‘Do-It-Yourself’ Intervention?

A Family Coaching Resource from Recovery Systems Institute

Contents

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Introduction

A while back I found myself explaining to one parent why, with all the counselors and therapists around, more of them weren't organizing interventions on reluctant alcoholics. "Well, intervention's a different skill set from therapy," I offered. "Many very competent counselors just aren't comfortable with it. And interventions are time-consuming, with all the organization and prep involved. Plus a lot of families just can't afford it, on top of the cost of treatment."

"So what's the alternative for those folks?" he wanted to know.

Good question. The need's still there. So we've provided this brief guide.

Chandler Scott McMillin

Overview

let's suppose that, for whatever reason, you don't have access to a professional interventionist. can you still organize and conduct an intervention?

Sure. It requires additional work and commitment on your part, and the family bears more responsibility for the outcome. Nonetheless, so-called 'DIY' interventions can and do succeed.

I've shown many families how to do it, using this method.

First, it helps to conceive of an intervention in five parts:

1. Evaluating the problem. We're looking to form a simple database of information, including how far the addiction has progressed, and any factors that need to be considered.
2. Assembling the right team. Normally that's 3 to 6 individuals of significance in the alcoholic's life.
3. Presenting evidence and answering objections. This represents the 'meat' of the intervention. The team explains why they've come together and why they believe treatment now is the answer. Then they respond to the alcoholic's predictable objections to it.
4. Offering treatment and our support. The team's done their homework and has a ready option for treatment. The goal is to simplify the alcoholic's decision to 'yes' or 'no'.
5. Applying leverage(as needed). Addicts are terribly ambivalent about treatment. We use incentives and consequences to tip the balance in favor of recovery versus continued drug/ alcohol use.

All five are important, but if I had to pick the keys to success, it'd probably be 2 and 5. A carefully selected, well-prepared team adds greatly to your credibility. And the right leverage will make the decision for treatment much easier.

There's no single 'correct' way to intervene, as you'll see in the examples here and the Casebook that accompanies this guide. Still, there are principles that can be applied successfully to almost any situation where a concerned family is challenged with motivating a reluctant alcoholic/addict.

five simple steps

One: Evaluate the problem

Two: Assemble the team

Three: Present evidence & answer objections

Four: Offer treatment

Five: Apply leverage

2 What is Intervention?

what is a (DIY) family intervention?

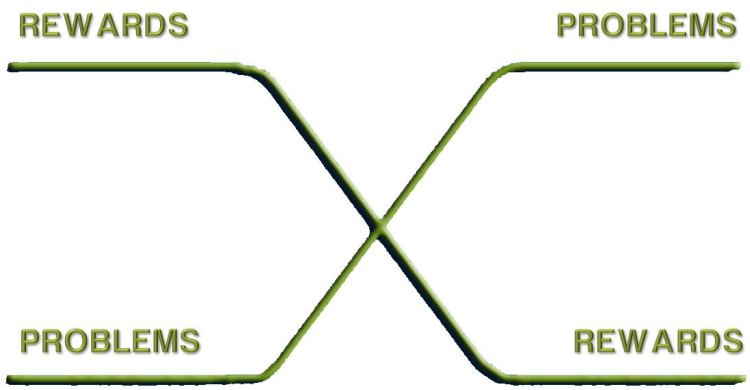
A structured team effort to convince someone in the family to enroll in treatment. A broad definition to reflect a wide range of family situations.

why intervention works

It's largely because of the progressive nature of alcohol and drug addiction.

With addiction, motivation for change generally stems from the problems associated with alcohol or drug use, and it develops over time as those problems worsen.

It can be diagrammed like this:



In the early stages of addiction, drug and alcohol use is more about how good it makes you feel than the problems it causes. So the user has little or no motivation for change. Things are working for him, right?

But as time passes—could be a lot of time, or only a little—the problems mount. And the more problems the user experiences (plus the more discomfort they cause), the greater the incentive to change.

