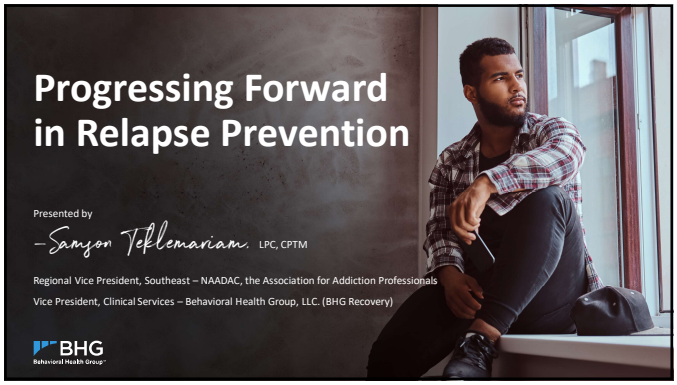
Progressing Forward in Relapse Prevention
Presented by
– Samson Teklemariam, LPC, CPTM
Regional Vice President, Southeast – NAADAC, the Association for Addiction Professionals
Vice President, Clinical Services – Behavioral Health Group, LLC. (BHG Recovery)
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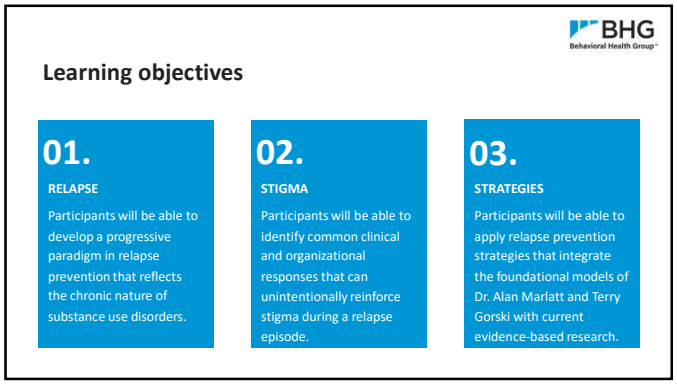
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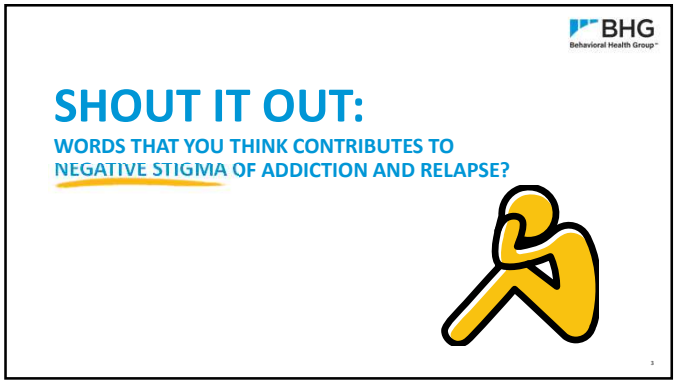
Learning objectives
01.
RELAPSE
Participants will be able to develop a progressive paradigm in relapse prevention that reflects the chronic nature of substance use disorders.
02.
STIGMA
Participants will be able to identify common clinical and organizational responses that can unintentionally reinforce stigma during a relapse episode.
03.
STRATEGIES
Participants will be able to apply relapse prevention strategies that integrate the foundational models of Dr. Alan Marlatt and Terry Gorski with current evidence-based research.

2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SHOUT IT OUT:
WORDS THAT YOU THINK CONTRIBUTES TO NEGATIVE STIGMA OF ADDICTION AND RELAPSE?

3

Relapse

Photo by Alex Green on Pexels

WORD ASSOCIATION

- Recurrence
- Remission
- Fall back
- Lapse
- Recidivate
- Regress
- Abstinence violation
- Sobriety break
- Fail
- Relapse
- Return to use

4

4

PROGRESSIVE PARADIGM IN RELAPSE PREVENTION

Words matter

Substance Use Disorder

- SUD/OUD/Addiction is most often defined as a chronic illness involving a common repeated cycle of abstinence and **relapse**.

Relapse

- Relapse refers to a return to a previous level of substance use after a period of considerable reduction or abstinence from substance use.

