



**CONTINUING EDUCATION (CE) COURSE MATERIAL**  
**Course No. CE1503 – Relapse and Burnout Prevention**

**COURSE OBJECTIVE**

An investigation and study of the dynamics of relapse in the process of recovery from chemical addiction and co-dependency. A discussion and study of the phenomenon of burn-out among counselors and others in the helping professions; and a study of those issues and concerns that surface when a recovering counselor becomes impaired.

**COURSE MATERIAL**

Recovery is a long-term process with a great many pitfalls, starts and stops. Staying stopped and enjoying a new sober life and lifestyle are what motivates continued recovery.

Relapse is not failure; it is part of the process.

Stopping smoking, losing weight, working out, exercising, wasting time, swearing, gambling, drinking, drugging ...  
unwanted behavior patterns and habits are difficult to break;  
new habits are hard to begin; some more than others.

Change is difficult. And, as Scott Peck says: "Life is difficult."

The difficulty of change cannot be an excuse, but the unreal expectation of perfection should not be allowed to keep someone from trying.

- ❑ 50% of all the HIGHLY MOTIVATED clients relapse in the first year.<sup>1</sup>
- ❑ 50-90% of treated individuals with addictive behaviors relapse. <sup>2</sup>
- ❑ Individuals with mental health problems and CD have a higher rate of relapse than the standard CD client <sup>3</sup>

**Results of Continued Relapse:**

- ❑ Clients, families, providers become pessimistic and burned out;
- ❑ Options disappear; Resources become exhausted;
- ❑ Providers (public and private) refuse services to conserve resources;
- ❑ The client faces distress, disability, discouragement and death.

**Relapse Defined:**

The recurrence of symptoms of a disease after improvement.

In CD: A single event (taking a drink, pill or fix) = lapse  
or a serial event ( a drinking or drugging binge) = relapse

With other Addictions: Reverting to old behaviors: placing a bet; eating some forbidden or fattening food; an inappropriate sexual liaison; working a ten- hour day; getting involved in a dysfunctional-abuse relationship, etc.

In DD: Re-hospitalization to psychiatric facility; legal system problems;

<sup>1</sup> BG Breining, Dr.AD, *Chemical Dependency and other Addictive Disorders – Workbook Five* (2000).

<sup>2</sup> Hunt, Barnett , *Journal of Clinical Psychology*, No. 27 (1971).

<sup>3</sup> Nace , *Journal of Alcoholism Studies*, No. 47 (1986).



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return of hallucinations; lowered mood rating; self-harm, etc.

Focusing on the "Event" and ignoring the factors that precipitated the "event" fails to credit the good that took place during recovery, and the lessons of comfort and value learned during the recovering time.

Relapse is a process, not an event. <sup>4</sup>

**Short-term Goal** = abstinence and emotional stability

**Long-term Goal** = Recovery: Resolution of difficulties and enhancement of lifestyle. A lifetime process that involves therapeutic experiences of a psychological, physiological, spiritual, and social nature.

A "**Lapse**" precedes "**Relapse**" (**Lapse = a fall from a higher to lower state**)

Moving downward / backward from AWARENESS of one's HIGHER state to the more familiar, secure EGO / STRIFE state of one's LOWER dimension or FORCE.

Going back to the more primitive self; the LOWER force of the under-developed EGO that requires quick and easy solutions

### **WHEN RELAPSE IS ALMOST INEVITABLE**

**When** the addict GIVES IN totally to the OLD SELF - THE LOWER SELF - the UNWORTHY self that has little value other than the ability to survive.

A lapse is a recurrence of pretreatment behaviors (stinkin' thinkin') and/or intensification of psychiatric or emotionally immature symptoms.

The continued use of old solutions in response to the lapse results in relapse. (Thinking errors, denial, blaming, criticizing, negativism, etc.) (Marlatt & Gordon)

Periodic crises, handled with new solutions and tools will not result in relapse; but relying on the old, failed ways will. Positive growth, in the face of crisis will cause baseline functioning to get better each time.

The recurrence of symptoms is an opportunity for learning, fine-tuning, breaking denial, progress, gaining humility, surrender, acceptance, hope.

**Positive activity:**

Social support: (90 in 90); "stick with the Winners"

Skills training: "how stay clean" "how avoid stress and anger"

Peer support: share feelings, listen to others

Avoiding places and persons that encourage use of chemicals

Avoid "HALT" (Hungry, Angry, Lonely, Tired)

Having fun without booze or drugs: picnics, ball games, parties, outings

AA, NA, Alanon, Recovery, Social clubs

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<sup>4</sup> T. Gorski, *Passages through Recovery*, Hazelden (1989).