When the problems begin to outweigh the rewards, the alcoholic seriously considers help. We might argue that the real motivator for recovery is addiction itself.

So why don't addicts seek help on their own? Because there are powerful barriers in the way—barriers that fall into three broad categories.

What is Intervention

barriers that keep alcoholics from getting help

first, the psychological defenses that grow up to surround addiction, and prevent the alcoholic from accurately perceiving the extent and severity of the problem. These defenses aren't conscious. The alcoholic really believes he's OK, even when others around him long ago decided otherwise.

second, the stigma associated with acknowledging an addiction—stigma based in society's traditional judgment of the alcoholic as weak, irresponsible, or immoral. This causes people to fight the diagnosis as if it were an accusation.

third and most important is the enabling syndrome that surrounds the alcoholic—the network of other people who protect him or her (often with the best of intentions) from the natural consequences of addiction—the same consequences that would otherwise motivate change.

That's why intervention works: we're really just removing some key barriers to change.

Intervention is a way of overcoming those barriers, by accomplishing three tasks:

- We practice communicating in such a way that the alcoholic can hear us despite his defenses.
- We express support to reduce the shame that accompanies the decision to seek help.
- We identify and address enabling, and if possible, turn the main enablers into interveners.

That's why intervention works: we're really just removing some key barriers to change.

3 Frequently Asked Questions

is intervention the right move for us?

You're not alone in wondering—most families do. A family can be as ambivalent about intervention as the alcoholic is about recovery. Some common questions:

how do I know intervention will succeed?

There's no guarantee, of course. Would it help to know that the great majority of interventions result in an agreement for treatment? When interventions do fail, it's usually because of a flaw in planning or organization. And in the rare case where intervention doesn't lead immediately to treatment, it sets the stage for a later decision to seek help—after the alcoholic has experienced more problems.

could intervention make the situation worse?

A well-conducted intervention is a positive, supportive experience designed to reduce anger and tension within the family. You address the issue in a controlled setting in hopes of forestalling a future crisis resulting from drug or alcohol use—a crisis that could prove a great deal more dangerous.

Intervention includes expressions of hope, love, and support—an antidote for shame and hopelessness.

I don't think you can make someone do something against their will.

Neither do we, and it's a mistake to try. The goal of intervention is to tip the alcoholic's decision-making process in favor of treatment, by altering the circumstances that surround the addiction. The alcoholic is repeatedly reminded that the decision is his/hers alone to make.

what if we want to try another approach first?

Most families consider intervention only after other approaches have failed. You're free to try something else. Intervention remains an option if it doesn't work.

I don't know that I'm the right person to participate.

Most people wonder the same thing. It should help to realize that interventions are generally a very positive experience for the participants. But participation is your decision. You might talk it over with others who will be involved—see if that provides some reassurance. If not, you can always opt out, even relatively late in the process.

Frequently Asked Questions

what if treatment doesn't work? What then?

You mean if the alcoholic relapses? That's always a possibility. After all, most of the original members of AA had relapsed many times before they finally 'got it'. But once they did, their lives were completely changed. Try looking at it this way: What if treatment does work? Think how the family's life will be changed for the better.

A successful intervention sets the stage for recovery. The goal isn't only to get the alcoholic into treatment—it's to improve his/her chances for success.

I'm not comfortable with the idea of confronting someone in a personal way.

Hardly anybody is. That's partly why intervention is a group activity—the participants draw strength from one another.

some things you can do to help resolve ambivalence:

Read up on addiction and on intervention. There's a reading list at the end of this guide. The better you understand the problem, the better prepared you are for the solution.

Talk with a professional, a counselor or therapist, about your situation. Get an objective view of your situation and the various options for addressing it.

Talk with friends who've been involved in an intervention. If you don't know any, you can probably find a couple at your friendly local Alanon meeting.

We don't have to resolve all our questions or concerns in order to be an effective intervener. Just enough to make us feel more confident. And we should never forget that intervention became a common approach precisely because it works so well.

4 When to Intervene

how do we know if this is the right time for intervention?