Alternative Relapse Definitions

- **Recurrence** of a condition that was previously overcome
- When **a person stops** maintaining his or her goal of reducing or avoiding use of alcohol or other drugs

Moe, F. D., Moltu, C., McKay, J. R., Nesvåg, S., & Bjornestad, J. (2022). Is the relapse concept in studies of substance use disorders a 'one size fits all' concept? A systematic review of relapse operationalizations. Drug and Alcohol Review, 41(4), 743-758.

5

5

PROGRESSIVE PARADIGM IN RELAPSE PREVENTION

Words matter

And yet, in a recent review of SUD/Relapse-related studies 32% of studies had no definition of 'relapse' and where relapse is defined, it is according to:

- Measure (26%)
- Time (17%)
- Use (26%)
- Amount/frequency (27%)

Inconsistent language use:

- Sobriety
- Abstinence
- Relapse
- Recurrence
- Remission
- # of days/months/years?
- Safety, reduction of harmful use?
- Less risky ROA?
- Decreased negative symptoms (i.e. feeling better)

Bjornestad J, McKay JR, Berg H, Moltu C, Nesvåg S (2020). How often are outcomes other than change in substance use measured? A systematic review of outcome measures in contemporary randomized controlled trials. Drug Alcohol Rev;39:394–414.

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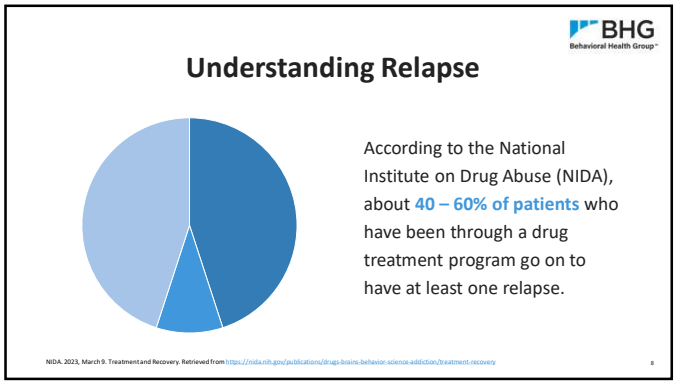
Top 5 Most Common Myths about Relapse
1. ~~Preventing relapse is all about willpower~~
2. ~~Hitting rock bottom is a pre-requisite for sobriety~~
3. ~~If sobriety isn't your ultimate goal, you aren't in recovery~~
4. ~~Relapse is a failure~~
5. ~~Medication-Assisted Treatment is not really recovery~~
Photo by Luis Quintero on Pexels
7

7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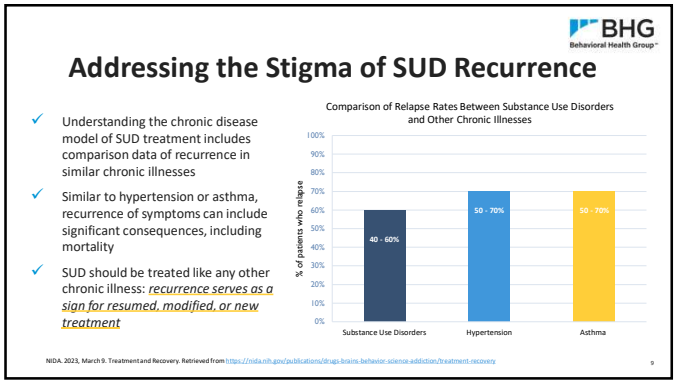
Understanding Relapse
According to the National Institute on Drug Abuse (NIDA), about 40 – 60% of patients who have been through a drug treatment program go on to have at least one relapse.
NIDA. 2023, March 9. Treatment and Recovery. Retrieved from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery
8