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Volunteering to help others : 12-step list, sponsoring, making coffee  
Identify family and friends to turn to for encouragement : list  
Develop PRO-RECOVERY peer groups: stick your hand out  
Grieve the loss of "Old groups" : talk with others about this, don't go back

**Negative activity:**

Impulsive behavior in other areas of life; Negative emotional state;  
Stressful life events; Getting angry, depressed, anxious; HALT;  
Romanticizing or glamorizing use of drugs (positive expectations),  
Selective positive memory - Euphoric recall;  
Forgetting pain and negative consequences;  
Distorted thinking: excuse making; blaming; grandiosity; uniqueness Isolation and loneliness;  
Peer pressure; fighting; Interpersonal conflict

**Tools to use:**

"Failsafe Cards" "failsafe planning": what triggers of past have resulted in relapse?-what behaviors will short-circuit the relapse? - the more specific, the more helpful- (3x5 cards);

Contracts with penalties and REWARDS; ritualistic contract review; client self-rating of chances of success;

"Just-in-case fire-drill" plan;

Random urine monitoring;

**Relapse protocol:**

Explicit procedures in response to a relapse- loss of privileges, but chance to earn them back after completing a series of relapse exercises:

- A) Write out or tape:
  - 1) What triggered relapse?
  - 2) What happened when you relapsed?
  - 3) How are you responsible?
  - 4) What could you have done differently?
  - 5) What will you do differently next time?
  - 6) Why should you forgive yourself?
  - 7) How do you plan to avoid further relapses?
  
- B) Present paper or talk on readings and thinking about relapse.

**CAUTION:** Some clients will relapse to gain attention; so don't make a huge deal out of protocol, just make it part of system.

**"Drunk-a-logs"**, allowing clients to share the pain of the past, what happened, and how much better it is now can be very beneficial. Letting them write out the costs and benefits of sobriety and stability will force them to look at REALITY. **(No War Stories or glamorizing)**

**Skills Training:** Develop better ways to handle stress, anxiety, anger, depression, loneliness, and isolation. (Peer input)



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Relaxation techniques, assertiveness, problem-solving, constructive thinking, coping techniques.

Daily or weekly scheduling of activities of a balanced nature.  
Nutritional - Exercise counseling

**Recovery plan** with a FEW attainable goals and objectives - review with care and support

**MOTIVATION:** "Attitude change follows behavioral change"

Painful consequences can be the hammer, but once removed compliance will cease; but while it can be used, it ought to be used.

**Expand social system:** family, friends, pro-recovery peers

**Examination of negative consequences**, without blame, can create a "safe" atmosphere and disarm the "fight or flight" response.

Discussions of negative consequences of instability due to drug use

Tapping the client's goals and our JOINT goals will keep client "on track"

Keeping the treatment contract establishes clear goals and expectations, choices for the client, and something to live for/succeed at.

Simple, clear, concise, time-limited, with rewards and consequences.

One day at a time-hang in there just for today-

**Set achievable goals.**

**Signs and Symptoms of Professional Burn – Out and / or Impending Relapse <sup>5</sup>**

SOCIAL WITHDRAWAL AND ISOLATION

OCCASIONAL MOOD SWINGS

UNPREDICTABILITY - DECLINE IN QUALITY OF WORK

POOR STRESS TOLERANCE

INCIDENTS OF QUESTIONABLE OBSERVED JUDGMENT

EPISODES OF "FORGETFULNESS"

ABRUPT, UNEXPLAINABLE DISRUPTION IN WORK SCHEDULE

DEFENSIVENESS IF QUESTIONED OR CONFRONTED

IRRITABILITY - ARGUMENTATIVENESS

NEGATIVITY - CYNICISM - INAPPROPRIATE BEHAVIOR

LOSS OF FORMER CREATIVITY

LOSS OF SENSE OF FINANCIAL RESPONSIBILITY

IMPULSIVE SPENDING

ERRATIC BEHAVIOR - UNUSUAL UNKEMPTNESS

UNEXPLAINABLE, UNUSUAL ABSENCES WITH ELABORATE EXCUSES

EXPLOSIVE, UNWARRANTED TEMPER TANTRUMS

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<sup>5</sup> Crosby & Bissell, *To Care Enough*, Johnson Institute (1989).



