged learning from lapses rather than viewing them solely as failures, emphasizing reflection, skill development, and renewed engagement with recovery goals. These contributions have been highly influential, providing structured therapeutic tools, promoting a sense of agency among individuals in recovery, and reframing relapse as part of an ongoing process rather than simply a breakdown of willpower. Nevertheless, as my review suggests, cognitive-behavioral models may sometimes center predominantly on individual coping processes (Klein, 2021). While clinically valuable, this focus can risk under-acknowledging broader relational, social, and structural influences on substance use trajectories.

Subsequent developments have sought to address these limitations by incorporating interpersonal and contextual factors more explicitly. Hunter-Reel and colleagues (2009), for example, highlighted the central role of relationship stress, social conflict, and interpersonal environments in shaping relapse vulnerability. This extension underscores that relapse rarely

occurs in isolation but unfolds within relational contexts that can either support or undermine recovery. Contemporary longitudinal research continues to reinforce this perspective.

Prospective cohort studies, particularly among individuals with co-occurring psychiatric conditions (e.g., Andersson et al., 2023), consistently identify mental health distress, social instability, and environmental stressors as significant relapse predictors. Similarly, research examining social support and self-efficacy (Al-Ziadat, 2024) suggests that confidence in sustaining recovery is often relationally generated. Supportive relationships, stable living environments, and meaningful social roles frequently contribute as much to recovery stability as individual coping skills. These findings continue to move relapse research toward more ecological and relational understandings.

Ecological frameworks further expand this perspective by conceptualizing relapse as emerging from multiple interacting levels of influence. Barati and colleagues (2023) synthesize evidence demonstrating how individual vulnerabilities, interpersonal relationships, community resources, policy environments, and broader social determinants collectively shape relapse risk. This aligns closely with public mental health and ecological approaches that emphasize how recovery is embedded within wider social, political, and economic contexts. Housing stability, employment opportunities, stigma, discrimination, access to healthcare and recovery services, and experiences of community belonging all influence relapse and recovery trajectories. From this standpoint, relapse may not only reflect individual difficulties, but also systemic barriers, chronic stressors, and unmet social needs.

Importantly, these systemic influences are not **experienced** equally across populations.

Research increasingly demonstrates that structurally marginalized groups, including people of colour, lower-income communities, women, migrants and ethnic minorities, and sexual and gender minorities, often experience disproportionate barriers to accessing recovery-

supportive resources (see Banks et al., 2023; Wagner & Baldwin, 2020; Pouille et al., 2021). These groups may encounter intersecting experiences of stigma, discrimination, poverty, criminalization, trauma exposure, and reduced access to culturally responsive care, all of which may compound relapse vulnerability (Bommersbach et al., 2022; Witkiewitz et al., 2013). Research has additionally highlighted gendered differences in relapse risk and recovery trajectories, with factors such as poverty, unemployment, caregiving responsibilities, and social stigma differentially shaping recovery experiences for women and men (Grella et al., 2008). Similarly, sexually minoritized groups report unique recovery challenges linked to discrimination and reduced social support (Bohn et al., 2026).

Repeated relapse may also lead to exclusion from, or reduced access to, structural and recovery-supportive resources. In some treatment systems, individuals with multiple relapse histories may experience punitive responses, discharge from programmes, loss of housing opportunities, reduced trust from services, or barriers to continued care and support (White et al., 2005). Such responses may further erode recovery capital by increasing instability, shame, social exclusion, and disengagement from treatment, particularly for individuals already facing structural disadvantage.