8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Addressing the Stigma of SUD Recurrence
✓ Understanding the chronic disease model of SUD treatment includes comparison data of recurrence in similar chronic illnesses
✓ Similar to hypertension or asthma, recurrence of symptoms can include significant consequences, including mortality
✓ SUD should be treated like any other chronic illness: recurrence serves as a sign for resumed, modified, or new treatment
Comparison of Relapse Rates Between Substance Use Disorders and Other Chronic Illnesses
% of patients who relapse
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
40 - 60%
50 - 70%
50 - 70%
Substance Use Disorders
Hypertension
Asthma
NIDA. 2023, March 9. Treatment and Recovery. Retrieved from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery
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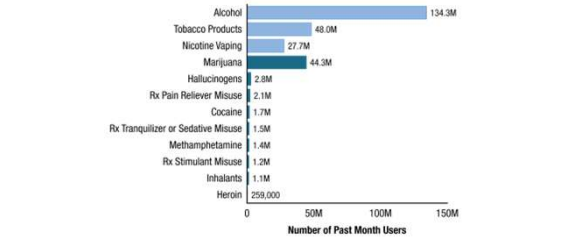
Past Month Substance Use: Among People Aged 12 or Older; 2024

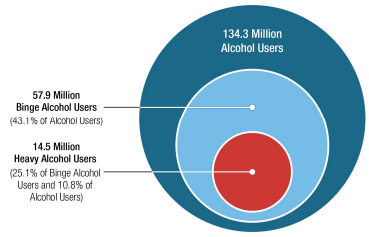


Rx = prescription.
Note: The estimated numbers of current users of different substances are not mutually exclusive because people could have used more than one type of substance in the past month.

Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report

10

Alcohol Use, Binge Alcohol Use, or Heavy Alcohol Use: In the Past Month: Among People aged 12 or Older; 2024



Note: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as binge drinking on the same occasion on 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report

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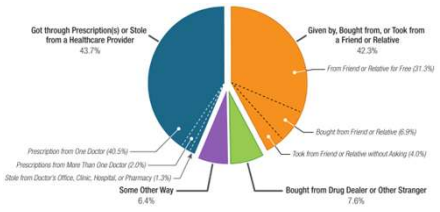
Source Where Prescription Pain Relievers Were Obtained for Most Recent Misuse: Among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year; 2024



8.0 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: The percentages for the subdivisions may not add to the percentage for the whole division due to rounding.
Note: Respondents with unknown data for the Source for Most Recent Misuse or who reported Some Other Way but did not specify a valid way were excluded.

Substance Abuse and Mental Health Services Administration. (2025). Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
https://www.samhsa.gov/data/report/2024-nsduh-annual-national-report

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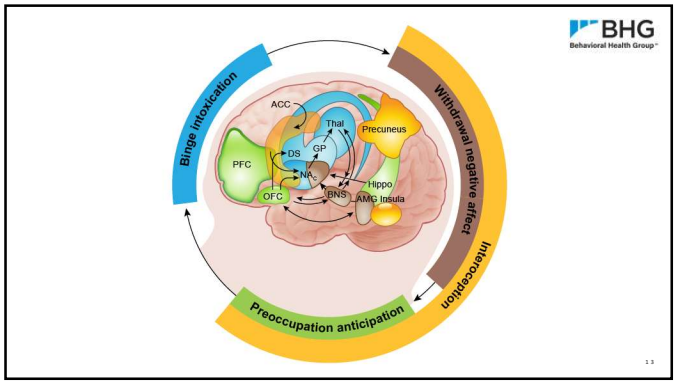
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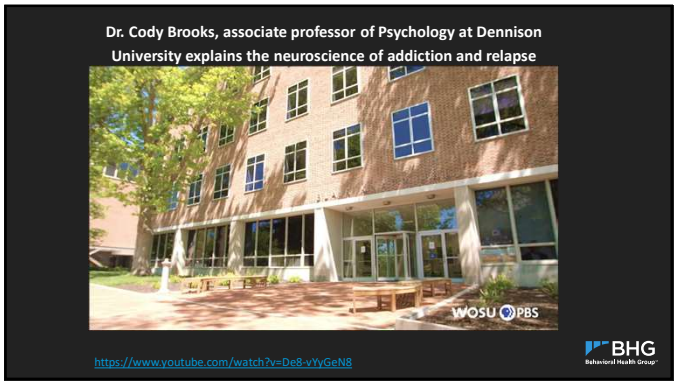
Binge intoxication
Withdrawal negative affect
Preoccupation anticipation
Intoxication
ACC
Thal
Precuneus
GP
DS
PFC
NAc
Hippo
OFC
BNST
AMG
Insula

