weitzman institute

Translating Research into Practice on Alcohol and Polysubstance Use Disorders
by Educating the Interprofessional Primary Care Team

Welcome to Alcohol Use Disorder ECHO!

We will begin the session shortly.

*Please keep your microphones on **mute** for now to avoid background noise.*

You are muted if there is a line across your microphone icon.

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Welcome to Alcohol Use Disorder ECHO!

ECHO Session #10:
Preventing and Managing Relapse: A Comprehensive Approach

July 16, 2025

Technology: Your Zoom window

Sound

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Chat

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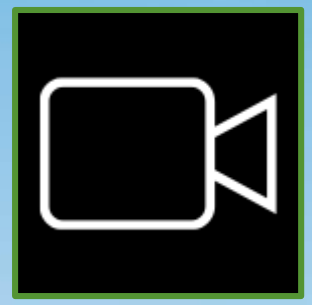

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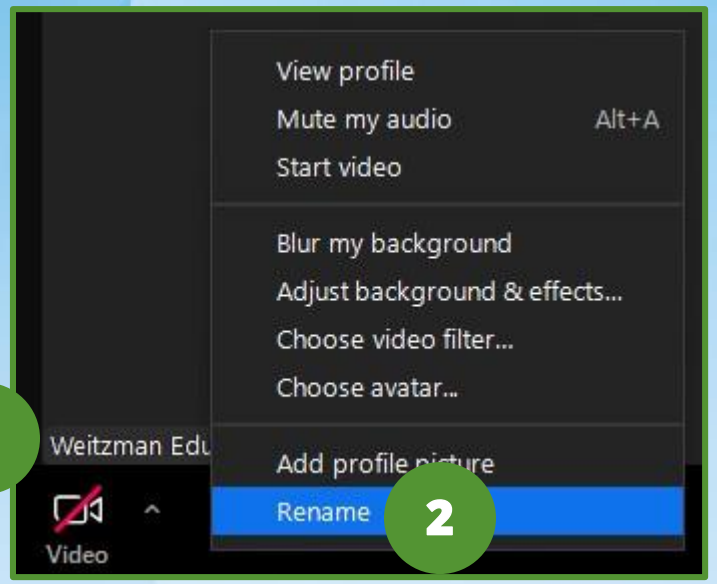
Technology: Your Zoom window, continued



Change your name

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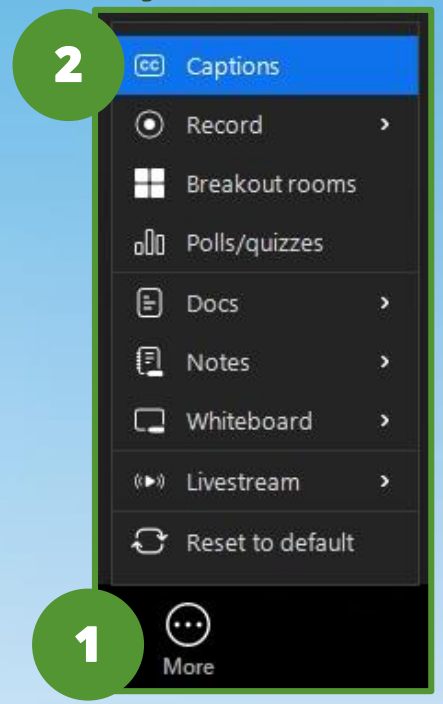
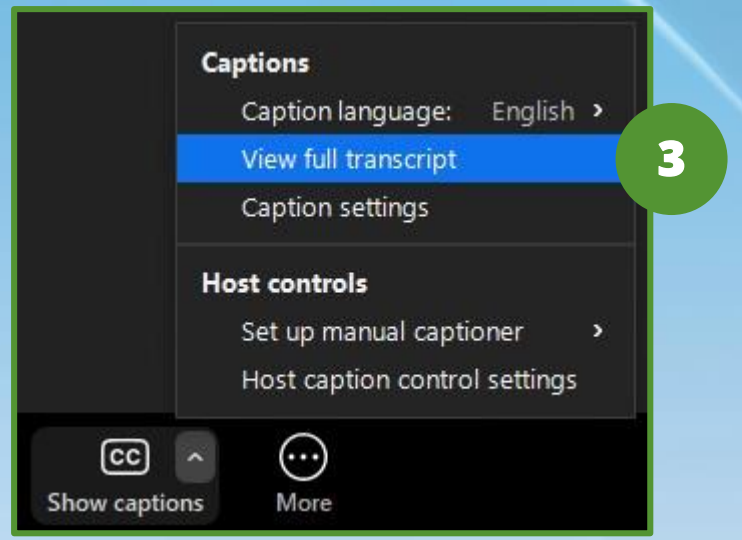
2. Select “Rename”.