Ecological perspectives also help explain temporal fluctuations in relapse risk, as changes in employment, relationships, mental health, housing, or social networks can significantly alter recovery stability. Recognizing this complexity encourages responses to relapse that extend beyond individual therapy toward community support, anti-stigma initiatives, policy reform, and integrated systems of care. Alongside these developments, there has been increasing interest in strengths-based approaches to addiction recovery. Rather than focusing solely on relapse prevention, scholars have begun emphasizing the protection

and accumulation of recovery resources. Ogilvie and Carson (2025), for example, advocate a shift from “relapse prevention” toward “recovery protection,” foregrounding resilience, identity development, and resource building. Central to this shift is the concept of recovery capital, derived from Cloud and Granfield’s (2008) theory, which conceptualizes recovery as supported by the accumulation of personal, social, cultural, and community resources. Systematic reviews (Bunaciu et al., 2024; Hennessy, 2017; Pouille et al., 2022) demonstrate how this framework has helped integrate clinical, social, and public health perspectives, emphasizing that recovery is sustained not solely through individual effort but through access to supportive resources and environments. Recent work by Best and colleagues (2026) extends this further through an “outside-in” model of recovery capital growth, highlighting how community resources and social inclusion drive personal recovery development and challenging individualized narratives of addiction recovery.

Despite the growing prominence of recovery capital theory, its integration with relapse theory remains relatively underdeveloped. Limited attention has been paid to how relapse experiences themselves may reshape recovery capital, sometimes diminishing resources, but occasionally generating insight, renewed motivation, or reconnection with support networks (see Klein et al., 2022; Klein et al., 2024). Taken together, these findings suggest that relapse cannot be reduced to an individual behavioral event. Rather, it is a relational, social, and systemic phenomenon that interacts dynamically with recovery resources. While traditional relapse prevention models have emphasized coping skills and self-efficacy, emerging evidence highlights the equally important roles of relational support, identity reconstruction, and structural conditions. Repeated relapse may simultaneously challenge self-efficacy while generating insight and opportunities for growth. These complexities point to the need for integrative frameworks that bring psychological, social,

and structural perspectives together. In the following section therefore, I introduce the concept of relapse capital as one such framework, seeking to capture how relapse may both erode and generate recovery resources within longer-term recovery journeys.

Relapse Capital: An Introduction to the Model

The proposed concept of relapse capital refers to the personal, social, and community resources, as well as vulnerabilities, that shape how relapse from substance use is experienced, interpreted, and integrated into recovery trajectories. Crucially, relapse capital includes both capital-enhancing (positive) and capital-depleting (negative) processes. As Table 1 illustrates, the relapse capital domains overlap dynamically rather than operating independently, reflecting the more fluid and socially-embedded nature of recovery processes.

[Table 1 near here]

Personal Relapse Capital

At the personal level, relapse may involve both the erosion and development of psychological resources. Negative impacts frequently include reduced self-efficacy, heightened shame, emotional distress, and renewed cycles of craving, all of which may undermine confidence in recovery and increase vulnerability to continued substance use. Relapse can also disrupt a person's sense of identity, agency, and trust in their ability to sustain change (Collinson & Best, 2019). In some cases, ongoing relapse and substance use cycles may negatively affect educational engagement, vocational functioning and confidence in pursuing future goals or opportunities (Keane, 2011). Individuals may additionally lose confidence in their ability to manage everyday responsibilities, such as maintain stable routines, managing finances, or sustaining a home environment, further impacting their sense of autonomy and personal agency (Patton et al., 2022).

However, emerging qualitative evidence suggests that relapse experiences can also facilitate important learning and growth processes. For example, our recent study (Klein et al., 2022) found that individuals with repeated relapse histories often reported increased awareness of triggers, deeper understanding of emotional needs, and strengthened motivation to re-engage with support. Some participants described relapse as clarifying what recovery requires in practice rather than in theory, drawing from valuable coping strategies. Such learning processes may contribute to identity development, resilience, and more sustainable coping strategies over time. Individuals may also develop greater confidence in managing practical aspects of daily life and recovery, including finances, routines, employment, and independent living. From this perspective, personal relapse capital encompasses both losses and potential gains in internal recovery resources, including self-esteem, self-efficacy, resilience, motivation, meaning, and hope. For some individuals, relapse may later come to be understood not only as a marker of vulnerability, but also as a potentially transformative experience that contributes to identity development and more sustainable recovery trajectories.