13


Dr. Cody Brooks, associate professor of Psychology at Dennison University explains the neuroscience of addiction and relapse
WOSU PBS
https://www.youtube.com/watch?v=De8-vYyGeN8
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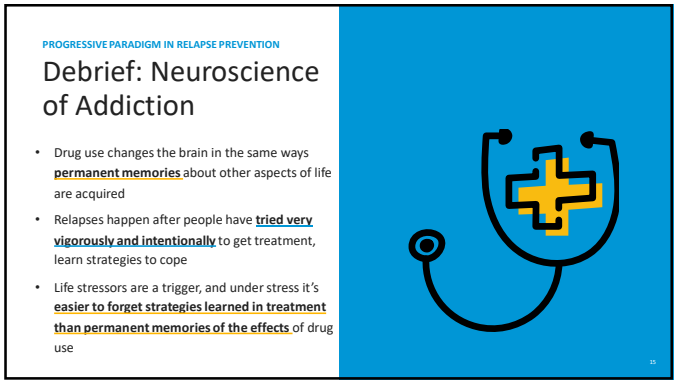
PROGRESSIVE PARADIGM IN RELAPSE PREVENTION
Debrief: Neuroscience of Addiction
• Drug use changes the brain in the same ways permanent memories about other aspects of life are acquired
• Relapses happen after people have tried very vigorously and intentionally to get treatment, learn strategies to cope
• Life stressors are a trigger, and under stress it's easier to forget strategies learned in treatment than permanent memories of the effects of drug use

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DEALING WITH STIGMA: WHAT THOSE WITH SUDS USUALLY GET

- Disappointment
- Frustration
- Sorrow/grief
- Shame/guilt
- Loss of control
- Have to start over again
- Lost a phase
- Lost privileges
- Lost rights
- No more medications
- Restricted access to medications

DEALING WITH STIGMA: WHAT THOSE WITH SUDS NEED

- ✓ Compassion / Support / Guidance
- ✓ Evidence-Based Treatment
- ✓ Affirming responses
- ✓ Normalization (*isn't this an expected part of recovery?*)
- ✓ Validation (*if they are in front of you, then they are already on the right track*)
- ✓ Objective discussion on the risks of continued use and individualized treatment

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Understanding Stigma and Bias with SUDs

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- Everyone has experiences, beliefs, and messages that shape how they view people with SUDs.
- Stigma can be conscious or unconscious, coming from personal experiences, media, or societal narratives.
- Awareness of our own "blind spots" is essential to fair and effective care.
- Bias can shape attitudes, language, and responses to people with SUD which also shapes perceived safety and availability for help / rehabilitation.

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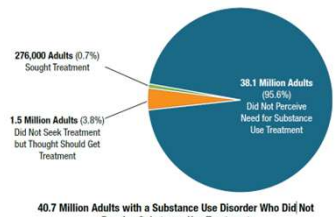
Impact of Stigma and Unmet Need for Treatment

- Most with SUD do not perceive a need for treatment – 95.6% of adults with SUD in 2024 did not seek treatment because they didn't think they needed it
- Common reasons for not seeking help:
  1. Belief they could handle it themselves (75.5%)
  2. Not ready to start treatment (65%)
  3. Not ready to stop or cut back (59.5%)

Figure 73. Perceptions of Need for Substance Use Treatment: Among Adults Aged 18 or Older with a Past Year Substance Use Disorder Who Did Not Receive Substance Use Treatment in the Past Year; 2024



40.7 Million Adults with a Substance Use Disorder Who Did Not Receive Substance Use Treatment

Note: The percentages may not add to 100 percent due to rounding.

Note: Adults with unknown information for perceptions of need for substance use treatment were excluded; therefore, the sum of the interior pieces does not add to the whole.