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1. If “Show Captions” does not appear in the bottom toolbar, select “More”.
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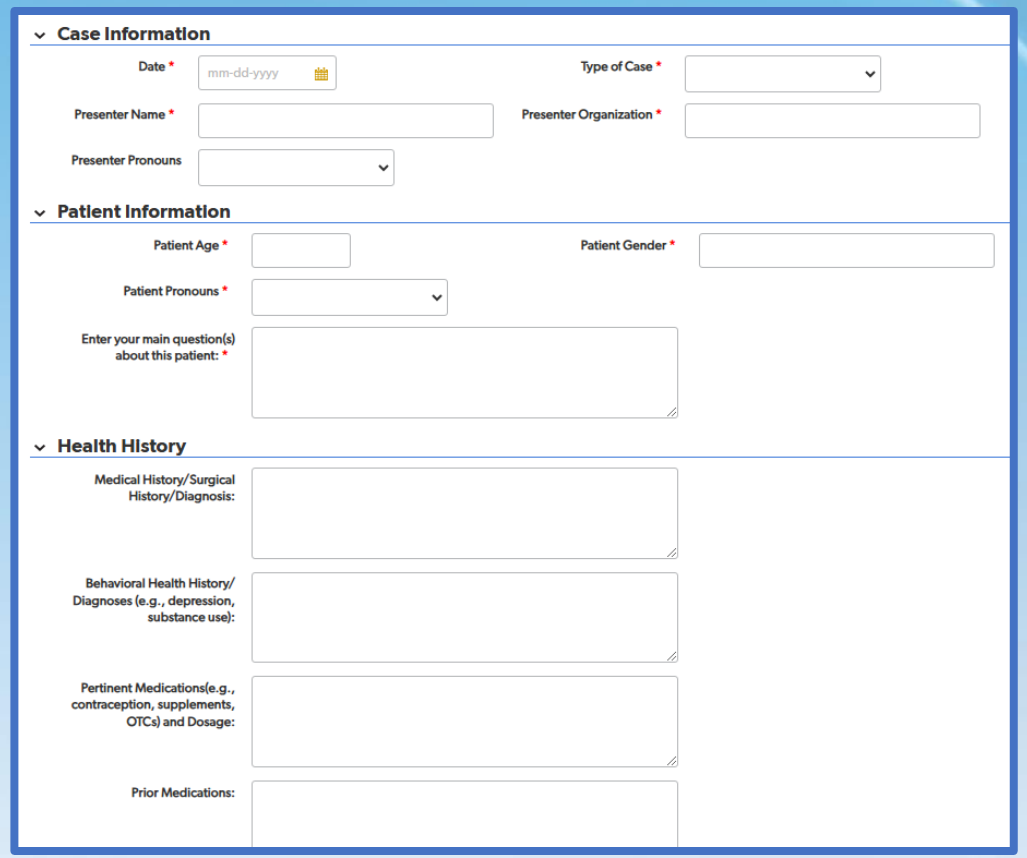
Important Program Logistics

- **Submitting a Case**
  - **What:** Any *alcohol use disorder* patient or client case that you find educational, challenging, or interesting!
  - **When**: Schedule ahead of time with Emma, warshae@mwhs1.com
  - **How:** Virtual Case Form sent to you via email
  - Do NOT include patient identifying information

Case Form



Case Information

Date * mm-dd-yyyy

Type of Case *

Presenter Name *

Presenter Organization *

Presenter Pronouns

Patient Information

Patient Age *

Patient Gender *

Patient Pronouns *

Enter your main question(s) about this patient: *

Health History

Medical History/Surgical History/Diagnosis:

Behavioral Health History/ Diagnoses (e.g., depression, substance use):

Pertinent Medications(e.g., contraception, supplements, OTCs) and Dosage:

Prior Medications:

Continuing Education Credits

In support of improving patient care, Moses Weitzman Health System is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This series is intended for primary care providers (MDs, DOs, NPs, PAs), behavioral health providers (psychiatrists, psychologists, social workers, therapists), nurses, and other members of the care team.

Please complete the survey and claim your post-session certificate on the WeP after today's session. **Please note: Pharmacists must claim credits within two weeks following today's session or we will not be able to award ACPE credits.**

You will be able to claim a comprehensive certificate on the WeP at the end of the series, October 1, 2025.