Social Relapse Capital

Relapse is inherently relational, and social responses from family members, peers, professionals, and recovery communities strongly shape its consequences. Supportive reactions can reduce shame, strengthen relational bonds, and facilitate re-engagement with recovery resources, whereas stigma, exclusion, or punitive reactions may exacerbate harm and disengagement (Best et al., 2017; Sonbol et al., 2024; White et al., 2005). Changes in social networks, including distancing from substance-using environments and building recovery-supportive relationships, have consistently been associated with more stable recovery outcomes (Vigdal et al., 2023). Relapse may also strain relationships, reduce trust,

diminish social capital, and reinforce social marginalization, particularly when individuals experience rejection from family members or peers. Cultural norms surrounding substance use, including the normalization of heavy drinking or polysubstance use within certain social contexts, may further complicate recovery trajectories.

Importantly, some youth-focused recovery systems have developed explicitly relational and non-punitive approaches to relapse that may offer valuable insights for broader service development. Recovery high schools, collegiate recovery programs, and alternative peer group models seem to increasingly recognise relapse as relatively common within adolescent and young adult recovery trajectories, and therefore seem to prioritise continued engagement, peer connection, accountability, and relational support over exclusionary responses (see Cleveland et al., 2007; Finch et al., 2018; Moberg & Finch, 2013). Within these settings, relapse may be approached as an opportunity for reflection, collaborative problem-solving, and strengthening recovery-oriented identity rather than solely as programme failure. Such approaches acknowledge that meaningful change and recovery development may still occur even when relapse is present, particularly among young people navigating complex developmental, social, and environmental pressures.

Viewing relapse through a social capital lens, therefore shifts attention away from individual responsibility alone and toward the relational processes that shape recovery possibilities. This domain highlights the importance of recovery-supportive relationships, peer belonging, and socially inclusive responses that maintain connection following relapse rather than withdrawing care, support, or opportunities for recovery engagement.

Community and Structural Relapse Capital

Relapse, like recovery, unfolds within broader structural contexts, including housing, employment, healthcare access, criminal justice systems, and policy environments. For some individuals, relapse may prompt renewed engagement with services, peer support networks, or community recovery initiatives, thereby strengthening connections to supportive environments and increasing access to recovery-promoting resources. However, structural stigma and social inequality remain significant barriers to sustained recovery (Galanis et al., 2025). Individuals may experience disruptions to housing, treatment, or employment opportunities following relapse (Guenzel & McChargue, 2019). For example, some recovery housing models require ongoing abstinence and may terminate placements following substance use, while treatment programmes have historically used administrative discharge procedures in response to continued use (Gallant et al., 2024). From a risk environment perspective, these service responses can themselves contribute to vulnerability by disrupting access to housing, care, and other recovery-supporting resources (Rhodes, 2002; 2009). Such dynamics may contribute to social exclusion, disengagement from services, and increasing instability.

From an intersectional social determinant of health perspective, these consequences are recognized to not be experienced equally across populations. For example, individuals with greater financial, social, or familial resources may retain access to private treatment, stable housing, or supportive networks following relapse, whereas those relying on publicly funded systems may face more severe consequences, including homelessness, treatment exclusion, criminalization, or prolonged disengagement from care (Wagner & Baldwin, 2020). Structurally marginalized groups, including people living in poverty, racial and ethnic minority communities, women, migrants, and sexual and gender minorities, often experience cumulative disadvantages that reduce access to recovery-supportive resources and increase

vulnerability to structural stigma following relapse (Banks et al., 2023; Bommersbach et al., 2022; Grella et al., 2008).

Considering relapse capital at the community and structural level therefore highlights how recovery outcomes are shaped not only by individual behavior, but also by how societies distribute opportunity, care, safety, and inclusion. From this perspective, community relapse capital refers to structures, systems, and policy approaches that respond to relapse in supportive, non-punitive, and recovery-oriented ways.