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What we know about Relapse: From Research to Practice

HIGHLIGHTS FROM THE LAST 10 YEARS OF RESEARCH

- Younger patients are at increased risk of relapse
- Having a co-occurring disorder is associated with elevated risk of relapse
- Having completed inpatient stay is associated with reduced relapse risk
- Transitioning from inpatient to IOP/PHP or from withdrawal detox to OTP/IOP is associated with reduced relapse risk
- Overall risk of relapse is related to **characteristics of treatment sites**

CHARACTERISTICS OF TREATMENT SITES FOR SUCCESSFUL RELAPSE PREVENTION

Historically, research showed that longer time in treatment is related to better outcomes.
Current studies, however, show:

- ✓ Level of activity/involvement in treatment
- ✓ Greater service intensity (frequency of encounters w/ treatment team members)
- ✓ Success planning includes additional recovery initiatives outside of formal treatment environment
- ✓ Integration of housing and employment support

Bjornestad J, McKay JR, Berg H, Moltu C, Nesvåg S (2020). How often are outcomes other than change in substance use measured? A systematic review of outcome measures in contemporary randomized controlled trials. Drug Alcohol Rev;39:394–414.

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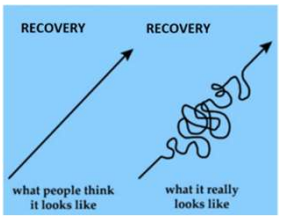
Recognize Recovery as Nonlinear

*"A process of change through which individuals **improve their health and wellness**, live a **self-directed life**, and **strive to reach their full potential**."*

- Recognize that all substance use is not addiction
- SUDs exist on a spectrum (mild, moderate, and severe)
- Remission from SUD is characterized by the absence of diagnostic criteria, not the absence of substance use
- There are MANY paths to recovery
- Abstinence from substances is often is the ideal outcome, but not the only outcome



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Dr. Alan Marlatt

Normalizing conversations around relapse

- ✓ Lots of focus on the ***why*** (***why*** those with SUDs shouldn't return to SU)
- ✓ Exploring feelings / understanding the root cause

Still a return to use?

- *You talked with me a lot about why I shouldn't use*
- *But never taught me how*

- ✓ Relapse happens a lot, but nobody seems to be talking about it
- ✓ How can they be prepared without being prepared?

https://www.youtube.com/watch?v=mH4Rp7yVEfY&t=9s

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Two **Foundational** Relapse Prevention Models

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GORSKI'S EARLY WARNING SIGN MODEL

- ✓ Stress
- ✓ Denial
- ✓ Internal dysfunction
- ✓ External dysfunction
- ✓ Option reduction
- ✓ Relapse

MARLATT'S CBT DRIVEN MODEL

- High Risk Situation
- Ineffective coping response
- Decreased self-efficacy and increased positive outcome expectancies
- Lapse (varies)
- Abstinence Violation Effect / belief in positive effects of use
- Relapse

Both models
are necessary to progress forward

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Adopting a Progressive Paradigm

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Understanding an Expected Norm:
RELAPSE IS A PART OF RECOVERY

LAPSE IN PATTERNS OF THINKING

- ✓ Justification
- ✓ Projection
- ✓ Disqualifying the positives
- ✓ Catastrophizing
- ✓ Hyper focusing on fear

LAPSE IN PATTERNS OF FEELINGS

- ✓ Not managing stress
- ✓ Unaddressed hopelessness
- ✓ Ruminating over anger
- ✓ Overconfidence
- ✓ Validating loneliness with isolation

LAPSE IN PATTERNS OF ACTION/BEHAVIOR

- ✓ Returning to a place where you used
- ✓ Speaking with a past dealer
- ✓ Maintaining unsafe relationships
- ✓ Avoiding support

WHAT ELSE?

- ✓ Not present
- ✓ How should I feel?
- ✓ How do people expect me to feel?
- ✓ How do I think I feel?
- ✓ Do I feel safe to feel?

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LEARNING FROM A LAPSE

- Drifting back to old patterns is not a recurrence, create alerts to STOP at the point of drift.
- If drift leads to a return to use, analyze the drift not the use.
- Center interventions on interrupting the lapse.
- Reestablish and affirm treatment success.
- Develop deeper awareness of the effects of lapse and lapse vulnerabilities.