Try the scales method. Imagine a set of scales with arguments on either side. On one scale, arguments for intervention. On the other, arguments against.

For instance:

> *Johnny, 27, is a computer software salesman who lost his retail job about six months ago. He lost his rented condo because he couldn't pay the rent and his parents allowed him to move back into a basement apartment in their home. He's supposed to be looking for another job but without a degree his prospects appear slim. The basement apartment is a nice setup in that there's a separate entrance that allows him to come and go as he pleases.*

A few months back Johnny's parents received a call from his ex-fiancé asking if they knew about Johnny's drug use. They were aware of his drinking but apparently for the past year he'd been taking Oxycontin, a potent pain reliever he got from a buddy at his former workplace.

According to the fiancé, he was combining the two substances on a regular basis to get the high he favored. To support this habit, he did some minor dealing on the side—mostly pot and Ecstasy to university kids, but occasionally prescription opiates as well. He'd missed a lot of work because of his drug and alcohol use, and that was a big part of his termination. It was also a major issue in her decision to break off their engagement.

The parents' reaction was, understandably, shock. They consulted a counselor in a nearby suburb. The counselor took a detailed history and confirmed their fears; it was likely that Johnny would require treatment. They'd heard about intervention and wondered if that was the solution for them.

In the end, they weighed the alternatives:

against intervention—

- They didn't have a lot of factual information about Johnny's drug use, other than what they heard from the young woman.
- They were concerned that they might be betraying Johnny by taking someone else's word rather than trusting him. Johnny had a temper, and he'd no doubt be very angry at the accusation of drug sales and use.

When to Intervene

in favor of intervention—

- They believed the ex-fiancé. Had known her for years and found her trustworthy. She offered additional confirmation from two of his former friends. And she was willing to help if they decided to intervene.
- On reflection, they realized there had already been signs of a problem. For instance, after their son moved back in, strangers coming and going at all hours, some of them scary-looking. Johnny having cash even though he was unemployed. His irritability and defensiveness, a change for the worse.
- Johnny had had problems before, as a young child. He'd been referred for counseling in elementary school and had been arrested twice in junior high, both times for minor theft. A year with a counselor had helped and he seemed to straighten himself out by the time he was old enough for college. But his parents never quite forgot the experience.
- Finally, they were afraid of what might happen if they failed to act. Their son was probably selling drugs out of their home. What if the police became involved? If they simply kicked him out of the house (his father's first impulse), he'd continue his drinking and drug use elsewhere, in a worse environment.

In the end, the arguments for intervention simply outweighed those against it.

Suppose the scales had balanced against an intervention at present? Then they'd simply wait. They could collect additional evidence; they could talk to other people who might have something to add; they could have explored other approaches with a counselor.

On the other hand, a powerful argument in favor of intervention is what might happen if the drinking or drug use continues to escalate—which it normally does.

Do your own 'scales' diagram to see the arguments for and against intervention.

5 Leverage and Where to Locate It

The hidden key to success is leverage.

Interventions often succeed because the intervention team has the right leverage, or fail because they don't.

Our working definition of leverage: the team's ability to tip the scales of the alcoholic's decision-making process towards treatment and away from continued drug and alcohol use, by applying incentives and consequences.

For leverage to work, the team needs credibility. In other words, the alcoholic must be convinced that this time, they really mean it.

It's worth our time to identify any leverage that exists in the current situation, and if there's not enough, to develop more. We just may need it.