Accessing session recordings and materials

1. Navigate to the **Continue tab** of the activity site within the Weitzman Education Platform.
2. Select the **Session Recordings and Materials link**. This may appear at the bottom of the list of the individual sessions. After reviewing the FAQ's on the Overview tab, select the **Register tab**.
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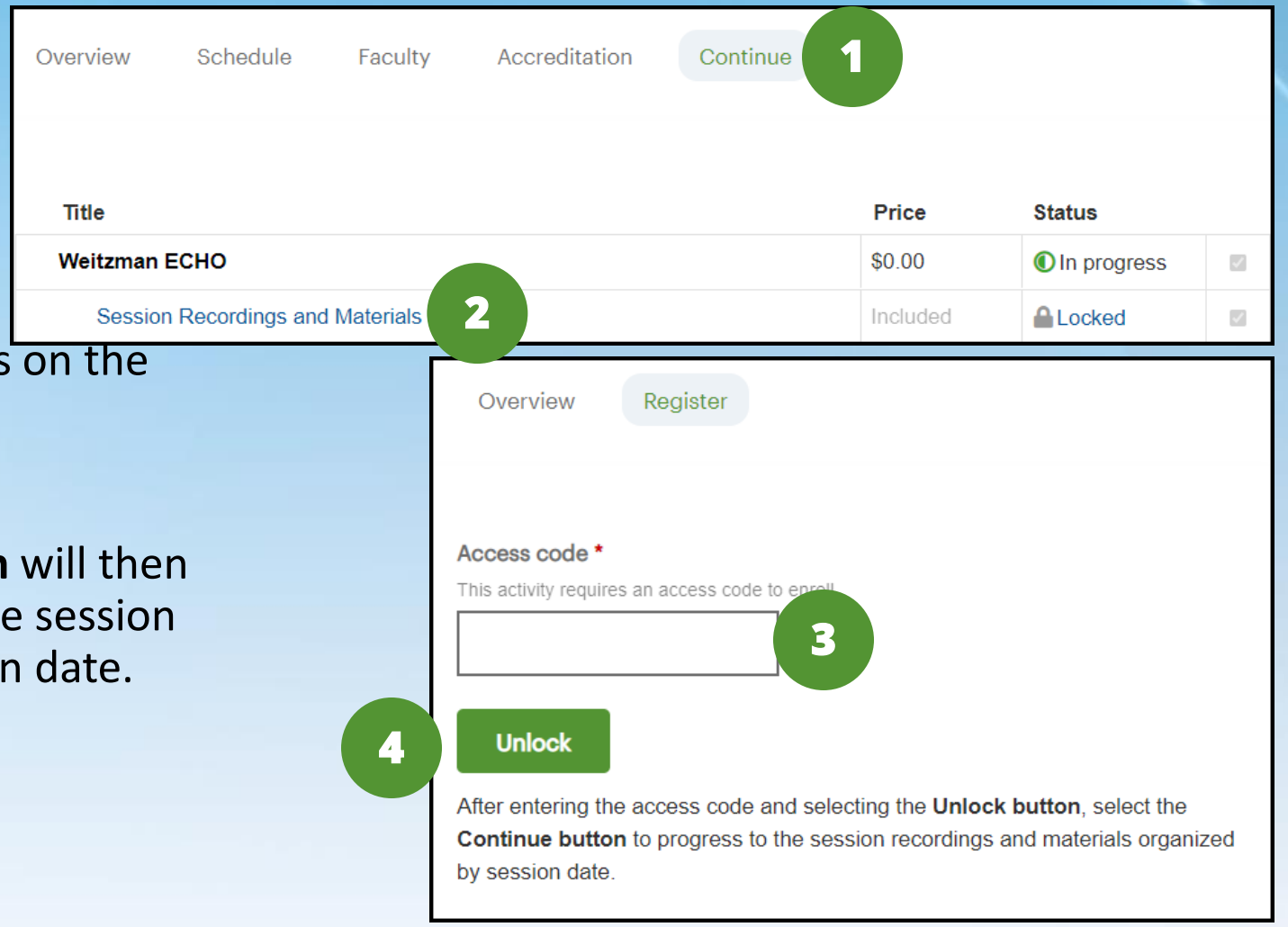
4. Select the **Unlock button**. A **Continue button** will then display and you will be able to progress to the session recordings and materials organized by session date.



This Weitzman ECHO has been made available by:

NIH R25 Alcohol and Other Substance Use Research Education Programs for Health Professionals

This project is supported by the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health under Award Number R25AA031951 to translate research into practice on preventing, screening for, and treating alcohol use disorders in primary care. The content is solely the responsibility of the Weitzman Institute and does not necessarily represent the official views of the National Institutes of Health.

Disclosures

With respect to this ECHO series, the following disclosure has been made:

- Dr. Carolyn Rekerdres, faculty for this ECHO series, is an independent consultant for Johnson & Johnson
- Dr. Carlos Tirado, faculty for this ECHO series, owns stock and has a grant or contract with Spark Biomedical

Speakers are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information presented, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion

The views expressed in this presentation are those of the presenter and may not reflect official policy of Moses/Weitzman Health System.

All disclosures of potential relevant financial relationships have been reviewed and mitigated through Moses/Weitzman Health System's accreditation review process.