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FAMILY ISOLATION, COMPLAINTS  
CLIENT, STAFF COMPLAINTS AND / OR CONFLICTS  
VERBAL ABUSE OF COLLEAGUES, STAFF AND / OR CLIENTS  
MISSED AND / OR TARDY DEADLINES  
NEGLECT OR ABANDONMENT OF SOCIAL, LEISURE ACTIVITIES

PHYSICAL OVERT SIGNS OF ANXIETY - THEN CALMNESS  
CHANGES IN PUPIL DILATION  
HAND TREMORS, MEMORY LOSS, INABILITY TO CONCENTRATE  
LEGAL / POLICE PROBLEMS  
UNAVAILABILITY IN EMERGENCY SITUATIONS  
= INTOXICATION ON OR OFF THE JOB SITE

**SUMMARY OF GORSKI'S "STAYING SOBER" <sup>6</sup>**

Mistaken beliefs can cause relapse.  
Relapse can be prevented by understanding the recovery process.  
The loss of judgment and behavioral control can develop emotional, physical, and mental problems that lead to relapse.  
Abstinence allows the recovery process to begin.  
Recovery from addiction includes a tendency towards relapse.  
Relapse tendencies are a normal and natural process of recovery.  
A "dry drunk" is an indication of dysfunction without drinking or using.  
The relapse syndrome can be interrupted thru conscious awareness.

Mood-altering drugs will: alter thinking, damage the mind, and effect behavior and relationships.

**Disease**

An addiction is accompanied by: obsession, compulsion, loss of control.  
Even when not using, an addict thinks about using, plans and looks forward to using again.  
Addiction robs a person of choice, while dictating frequency, quantity and nature of use.  
Addiction is primarily a physical disease, secondarily psychological.  
Genetic predisposition will determine how much of a drug, over how long a period of time will be necessary to trigger addiction.  
Drug use begins for psychosocial reasons;  
Addiction happens for physical reasons.  
Addicts do not learn how to cope with feelings, situations or people because drugs have been used for these experiences.

**Withdrawal**

The pain experienced when an addict stops using.  
It is created by physical damage and the body's needs for the substance to cope with life.  
Two phases develop: Acute Withdrawal = 3 to 10 days;  
Post Acute Withdrawal (**PAW**) = months to years

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<sup>6</sup> T. Gorski, *Staying Sober*, Independence Press (1986).



### **Delusional Thinking**

Denial of an illness is increased by neurological impairment that distorts reality; by blackouts (alcoholic amnesia) that create blank spots; and by the effects of intoxication on memory and perception.

### **The Addiction Cycle**

- Short-term gratification
- Long-term pain
- Addictive thinking
- Increased tolerance
- Loss of control
- Bio-psycho-social damage

### **Recovery**

- Total abstinence is a necessary first step; any use keeps addiction alive.
- AA is single most effective treatment for alcoholism.
- Professional counseling can be helpful adjunct to a 12-step program to deal with other problems.
- Reorienting life around values that are not drug centered is an essential part of recovery.

### **Post-Acute Withdrawal (PAW)**

- A group of symptoms that occur after acute withdrawal :
- Inability to think clearly
- Memory problems
- Emotional over-reactions and/or numbness
- Sleep disturbances
- Coordination problems
- Stress sensitivity

### **Patterns of PAW**

- If it gets better = regenerative
- If it gets worse = degenerative
- If it stays the same = stable
- If it comes and goes = intermittent

### **Managing PAW Symptoms**

- Take care of yourself
- Pay attention to your program of recovery
- Avoid the triggers: stress, anger, loneliness, hunger, etc.
- Talk to people who understand your problem
- Ventilate;
- Test reality
- Problem solving and goal setting;
- Backtrack
- Learn about addiction
- Take care of nutrition needs;
- Exercise ; Relax
- Find a spiritual discipline
- Strive for balance



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### **Development of Recovery**

Pretreatment	Recognition of addiction
Stabilization	Withdrawal and Crisis Management
Early Recovery	Acceptance & Non-chemical Coping
Middle Recovery	Balanced Living
Late Recovery	Personality change
Maintenance	Growth and development

### **Bernard G Breining, Dr.AD: Theory on Relapse and Recovery**

In addition to the obvious physical, psychological and environmental stressors that lead to relapse, as elucidated by Gorski and others, my experience of the past twenty five years leads me to believe that relapse happens even more naturally, and with the same frequency as non-relapse.

### **Chances of Recovery**

- The greater the motivation to avoid problems by changing, the higher the incidence of uninterrupted recovery.
- Legal, financial and domestic pressures can increase relapse - in the early stages of recovery - to a great degree.
- A well-founded sense of self-esteem and self-worth will enhance the recovery process.
- A well designed treatment plan - with client input - and a reliable monitoring system will enhance the recovery process.

### **Frequency**

- Highly motivated persons, with a rigid treatment plan and a reliable monitoring system in place will relapse 50% of the time in the first year of sobriety.
- After the first attempt at controlling the addiction and failing, up to 80% will remain clean and sober for many years.
- Persons with less motivation to change will relapse at a higher rate than those who want to change, and the rate of relapse can reach over 90%, depending on the desire and/or need to make life changes.