Sometimes leverage is clearly available, but for one reason or another, the family doesn't recognize it. Here's an example:

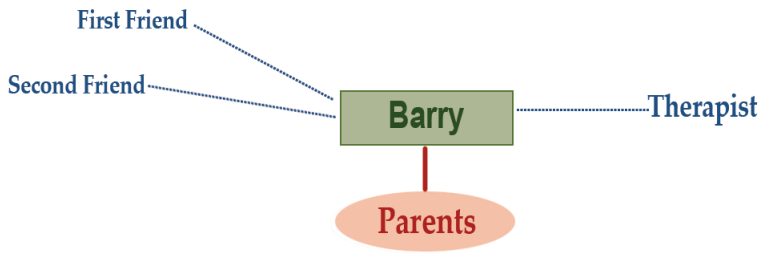
> *Barry, age 36, is a freelance magazine writer who has been using cocaine for at least three years, in increasingly heavy amounts. His lifestyle has suffered: he's lost most of his steady writing jobs and his income is off significantly. Barry blames this on a down economy, however, rather than missed deadlines. He's managed to hang on to his expensive apartment only because his father, a successful real estate attorney, has taken over the mortgage, as well as providing money for basic living expenses.*

Barry's mother has a number of health problems and the family avoids upsetting her. His father has always been critical of Barry's choice of career (he was supposed to study law) and has repeatedly threatened to cut off financial support, although it's never actually happened. Barry has successfully hid his drug use from his parents, however, and even uses his arguments with his father as a excuse for his behavior.

Barry has become increasingly isolated but stays in contact with two close friends from college and continues to see his longtime therapist every month or two. His friends and therapist are quite concerned about Barry's deteriorating health and mental state, and have pleaded with him to get help individually in the past, without success. Barry drinks heavily, and a few months earlier experienced several seizures and wound up in the hospital. He begged his friends not to tell his parents, swearing he'd go to treatment on his own, but he never followed through. Instead, he insists he's already stopped using, although his condition hasn't improved and his friends frankly don't believe him.

Leverage and Where to Locate It

we might diagram Barry's leverage profile like this:



Barry's *friends* have influence and are willing to do whatever they can to help. Same for his former therapist, although they are in less frequent contact. But the real leverage in this situation comes from Barry's *parents*.

Without their financial support, he literally couldn't continue his lifestyle. He couldn't afford the drugs and alcohol, or keep up the pretense of being a normal functioning adult. He'd have to find another undemanding source of income, or the edifice of his daily life would collapse.

So it's fair to say that the main barrier to this intervention isn't actually Barry. It's his parents. If they change, he'll have to.

His parents will no doubt have very cogent emotional reasons for their enabling, and those will have to be addressed. Once they give their full support to intervention, however, the chances of success ratchet upwards.

The goal will be to present Barry with a clear yes -no, up-down choice between treatment, and a radical change in his lifestyle. Since underneath it all Barry is quite unhappy, he'll probably jump at the chance for help.

Leverage and Where to Locate It

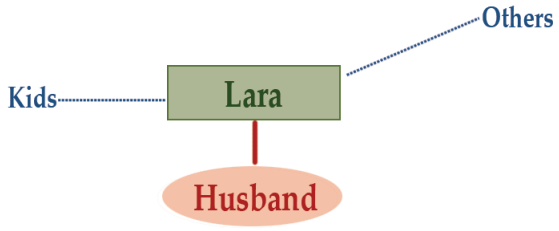
leverage missing: presumed non-existent

Sometimes the leverage isn't readily available, and the interveners must develop it before they confront the alcoholic. An example:

> *Lara is 46, married, with two children ages 18 and 20. She is a stay-at-home mom with a very strong personality who tends to dominate others around her. Her main weapons include an acid tongue and a temper that flares powerfully at the most minor provocations. Lara's drugs of choice are wine and cognac, and her drinking has escalated over the past year to include regular blackouts and several dangerous incidents where she passed out on the couch and nearly burnt herself with a smoldering cigarette. Her kids and husband, afraid to leave her alone, have developed an informal routine of 'coverage' to ensure someone is always around to keep an eye on her in the evenings. Lara has serious health problems—emphysema is one—but she refuses to quit smoking and insists her breathing difficulties are just a product of lifelong asthma. Over the years her family has recruited different authority figures for 'heart to heart' talks with Lara, to no effect. Lara stubbornly refuses to acknowledge anyone's right to 'interfere' in her life.*

The family admits to another reason they are afraid to confront Lara: Her mother, also an alcoholic, took her own life at roughly the age Lara is now. They fear Lara, if pushed, could follow the same path.

we might diagram Lara's leverage profile this way:



Lara's husband, a tax accountant, provides direct financial support for the family, but it seems as if he's thoroughly intimidated by his wife. Her children, now almost grown, play a role in babysitting Lara to prevent her from harm. The enabling of her husband and children are essential to Lara's ability to continue drinking without some experiencing a possible disaster. Obviously they're not willing to allow Lara to come to harm in hopes of getting her attention. But that isn't necessary. What's really needed is a new approach: One that Lara can 'hear' in a way she hasn't heard other attempts.