All Are Welcome

Learning objectives

By the end of this session, participants will be able to…

1. Participants will be able to define Alcohol Use Disorder (AUD)
2. Participants will have a general understanding of what Relapse Prevention in AUD is.
3. Participants will understand the importance of Relapse Prevention
4. Participants will be able to define Recovery

A. Definition of AUD

"A problematic pattern of alcohol use leading to clinically significant impairment or distress."

a) DSM – 5 Criteria Review
   1. Mild – two or three symptoms
   2. Moderate – four or five symptoms
   3. Severe – six or more symptoms

   Alcohol Symptoms Checklist

b) Chronic remitting/relapsing nature of the disorder
   1. Involves cycles of remission and relapse, non-linear progression to recovery
   2. Influenced by complex biological, psychological, and social factors
   3. Often complicated by co-occurring conditions (both mental and physical)
   4. Alternations in brain chemistry and structure r/i problems w/reward and decision making, increased cravings, and reduced ability to control impulses. Even greater impact with family history, TBI, I/DD, and youth.

B. What is Relapse Prevention in AUD

Understanding the process, factors, predictors, and strategies.

Understanding Relapse in AUD

- What is a relapse vs. a lapse
  - Psychological and Behavioral Dimensions)
  - Lapse
    - Common in early recovery, such that it is almost to be expected
    - Sometimes referred to as a slip
    - Alcohol is consumed but quickly recommit to recovery
    - Triggers are often People, Places, and Things (associated with alcohol use)
    - Can feel like a setback, even when recovery is rapidly regained
    - Better to be viewed as a learning opportunity
  - Relapse
    - Persistent and prolonged use of alcohol and not reconnecting with recovery plan
    - Alcohol use typically escalates and psychological, health, social, occupational, and legal consequences may occur

"The nuances of lapse vs. relapse may be difficult to identify, but potentially important to build a path to recovery."

— Heather Bell & Kurt DeVine

Relapse Prevention Models

- Marlatt and Gordon Relapse Prevention Model

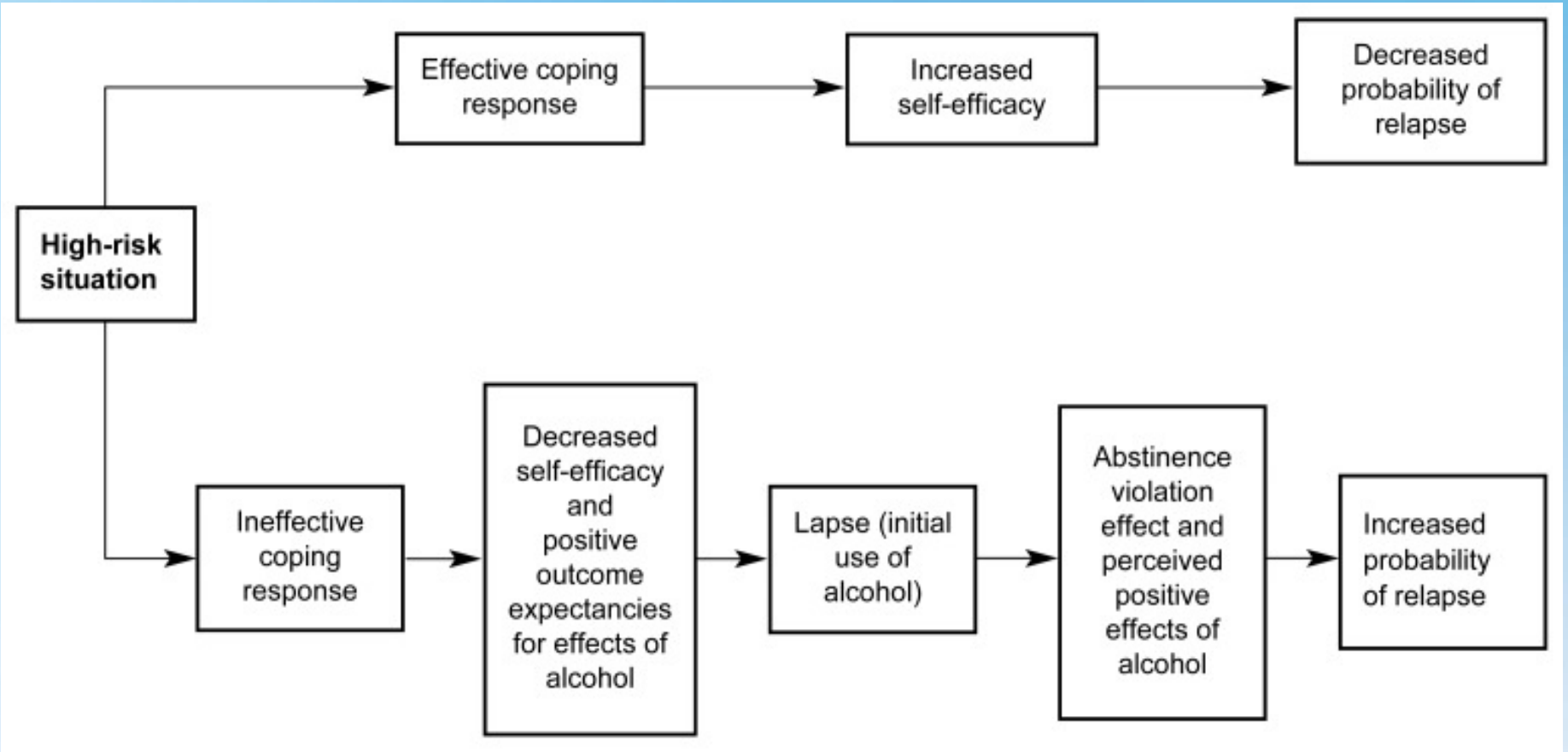
- Gorski – CENAPS Model

Marlatt's Relapse Prevention Model

- Marlatt and Gordon (1985)
- Based on social-cognitive psychology (A Bandura)
- Cognitive-behavioral model of relapse process
  - High risk situations and the drinker's response to those situations