An Ocean–Tide Analogy

A central contribution of the relapse capital model is its recognition that personal, social, and community dimensions are deeply interconnected, aligned with Best and Laudet’s (2010) recovery capital model. A relapse event may influence these domains differently yet simultaneously, for example, strengthening resources in one area while diminishing them in another. An ocean–tide analogy may help illustrate this dynamic: Recovery can be conceptualized as an ocean representing the broader context of a person’s life. Within this ocean lie three interconnected domains: personal recovery capital (psychological resources such as identity, coping skills, and self-efficacy), social recovery capital (relationships, networks, and relational support), and community or structural recovery capital (access to services, housing, employment, and broader societal inclusion). These domains are not discrete but form part of a continuous, interacting system. Within this metaphor, relapse functions like the moon influencing the tides. When the moon rises, representing a relapse event, it exerts a gravitational pull across the entire ocean. Waves form across all three domains simultaneously, reflecting how relapse rarely affects only one aspect of recovery. Psychological wellbeing, social relationships, and structural conditions often shift together, although the magnitude and direction of change may vary. Importantly, each tidal movement

carries potential gains as well as losses. Relapse may erode recovery capital through increased shame, strained relationships, or reduced access to services. At the same time, it may generate insight, relational honesty, renewed engagement with support, or clearer understanding of recovery needs. These effects are not necessarily uniform: an individual might experience increased personal insight and strengthened social support while simultaneously facing structural exclusion, such as loss of housing or service access. Conversely, community re-engagement may occur alongside ongoing personal distress. This analogy also highlights temporality. Just as tides ebb and flow, the influence of relapse evolves over time. Immediate impacts may differ from longer-term consequences, and subsequent experiences can reshape how earlier relapse events are interpreted. Recovery therefore becomes a process of ongoing adjustment within a dynamic relational environment rather than a linear progression toward stability. Recognizing relapse in this way does not minimize the significant risks associated with renewed substance use, including overdose, health deterioration, social exclusion, and psychological distress. Rather, the relapse capital model encourages a more compassionate, developmentally informed understanding that acknowledges both vulnerability and potential growth. It invites clinicians, researchers, and policymakers to consider not only how relapse occurs, but also how responses to relapse influence whether recovery resources are diminished or strengthened.

Importantly, this analogy is not intended to suggest that relapse is inherently beneficial or that individuals should adopt a “wait and see” approach toward renewed substance use. The effects of relapse on recovery capital are often only fully understood retrospectively, as their meaning and consequences unfold over time within specific relational and structural contexts. In the immediate term, relapse may involve substantial risks, including overdose, psychological distress, interpersonal harm, housing instability, or

disengagement from support. Consequently, relapse prevention and harm reduction remain critically important. Rather than encouraging relapse experimentation, the relapse capital model is intended to guide more compassionate and recovery-oriented responses when relapse occurs. From this perspective, the central question becomes not only whether relapse has happened, but also how personal, social, and community recovery resources can be protected, restored, or strengthened in its aftermath.

Ultimately, viewing relapse as a tidal force within a broader recovery ocean underscores the importance of relational, social, and structural contexts in shaping recovery trajectories. It shifts attention away from individual blame toward a systems-oriented perspective that recognizes recovery as an evolving, contextual, and relational process.

Where to Go from Here? Implications for Practice, Research & Policy

Conceptualizing relapse through the lens of relapse capital offers a shift in how relapse is understood, responded to, and studied within addiction science and practice. Rather than positioning relapse solely as a failure of individual coping or motivation, this perspective foregrounds the dynamic interplay between personal, relational, and structural resources. Recognizing that relapse may simultaneously diminish and generate recovery capital opens space for more compassionate, context-sensitive, and recovery-oriented approaches across clinical practice, service development, research, and policy.