Instead of moving directly to confrontation, it's important to spend time teaching the family to behave differently around Lara. They've always been meek about address-

ing the effects of her drinking; we'll need to change that. She'll no doubt flash that famous temper, so it's important that the family learn to handle those outbursts. That'll require some assertiveness training. Most of all, they'll need to learn to deal with their anxiety about her response.

We're laying the groundwork for a new level of credibility. Lara's accustomed to dismissing her family's concerns. In many ways, she treats them as poorly trained house servants. We're out to make her change her opinion. Intervention will come later, when they're ready.

Without credibility, Lara simply won't believe anything they say. She figures they'll cave under the force of her anger, and so far, she's been right. That's what we need to change. Not just to get her into much-needed treatment, but to make recovery possible.

In both our examples, the key to intervention begins with those around the alcoholic. That's the real starting point. Maybe we trained the alcoholic not to listen to us, because we never said what we meant, or meant what we said. Fortunately, that's all fixable.

Leverage and Where to Locate It

a few more examples of identifying leverage

Mickey, 25, troubled since early teens, has been living away from home with drug-using friends, and doing an unknown amount of various opiates and stimulants. Mom's been giving him money every couple months despite Dad's disapproval (he and Mickey argue every time they see one another). He's currently on restricted probation and the judge promised a significant stretch in prison if he gets caught using drugs again (nobody's sure how he's beating the drug tests). Mickey's aunt and uncle want him in treatment but his parents are balking. His mother's position is that treatment won't work if he doesn't want help, and his father is just plain disgusted with the son.

Actual leverage rests with his parents. Mickey might hang on for a few months without Mom's financial support, but not longer. Dad's part of the problem too; pointless arguments with Mickey just provide additional excuses to get high. But if his parents can be recruited to a more positive attitude towards treatment and recovery, successful intervention is very likely.

Wanda, 17, has had problems with alcohol and drugs since age 12. She's run away from home and been brought back numerous times. Wanda's mother has two other children to raise, and has essentially given up on trying to change her eldest daughter. Her father is out of the picture entirely. She is on probation for a repeat drug offense. A few weeks back she visited her mother (the first time in several months) to say that she and her boyfriend have been fighting a lot and she thinks he's about to kick her out of the apartment. She expressed a desire to move back into the family home and perhaps attend community college. Her mother is reluctant to turn Wanda away but also very afraid of having an active drug user in the house. Wanda insists she's clean and doesn't need any more treatment.

Potential leverage is based on what Wanda says she wants—to move back in and return to school. That can be made conditional on: 1) An agreement to attend outpatient treatment; and, 2) Clean results on random drug tests. Wanda doesn't want to make such a commitment, so her mother will have to insist. Wanda will have the option of refusing. But facing the certain loss of residence and boyfriend (and presumably, supply of drugs), it's likely she'll comply.

Leverage and Where to Locate It

Lawrence, 69, is a widower, retired with plenty of money, and living alone in a big house on a hill. His children are grown and live in distant cities. He has always suffered from depression and was hospitalized twice in his early 40's before responding to electroshock therapy and medication. His housekeeper alerted his daughter to a dramatic increase in his drinking over the past year, and his arrest for drunk driving following a recent accident. Lawrence had kept this secret from his children. The housekeeper reported that he had become increasingly morose and self-pitying and had stopped taking his medication. She was worried about his mood. The children want to help but are not particularly close to their father.