Increased self efficacy	Decreased self efficacy
Effective coping responses Increased confidence of coping with the situations Reduces probability of relapse	Ineffective coping responses Expectation that alcohol will have a positive effect Abstinence Violation Effect -- Feelings of guilt and failure Increases probability of a relapse

The Cognitive-Behavioral Model of The Relapse Process



[Relapse prevention. An overview of Marlatt's cognitive-behavioral model]

Covert antecedents and immediate determinants of relapse intervention strategies

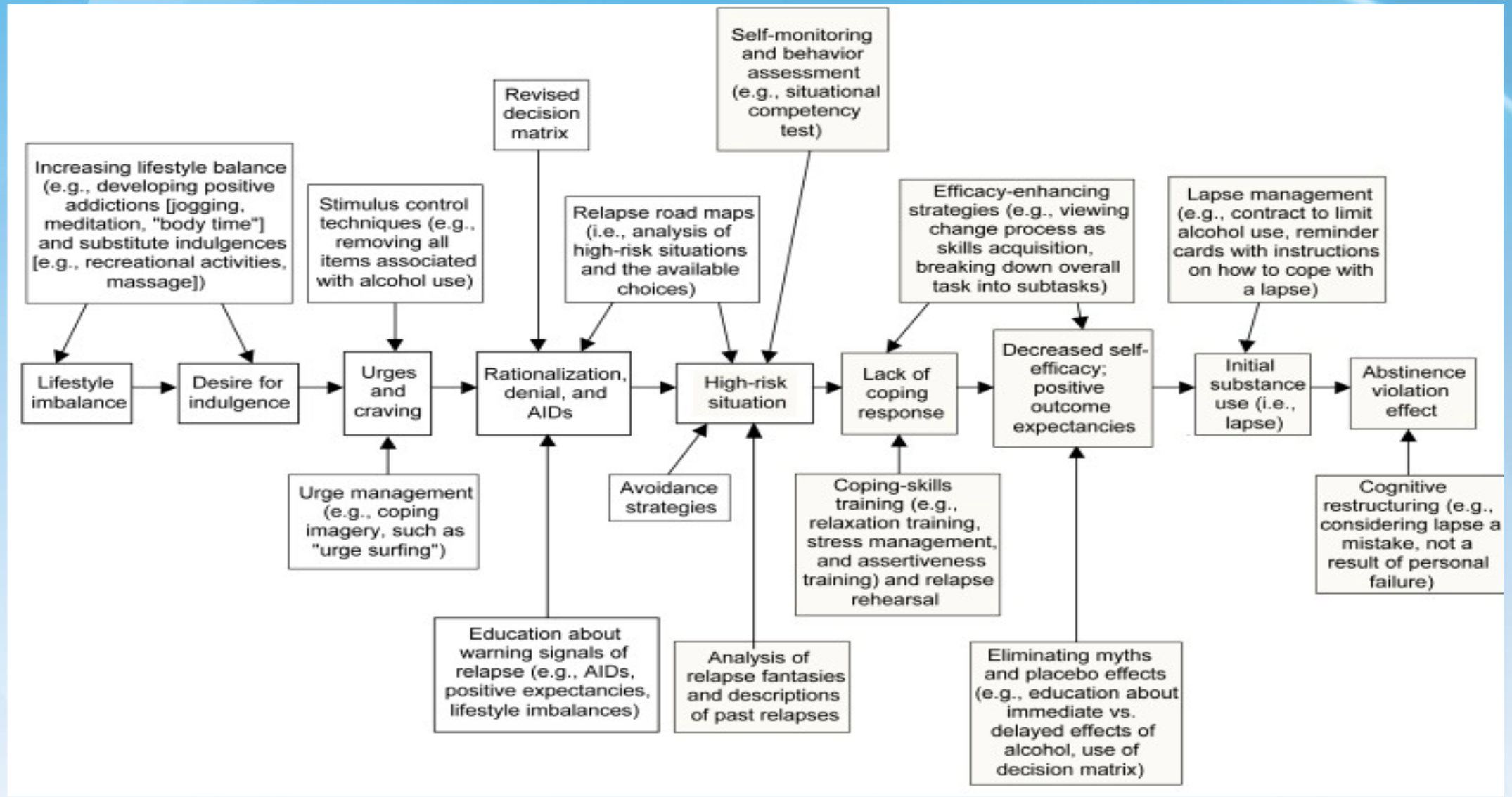
Goal: To identify and prevent or avoid determinants