### **Factors to Insure a Sober Recovery**

- Achievement of a painful stopping-off place. A "hitting bottom" place that creates more pain and discomfort than continued drug use.
- An intensive early involvement in a treatment milieu that supports and encourages abstinence and sobriety.
- A sense of appreciation and gratitude for a changed life style.
- An acceptance of the powerlessness over the drug, and a willingness to follow another's advice and counsel.
- A humble willingness to embark on a program of recovery that defies scientific inquiry and intellectual grandiosity.
- A surrender of the need for instant gratification and self-centeredness in favor of helping and listening to others.
- Acknowledgement of one's own limitations, and the acceptance of the need for a "sponsor" or "mentor" or "guide" to assist in the new journey.



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**SUGGESTED ADDITIONAL READING**

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Counseling for Relapse Prevention	by Gorski
Passages Through Recovery	by Gorski
Essentials of CD Counseling	by Lawson
Staying Sober	by Gorski
White Knuckles & Wishful Thinking	by G. DuWors
To Care Enough	by Crosby & Bissel
Beginning of a Miracle	by Meagher

**ACKNOWLEDGEMENTS**

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The information contained within this Course Material has been drawn from many sources, including the references cited herein, the Breining Institute “*Chemical Dependency and other Addictive Disorders*” Workbook Series, the professional, academic and teaching experiences of Bernard G. Breining, Dr.AD, and research input from Breining Institute graduate students.



**CONTINUING EDUCATION (CE) EXAMINATION QUESTIONS**  
**Course No. CE1503 – Relapse and Burnout Prevention**

You are encouraged to refer to the Course Material when answering these questions. Choose the best answer based upon the information contained within the Course Material. Answers which are not consistent with the information provided within the Course Material will be marked incorrect. A score of 70% correct answers is required to receive Continuing Education credit. GOOD LUCK!

**QUESTIONS**

1. "Recovery" is a:
  - a. Short-term process.
  - b. Long-term process.
  - c. Restoring your computer to its original configuration.
  - d. None of the above.
  
2. "Relapse" may be defined as:
  - a. The recurrence of symptoms of a disease after improvement.
  - b. A single event or lapse (such as taking a pill or drink).
  - c. Reverting to old behaviors.
  - d. All of the above.
  
3. "The Addiction Cycle" includes all but which of the following:
  - a. Short-term gratification.
  - b. Addictive thinking.
  - c. Post-Acute Withdrawal (PAW).
  - d. Bio-psycho-social damage.
  
4. "Acute Withdrawal" may:
  - a. Last several months.
  - b. Last several years.
  - c. Last 3 to 10 days.
  - d. None of the above.
  
5. "Post Acute Withdrawal" may:
  - a. Last several months.
  - b. Last several years.
  - c. Neither A nor B.
  - d. Both A and B.
  
6. Legal, financial and domestic pressures:
  - a. May be a primary motivation to avoid relapse.
  - b. Increase the incidence of relapse.
  - c. Are some things that we all must deal with.
  - d. Should be referred to a licensed attorney.



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7. Highly motivated persons with a rigid treatment plan and a reliable monitoring system in place:
  - a. Will generally never relapse.
  - b. Will generally relapse only 10% of the time.
  - c. Will generally relapse 50% of the time.
  - d. Will generally relapse within 30 days.
  
8. Relapse is likely to occur:
  - a. When periodic crises are handled with new solutions and tools.
  - b. When periodic crises are handled using old ways that didn't work before sobriety.
  - c. Whenever any problem arises.
  - d. None of the above.
  
9. Which question should not be asked upon relapse, in order to prevent a reoccurrence?
  - a. What triggered the relapse?
  - b. How are you – the person who relapsed – responsible?
  - c. Who else should be blamed?
  - d. What will be done differently next time?
  
10. Some factors which will assist in a sober recovery include:
  - a. Intensive early involvement in a treatment program that supports and encourages abstinence.
  - b. Willingness to embark upon a recovery program.
  - c. Acknowledgment of one's own limitations.
  - d. All of the above.

**This is a ten-question examination. Answer Questions 1 through 10 for full CE credit in this course. Questions 11 through 21 have been omitted.**



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**CONTINUING EDUCATION (CE) ANSWER SHEET**

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**SECTION 3.**  
Course Title: **CE-1503 / RELAPSE AND BURNOUT PREVENTION**

Answers (circle correct answer):

- |            |             |             |
|------------|-------------|-------------|
| 1. A B C D | 8. A B C D  | 15. A B C D |
| 2. A B C D | 9. A B C D  | 16. A B C D |
| 3. A B C D | 10. A B C D | 17. A B C D |
| 4. A B C D | 11. A B C D | 18. A B C D |
| 5. A B C D | 12. A B C D | 19. A B C D |
| 6. A B C D | 13. A B C D | 20. A B C D |
| 7. A B C D | 14. A B C D | 21. A B C D |

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Return Answer Sheet, with \$29 Continuing Education examination fee, by mail or facsimile to:  
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