Leverage: Like many depressed older alcoholics, Lawrence has isolated himself from others who might interfere with his descent into late-stage, terminal alcoholism. The arrest for DWI was serendipity; it interrupted the descent and convinced the housekeeper to contact the relatives. Depressed alcoholics like Lawrence aren't really committed to dying. They're just miserable, and alone, and without the resources to pull themselves out of their funk. They spent a lifetime building walls around themselves, and may not know how to ask for help.

The leverage here comes from the possibility of a real reunion with Lawrence's family. Lawrence will put up a fuss, of course, but nobody thinks he really means it.

Identify enablers in your own situation.

6 Assembling the Right Team

we're looking for three to six people

Preferably, the team will include the main enablers, who can provide leverage in the form of incentives and consequences; and others—people the alcoholic respects and who therefore provide positive influence.

For instance:

> *Barbara, 27, is spearheading an intervention targeting her mother Adrienne, 50. Making a list of the most important persons in Adrienne's life, she quickly identifies two key enablers: Her father Craig and her grandfather Hugh. Craig supports the family when Adrienne is out of work, which is most of the time. Hugh provides her with a refuge whenever she and Craig have had one of their numerous fights. For the intervention to succeed, both have to be involved. Barbara will participate but as her own relationship with her mother is rocky, will contribute mostly by coordinating meetings and training sessions, and gathering information about various treatment options.*

Hugh is more willing than expected; turns out he's been concerned about his daughter's drinking for a long time. *Craig* is ambivalent. His fear is that intervention will push Adrienne 'over the edge' and trigger more depression. Hugh actually helps to lessen Craig's concern, arguing that things have grown worse and cannot be allowed to continue as they have. Craig finally agrees. The three commit to intervention, and form the core of the team.

But Barbara feels strongly that the team should include others from outside the immediate family. They agree to recruit *Clark*, a family friend with many years of 12 Step recovery, and *Glenda*, Adrienne's oldest friend, with whom she's been out of touch for several years. The group feels that Clark could serve as moderator for the intervention, keeping the group on task. Glenda's presence would add extra weight to their message.

Barbara contacts Clark and Glenda and asks only that they agree to attend a meeting about her mother's problem. Because they're less familiar with the problem, she deliberately avoids asking for a commitment beyond simply sitting down and discussing the problem. That gives them a chance to ask questions and resolve any ambivalence they may feel about the prospect of intervention.

At that initial meeting, the five of them go over a simple worksheet, "Ten Questions" (see below). Barbara, Hugh, and Craig have already completed this inventory in some detail. Clark and Glenda haven't. The meeting is a chance for the two non-family members to learn about Adrienne's struggles with alcohol. That way they're motivated to participate.

Assembling the Right Team

make a list of prospective team members

It's best to start with a long list and winnow it down. Here's an example, for an alcoholic named Corinne, 32. The final team members are marked with a star:

1. Robert and Joanne ★—father and mother, main enablers.
2. Louise—favorite aunt, mother's sister, lives in a distant city
3. Terri—older sister, 37 ★
4. John—younger brother, 25
5. Darren—former boyfriend, broke up a year ago
6. Diane—former classmate, friend
7. Uncle Ted—father's brother, family friend ★
8. Aunt Liz—mother's sister, not close for several years
9. Victor—former longtime friend, now in recovery ★
10. Todd—young minister at their church who Corinne liked, has participated in interventions ★
11. Carol—former co-worker, friend, helped Corinne through a prior divorce, out of touch in recent months
12. Nessie—former classmate, longtime friend, lost touch in recent years

Corinne's parents provided the leverage, as they were their daughter's main financial support, but neither was expected to do much of the talking, as Corinne saw them as overcritical and had long ago stopped listening. Victor and Terri would be active, providing support and encouragement for doing something now. Todd would serve as the moderator. Uncle Ted was chosen because of his familiarity with the family's problems and his role as a wise family counselor. Brother John, on the other hand, would not participate; his own life was chaotic.