- Lifestyle balance is an importance aspect of preventing relapse
  - If stressors are not balanced by sufficient stress management strategies
    - Greater likelihood of alcohol use in an attempt to gain relief/escape from stress
    - Results in a desire for indulgence – develops into cravings and urges
  - Cognitive mechanisms contribute to covert planning of relapse episode
    - Rationalization & Denial
    - Apparently Irrelevant Decisions (AIDs) –
      - Precipitate high-risk situations
      - High-risk situations are the central determinants of a relapse
    - Outcome expectancies - positive expectations regarding alcohol effects lead to

  - Behavioral outcomes resulting in progression to a full relapse
    - Initial alcohol use (lapse) induces an **abstinence violation effect**
      - **"I've already messed up, I might as well keep going."**

Intervention strategies

- Identify high risk situations
  - Self monitoring
  - Behavior assessment
  - Analyses of relapse fantasies
  - Descriptions of
- Patient specific intervention strategies
  - Skills and relaxation training
  - Relapse rehearsal
  - Cognitive restructuring
  - Stress management
  - Efficacy-enhancing imagery
  - Contracts to limit alcohol use
  - Reminder cards
  - past relapses


Increasing lifestyle balance (e.g., developing positive addictions [jogging, meditation, "body time"] and substitute indulgences [e.g., recreational activities, massage])
Stimulus control techniques (e.g., removing all items associated with alcohol use)
Revised decision matrix
Relapse road maps (i.e., analysis of high-risk situations and the available choices)
Self-monitoring and behavior assessment (e.g., situational competency test)
Efficacy-enhancing strategies (e.g., viewing change process as skills acquisition, breaking down overall task into subtasks)
Lapse management (e.g., contract to limit alcohol use, reminder cards with instructions on how to cope with a lapse)
Lifestyle imbalance
Desire for indulgence
Urges and craving
Rationalization, denial, and AIDs
High-risk situation
Lack of coping response
Decreased self-efficacy; positive outcome expectancies
Initial substance use (i.e., lapse)
Abstinence violation effect
Urge management (e.g., coping imagery, such as "urge surfing")
Avoidance strategies
Coping-skills training (e.g., relaxation training, stress management, and assertiveness training) and relapse rehearsal
Cognitive restructuring (e.g., considering lapse a mistake, not a result of personal failure)
Education about warning signals of relapse (e.g., AIDs, positive expectancies, lifestyle imbalances)
Analysis of relapse fantasies and descriptions of past relapses
Eliminating myths and placebo effects (e.g., education about immediate vs. delayed effects of alcohol, use of decision matrix)

Gorski – CENAPS Model

Six Developmental Stages

1. Transition
2. Stabilization
3. Early Recovery
4. Middle Recovery
5. Late Recovery
6. Maintenance

Nine Core Principles

1) Self-Regulation
2) Integration
3) Understanding
4) Self-Knowledge
5) Coping Skills
6) Change
7) Awareness
8) Responsibility
9) Maintenance

*CENAPS Model of Relapse Prevention

Self Regulation

- Goal: Develop healthy coping mechanisms and emotional regulation skills

- Recognizing and managing:
  - Emotions
  - Thoughts
  - Behaviors
- Managing stress, avoiding impulsive thoughts and behaviors, promoting emotional stability and using intrinsic resources (internal locus of control, ie. mindfulness) instead of extrinsic resources (alcohol, external locus of control)

Zoom Poll:

True or False:

A person with a history of alcohol use disorder who takes a sip of wine during Communion at Catholic Mass is **no longer** considered to be in recovery

Answer: False

Integration

- Goal: Achieve internal harmony and congruences in values, thoughts, and actions

- Involves Self-assessment – a detailed reconstruction of the problems that led to seeking treatment and the history
- Integrate the physical, psychological, social, and spiritual self into a healthy, functional whole.
- Repair the splits or conflicts that drive addiction.

Understanding

- Goal: Promote informed decision-making and self-awareness

- Psychoeducation about
  - Bio/psycho/social model of addiction
  - Developmental model of recovery – prioritizing problems
    - "Where do I start?" and then "What's next?"
  - Stuck points
  - Complicating factors
  - Effective recovery planning

Self Knowledge

- Goal: Foster self-awareness to anticipate and manage relapse warning signs

- Learning how to identify sequences that lead to relapse
  - Personal warning sign list – identify, initial review, analyze, finalized list
- Components –
  - irrational thoughts,
  - unmanageable feelings,
  - self defeating behaviors

Coping Skills

- Goal: Equip individuals with tools to deal with life without the use of substances