Implications for Clinical Practice

For clinicians, adopting a relapse capital perspective encourages responses that are compassionate rather than punitive. Traditional models of relapse prevention have often emphasized risk management, coping skills, and behavioral control (Marlatt & Donovan,

2005). While these remain important, framing relapse exclusively as an individual's failed attempt at navigating triggers can inadvertently contribute to shame, self-stigma, disengagement from services, and reduced self-efficacy among people in recovery. Clinical work may therefore benefit from explicitly addressing internalized shame and self-stigmatizing beliefs that emerge following relapse experiences. Clinicians may help address this through interventions that promote self-compassion, cognitive reframing, and recovery-oriented identity development. For example, Compassion-Focused Therapy (Gilbert, 2010) may support clients in understanding shame responses as understandable reactions to adversity rather than evidence of personal failure. Narrative and systemic-oriented approaches may also help individuals re-author relapse experiences as part of a broader and non-linear recovery journey, reducing self-blame while strengthening hope, agency, and engagement with support (Luoma et al., 2008).

Viewing relapse as part of a broader recovery trajectory allows clinicians to acknowledge both the risks and the potential learning embedded within relapse experiences. This shift also supports more nuanced clinical formulation. Instead of focusing solely on internal psychological vulnerabilities, clinicians can consider how relational contexts, social networks, and structural conditions influence relapse trajectories. For example, interpersonal conflict, stigma, housing instability, or barriers to accessing care may play significant roles in relapse experiences. Recognizing these factors helps move beyond individual blame toward shared responsibility and collaborative care planning. Importantly, a relapse capital perspective highlights opportunities for intervention at multiple levels. Clinical work may involve strengthening personal coping skills, facilitating relational repair, supporting social network restructuring, or advocating for improved access to community resources. Such approaches align closely with trauma-informed and recovery-oriented care principles, which emphasize safety, empowerment, connection, and contextual understanding.

At the service level, conceptualizing relapse through relapse capital encourages the development of systems that prioritize inclusion, continuity, and relational support rather than exclusion or conditional access. Some services continue to operate abstinence-contingent models in which relapse may lead to discharge, loss of housing, or reduced access to support. While often motivated by safety concerns, these responses can inadvertently weaken recovery capital by increasing stigma, destabilizing housing, or disrupting therapeutic relationships. A relapse capital framework instead supports recovery-oriented systems that maintain engagement following relapse. This includes flexible service models, peer-led recovery supports, community-based initiatives, and integrated care pathways that recognize recovery as a long-term, non-linear process. Peer recovery communities, in particular, may play a crucial role in helping individuals reinterpret relapse as part of ongoing recovery rather than definitive failure.

The framework also highlights the importance of community resources and social inclusion. Employment opportunities, stable housing, education, meaningful social roles, and access to cultural and recreational activities all contribute to recovery capital. Service development that attends to these broader determinants of wellbeing may help reduce relapse risk while supporting sustainable recovery trajectories. Continuity of care is another critical implication. Recovery rarely unfolds within discrete treatment episodes; rather, it involves ongoing negotiation of challenges over time. Services that remain accessible following relapse — rather than withdrawing support — are more likely to facilitate long-term engagement and stability.

Implications for Research

For researchers, the relapse capital model offers a conceptual framework extending beyond traditional outcome measures focused primarily on relapse prevention. While prevention remains important in some contexts, it may not fully capture the relational, social, and structural dynamics shaping relapse within recovery — and recovery within relapse. Studying relapse through a capital lens invites consideration of how personal insight, social relationships, community participation, and structural opportunities evolve alongside substance use patterns. This perspective encourages longitudinal and ecological research designs that track trajectories over time rather than relying solely on cross-sectional snapshots. Such approaches better capture fluctuations, turning points, and contextual influences shaping relapse experiences, aligning with calls in addiction science to understand recovery as a developmental process rather than a singular endpoint. Integrating psychological, social, and structural factors can also support more interdisciplinary research. Collaboration across clinical psychology, public health, digital health, social work, and policy may generate richer understandings of recovery processes. Mixed-methods and participatory designs, particularly involving people with lived experience as co-researchers, are especially valuable in capturing relapse capital’s complexity.