The five were invited to attend, and all agreed except Todd, who was going on sabbatical. Victor would take over as moderator and Carol was invited to join.

Assembling the Right Team

not everyone who's involved should participate

Here are a couple examples of important persons who for different reasons didn't participate directly in an intervention.

First, Raymond:

Ray is a primary enabler for his drug-addicted daughter Iris, who has been through several treatment programs. The family is willing to make one more attempt at treatment (a long-term residential program) but Ray's wife (Iris' stepmother) expresses severe doubts about her husband's ability to contribute. "It's his temper," she explains. "He turns purple and starts yelling. It's gotten so he and Iris can't even be in the same room without fighting. Yet he keeps sending her money every month, which I'm pretty sure goes for dope. Guilt, I suppose." Ray wants to participate, but the team decides that Ray's temper would be a major distraction. Instead, his wife will speak for both of them. She'll let Iris know the money will not be forthcoming if she refuses treatment.

Nora:

Nora, on the other hand, is emotionally fragile and dissolves easily into mute sobs when placed under stress. As preparation for her brother's intervention continues, it becomes obvious that Nora won't be able to speak without collapsing into tears. The team decides that her extreme emotionality actually detracts from their credibility and asks her to instead write a letter which the moderator will read aloud during the intervention.

Make your own list of potential team members—our goal is the right mix of 3 to 6 people.

7 Team Preparation: What We Know

let's figure out how much we (as a team) know about the problem

These are open-ended questions. They don't require a particular answer. Our goal here is to clarify our view of the problem, before we go farther in search of a solution.

Answer the questions (below) on paper, the computer, or dictated into a recorder. Detail is good, and any real-life incidents are important to include, but we don't need a book. Just your thoughts and impressions.

Ten Questions

1. Describe the alcoholic/addict's recent drinking and/or drug use. By recent, we mean the past 6-12 months. You can go back farther if you feel it helps. And this is only to the best of your knowledge—we don't expect you've had a 24 hour camera trained on somebody. Any significant changes in drinking or drug use, for better or worse?
2. Describe the problems that you believe substance use may have caused or contributed to. Facts are great, but we're not in court, so don't feel you have to convince a jury.
3. Describe any efforts the alcoholic may have made to quit or control drinking on his own. Most have made such attempts in the past.
4. Describe any previous treatments, residential/outpatient/ etc. To your knowledge, what's the longest period the alcoholic has abstained or controlled his drinking?
5. Describe any previous efforts (if any) that you or others made in an effort to address this problem. Describe the outcome: good, bad, both, neither?
6. Describe any other factors you think might be at work in this situation (emotional illness, relationship or family conflict, medical problems, grief or loss, other circumstances, etc.):
7. What are the alcoholic's principal objections to treatment? In his own words where possible:
8. Describe your own feelings about treatment:
9. How about your feelings about the possibility of relapse after treatment?
10. And any other comments or thoughts you have on the subject, of course.

Team Preparation: What We Know

Here's an example from Corinne's intervention, prepared by her older sister, Terri:

1. Describe the alcoholic/addict's recent drinking and/or drug use:

"I don't see Corie that much anymore—none of us do. Used to be she'd show up like clockwork for birthdays and holidays but the past year that's fallen by the wayside. Twice she came to my apartment to borrow money. $100 one time, $250 the other. Like a dope I gave it to her. Don't expect to get it back. Both times she came by she smelled like alcohol. It was early in the morning. I don't know if she'd been drinking, it seemed to come from her clothes. I know Mom and Dad are paying her rent since she got fired (yes, she was fired, that was confirmed by one of her friends). All that schooling and now she can't even hold a job. The one time we got to talk where she wasn't being phony, she told me all about what happened with Darren. He was the love of her life but I guess he couldn't take all the drama. She thinks he deliberately avoids her now, won't return calls or texts. I guess he was very, very angry. I wish I knew more but my sister is like in hiding from us. You only see her when she wants something, and she looks a little worse for wear each time."