- Risk of relapse decreases as the ability to manage relapse warning signs increases
- Develop management strategies and skills
- Levels of management
  - Situational – avoid high risk situations
  - Cognitive/affective (thoughts/feelings) – challenge irrational thoughts and regulate previously unmanageable feelings
  - Core beliefs – identify and modify the deeply held beliefs that drive the dysfunctional thoughts and feelings

Change

- Goal: Commit to ongoing personal growth and lifestyle adjustments

- Develop a schedule of recovery activities
- Each critical re/lapse warning sign needs to be linked to a specific recovery activity

Awareness

- Goal: Maintain vigilance and self-monitoring to prevent automatic relapse behaviors

- Inventory taking to monitor adherence to recovery program
- Goal setting
- To-do lists
- Continuous reviewing

Significant Others

- Goal: Development of a supportive network of relationships who do not undermine the individual's recovery process.

- Recovery does not happen alone.
- Taking full responsibility for their actions and recovery process.
- Blaming of others or external circumstances undermines the recovery process.

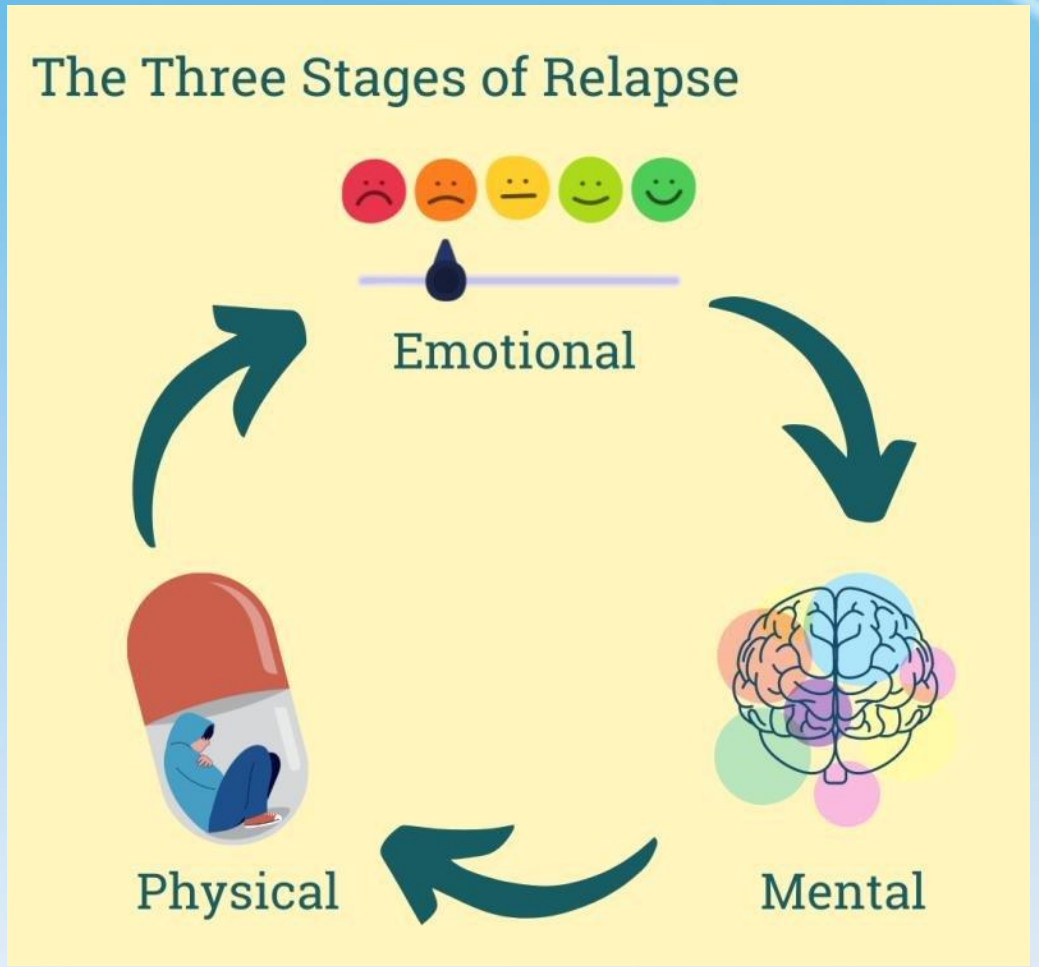
Maintenance

- Goal: Sustain recovery through regular self-care and structured support

- Recovery is a long-term process requiring ongoing maintenance which most often includes:
  - Ongoing therapy
  - Support group participation
  - Monitoring of relapse warning signs
    - Recommended schedule:
      - Monthly for first 3 months
      - Quarterly for 1 year
      - Semi-annually for 2 years
      - Annually after 3 years of uninterrupted sobriety

Relapse Process

- Stages of Relapse:
  - Emotional
  - Mental
  - Physical



Predictors of Relapse

- Individual Factors
- Social and Environmental Triggers
- Treatment Related Predictors