Implications for Policy

At the policy level, a relapse capital perspective highlights how relapse is often only marginally addressed within national drug strategies and treatment policies. When mentioned, it is typically framed as treatment failure or individual setback rather than as a common feature of substance use trajectories. Such framings risk reinforcing stigma, narrowing service responses, and prioritizing risk management over sustained engagement. Recognizing relapse as a multidimensional phenomenon, shaped by personal, relational, and structural factors, encourages policy approaches that move beyond deficit-oriented narratives. This

perspective underscores the importance of maintaining continuity of care following relapse rather than restricting service access. Structural factors such as housing, employment, social inclusion, and accessible healthcare significantly influence relapse vulnerability and recovery stability, yet these determinants remain insufficiently integrated into policy responses. Supporting peer-led initiatives, community-based services, and digital supports may strengthen relapse and recovery capital by promoting ongoing engagement rather than episodic treatment. Reframing relapse in policy discourse recognizes that it does not simply signal clinical failure but may reflect wider social and systemic conditions affecting wellbeing. Aligning drug policy with public mental health principles, including prevention, inclusion, harm reduction, and long-term support, may foster more responsive systems that acknowledge non-linear recovery trajectories while reducing stigma and improving access to care.

Conclusion

Relapse into substance use is neither simply a failure nor inherently beneficial; rather, it represents a complex, relationally embedded process within longer-term recovery trajectories. Dominant clinical and policy discourses have often positioned relapse primarily as an endpoint of unsuccessful treatment, yet lived experiences and emerging research suggest a more nuanced reality. By extending recovery capital theory to explicitly include relapse experiences, the concept of *relapse capital* offers a more clinically realistic and compassionate framework for understanding addiction recovery. Recognizing relapse as part of an evolving recovery journey, while fully acknowledging the significant risks associated with renewed substance use, may support more humane and effective responses across clinical practice, services, and policy. This perspective shifts attention from individual blame toward relational, social, and structural conditions that shape recovery possibilities. In doing

so, it challenges stigma, supports sustained engagement with care, and highlights opportunities for learning, resource development, and renewed connection.

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Declaration of Interest

The author reports there is no competing interest to declare.

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Table 1. Relapse Capital Indicators

	Positive Relapse Capital (Resource Building)	Negative Relapse Capital (Resource Erosion)
Personal	<ul style="list-style-type: none"> • Reflective learning experience following relapse • Increased personal insight and self-understanding • Strengthening of identity development in recovery • Enhanced self-efficacy and confidence in coping • Greater awareness of triggers and vulnerability factors • Improved understanding of coping needs and recovery priorities • Renewed motivation for recovery engagement • Potential for psychological growth and resilience development 	<ul style="list-style-type: none"> • Continued substance use without reflective learning • Reduced concern about consequences of use • Internalized shame and self-stigma • Erosion of self-efficacy and confidence in recovery • Reinforcement of negative identity narratives • Increased social isolation and withdrawal • Feelings of hopelessness or discouragement • Disengagement from recovery supports or services
Social	<ul style="list-style-type: none"> • Reassessment of relationships and social environments following relapse • Potential restructuring toward healthier social networks • Increased help-seeking and openness to support • Greater relational honesty and communication • Strengthening of supportive social connections • Opportunities to build relational recovery capital through compassionate responses 	<ul style="list-style-type: none"> • Social environments that normalize heavy or polysubstance use • Interpersonal conflict or relational strain following relapse • Experiences of stigma, judgement, or rejection • Weakening of recovery-supportive social networks • Reinforcement of substance-using identities • Increased social isolation or marginalization • Reduced willingness to seek support or disclose struggles
Community	<ul style="list-style-type: none"> • Engagement with new recovery resources following relapse • Increased access to services or therapeutic support • Connection with peer recovery groups or community initiatives • Greater awareness of available recovery infrastructure • Development of more sustained engagement with support systems 	<ul style="list-style-type: none"> • Limited access to recovery services or support resources • Punitive or exclusionary responses following relapse (e.g., removal from recovery housing) • Experiences of stigma within service systems • Structural barriers such as poverty, housing instability, or unemployment • Disruption of recovery stability and continuity of care

		<ul style="list-style-type: none">• Increased risk of disengagement from services or community support
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