Photo by Mental Health America (MHA) on Pexels

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Most Vital Evidence-Based Clinical Interventions
CBT Strategies for your Patients

A 2018 literature review of the most effective "relapse" prevention clinical interventions:

- ✓Identifying high risk situations
- ✓Seemingly irrelevant decisions (SIDs)
- ✓Covert antecedents
- ✓Functional Analysis (or, behavior chain)
- ✓Address immediate gratification using an objective decisional balance matrix
- ✓Re-incorporate SNAPs

Menon, J., & Kandasamy, A. (2018). Relapse prevention. Indian journal of psychiatry, 60(Suppl 4), S473. 25

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Most Vital Evidence-Based Clinical Interventions
CBT Strategies for your Patients: Individualize High Risk

	Risk Scenario	Risk to use?	How often does this scenario happen?	Total
	Score each scenario separately. Consider how risky each scenario is for you individually and then how often that scenario happens in your day-to-day life.	0 – No risk 1- Moderate risk 2 – High risk	0 – Rare to never 1 - Less than 1x / month 2 – More than 1x / month	
1.	Stressful workday.			
2.	Strong feelings.			
3.	Overly critical thoughts.			
4.	Interactions with someone who uses substances regularly.			
5.	Remembering painful events from past.			
6.	Overthinking about future challenges.			
7.	Arguments with friends / family / people.			
8.	Loneliness.			
9.	Social events.			
10.	Thoughts of abstinence (never use again)			

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Most Vital Evidence-Based Clinical Interventions
CBT Strategies for your Patients: Functional Analysis

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Reactive vs. Affirming Responses

4 Reactive responses

- x “Just give up, there’s no use in trying to change”
- x “I told you so,” or, “I knew you were going to relapse”
- x “You have to start all over again”
- x “You don’t deserve this medication”

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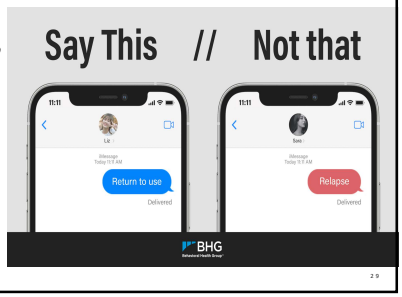
Reactive vs. Affirming Responses

4 Affirming responses

1. “I’m glad you survived, let’s get back to work”
2. “You are still present, what triggers caught you off guard and what triggers did you see coming”
3. “You’re getting better at recognizing lapses sooner, which means you are growing”
4. “Your upward spiral started when you showed up to treatment today”



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Are we assessing if this patient would benefit from MAT?

Discuss Treatment Options for Shared Decision-Making

Introducing MAT

1. "Have you ever heard of MAT?"
2. "Would you like additional support with managing withdrawal symptoms?"
3. "Reducing the severity of relapse is just as important as achieving sustained sobriety"

How do you discuss treatment options with your patients?

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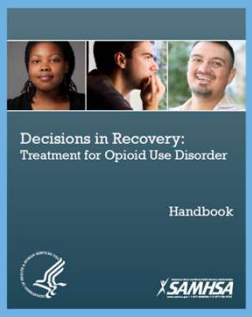
Be THAT Person

- ✓ Willing to ask the tough questions:
  - *"are you sure this current treatment model is still best for you?"*
  - *"have you spoken to a doctor recently about your overall health, including your recovery plan?"*
  - *"when was the last time you spoke to a qualified healthcare professional about medication?"*
- ✓ Willing to walk with someone in need to a referral partner:
  - *"let's explore alternative treatment options together"*
  - **Video Stories on the path of MATR**

https://www.youtube.com/playlist?list=PLBXgZMI_zqfTGp5CW6NTaIjIGUeXGCpxk



https://library.samhsa.gov/product/decisions-recovery-treatment-opioid-use-disorders/sma16-4993

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Additional Guided Discussion Questions:
"*If you return to use, here are a few safety considerations…*"

1. Quickly identify closest support for physical safety (E.R., 911, Sober Support, CBT Plan, Journal, Safe Family/Friend, etc.)
2. Schedule a session with your primary counselor/treatment provider
3. Assess your physical environment – will it enable recovery or promote continued use?
4. Remember **H.A.L.T.** in identifying/documenting your triggers (Hungry, Angry, Lonely, or Tired)
5. Reconsider treatment intensity/frequency

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QUESTIONS?

THANK YOU

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