Individual Factors

- Co-occurring psychiatric disorders
  - Depression
  - Anxiety
  - PTSD
  - Thought disorders
- Behavioral
  - Impulsivity, poor coping skills, low self-efficacy
- Genetic predisposition

Social and Environmental Triggers

- Peer pressure or social drinking environmental
- Lack of supportive relationships
- High stress life events or trauma

Treatment Related Predictors

- Incomplete treatment engagement
- Poor adherence to aftercare plans
- Lack of pharmacologic support, when indicated

Early Intervention Strategies

- Identification of Warning Signs
- Immediate Interventions
- Behavioral Strategies
- Pharmacologic Support

Long Term Relapse Prevention

- Structured Recovery Plans
- Psychosocial Support
- Lifestyle Modification
- Technology Assisted Tools

Special Populations

- Dual Diagnosis Management
- Cultural and socio-economic factors in Relapse
- Gender specific relapse risks
- Age specific relapse risks

C. Why is Relapse Prevention Important

1. Relapse rates: ~40-60% relapse, even with treatment
   a) Only 7.9% of persons in US, age 12+ w/AUD, received some form of treatment
   b) Only 2% of 28.1 million with AUD in 2023 received MAT
      1) 2.7% mild AUD
      2) 6% with moderate AUD
      3) 20.7% with severe AUD

      Alcohol Treatment in the United States NSDUH (2023)

2. Normalizing relapse can reduce the urgency to prevent them from occurring.
   - Consequences of relapse
     - Health
     - Legal
     - Psychosocial

Other and Emerging Relapse Intervention Strategies

- DBT based intervention strategies
  - Chain Analyses
- Mindfulness Based Relapse Prevention
  - Incorporation of mindful awareness of triggers and reaction modulation
- Eye Movement Desensitization and Reprocessing
  - DeTUR Protocol (Desensitization of Triggers and Urge Reprocessing)
- Transtheoretical Model and Stages of Change

D. Definition of Recovery

1. Limitations on historical definitions
   a) Require abstinence from alcohol use
   b) Don't include DSM5 diagnostic criteria in recovery process
   c) No link to remission/cessation from heavy drinking and improvement in biopsychosocial/quality of life elements
   d) No distinction between alcohol and other drug use

2. NIAAA definition of Recovery

   "Recovery is a process through which an individual pursues both remission from alcohol use disorder and cessation from heavy drinking."

   A person may be considered *recovered* if both remission from AUD and cessation from heavy drinking are achieved and maintained over time.

   *NIAAA Recovery Research Definitions

Patient Information: Male (He/Him), 36 Years Old

Main Questions/Concerns:

1. This is a patient with schizophrenia and a very severe history of illness. During his first break of psychosis he was violent towards himself and several years ago he randomly punched a clinic worker due to thinking his AH were that person insulting him. His drinking has always been a way for him to manage his AH. He has failed Clozapine in the past due to noncompliance.

Medical Background:

Pertinent Medical History/Diagnoses:
36-year-old male with history of obesity. No liver enzyme changes (yet).

Psychiatric History:
- History of Schizophrenia and multiple suicide attempts in the past.

Past and Current Alcohol and Substance Use:
- Daily to every other day binge drinking of 1-2 bottles of wine that he purchases from grocery delivery so that his grandmother (who has dementia) doesn't know about it.
- When asked about positives of drinking he says that blacking out from drinking is the only thing that stops the voices.

Relevant Labs:
- Elevated Cholesterol
- Triglycerides
- A1c = 5.7

Medications:
- Was on Invenga Trinza maxed at 819mg-tried to switch to Uzedy 150mg monthly (4 months ago) but pt has not been as compliant
- Naltrexone 50 mg daily
- Gabapentin 400mg TID
- Topiramate 50mg qhs but this MD suspects that he skips all oral meds most days
- Benztropine 1mg qhs

Social/Cultural Factors:

Social History:
- Pt lives with his ailing grandmother and spends some time with his uncle.
- His father works long hours at a used car dealership and cannot care for the pt.
- His mother is an alcoholic and pt's drinking worsens when he visits her.
- Pt has done well in inpatient stays in the past and was completely stable on a 234mg Sustenna shot while in jail for about 6 months, but his drinking behaviors quickly escalated when he returned home and then his AH and severe paranoia returned. Pt's baseline has not gone back to that level since.

Stage of Change: Pre-contemplation

Prior and Current/Proposed Treatment Plan:
- Prior and Current Treatment Plan:
  - Pt was on the ACT team but was largely non-engaging with motivational strategies as it is hard for him to have insight into the fact that the neighbors are not really yelling at him.
  - Pt is not actively suicidal or homicidal at this time and does not meet criteria for any involuntary hospitalization. He has always refused inpatient rehab, will not work with a peer due to thinking they are calling him "a homosexual."

Thank You!

- The next ECHO session takes place on: Wednesday, August 6th at 12:00 PM EST/9:00 AM PST
- Please complete your session evaluation to claim your CME credit