2. Describe the problems that you believe substance use may have caused or contributed to:

"There was the DWI a couple years ago. My parents paid for the attorney. Another accident where she went into a ditch and totaled her car. I don't know how she managed to avoid DWI on that one. I don't think she knows either, but maybe it's because the ambulance took her to the hospital. She didn't have insurance but my parents bought her another car. I mentioned she reeked of booze one morning at my house, it had to be before 9AM. I know her stomach's a mess, I don't think she eats right."

3. Describe any efforts the alcoholic may have made to quit or control drinking on his own:

"I know she quit for a while when she was in counseling. I'm pretty sure no more than a couple months. She's sneaky, I bet she put it past them. I don't think she's ever made a serious attempt to stay sober. I know she made fun of Victor when he first got into AA—called him a 'churchie'. Secretly admires him though, because he was really bad and turned his life around."

4. Describe any previous treatments, residential / outpatient/ etc. To your knowledge, what's the longest period the alcoholic has abstained or controlled his drinking?

"See above. Those couple months would be the longest she ever stayed sober. If she was really sober then."

Team Preparation: What We Know

5. Describe any previous efforts (if any) that you or others made in an effort to address this problem. Describe the outcome: Good, bad, both, neither?

"John and I tried talking to her a few years ago. She just blew us off. That's before John started falling apart—now he's got his own problems."

6. Describe any other factors you think might be at work in this situation (emotional illness, relationship or family conflict, medical problems, grief or loss, other circumstances, etc.):

"I've always felt my sister was bipolar or something. She gets manicky and spends money like water. I've seen her really depressed. I don't think she's ever seen a shrink. Grief over losing Darren, of course. That's a recurring theme in her life."

7. What are the alcoholic's principal objections to treatment? In his own words where possible:

"She'll say we'd drink too if we had her problems: The divorce (she always goes back to that), the breakup with Darren (he 'abandoned' her), and of course Mom, who she's never gotten along with. And she'll have some crazy scheme to make money that she'll insist is just about to pop. It never does."

8. Describe your own feelings about treatment:

"I believe in treatment, I really do, I have three or four good friends who've done well. The thing that worries me is if Mom and Dad will ever change. As long as they keep doing the same thing, Corie will. It's the pattern."

9. How about your feelings about the possibility of relapse after treatment?

"I've had friends who've relapsed and come back and done well."

10. And any other comments or thoughts you have on the subject, of course:

"I want to support this any way I can. I think if Corie could maybe get some psychiatric help along with treatment she could really improve a lot. She's really smart and I think underneath she wishes she could erase the past ten years and start over. Maybe in a way this is her chance."

Team Preparation: What We Know

here are some other examples from other interventions:

From Grace, on the effect of her father's relapse after his first treatment:

"It was about two years ago. A thirty day program, cost a fortune. He did fine after he got back for five or six months. It was like having Dad back again. Then my brother told me he had smelled alcohol on his breath on a Monday night when he was over there to watch the game. And again a few weeks later, in the afternoon. He and my sisters and I talked about it but none of us could make up our minds what to do. My mother said she hadn't noticed anything at all and we shouldn't bring it up because he'd just get upset. Then that Christmas Eve he was drunk when we went over there to open presents. There was no hiding it. Maybe he thought we didn't notice. But it was discouraging, after they spent all that money on rehab and all. Anyway, he's been drinking ever since."

what this tells us

The family lost a lot of faith in treatment. Part of intervention prep must involve developing a realistic plan for dealing with relapse if it threatens again.

From Luis, on his mother's emotional problems:

"I recall her waking us up in the middle of the night because she couldn't sleep. This was when I was like five years old. Then she went through a phase where she wouldn't leave the house, she'd send us to the grocery store and the cleaners to pick up stuff. My father was very quiet, he'd spend a lot of time at work so I was left to look after my mother. When I was 16 she overdosed on pills, she said it was an accident but nobody believed her and she wound up in the loony bin for two weeks. We actually enjoyed it while she was gone. When she came back she was on a lot of pills and ever since, it's ten years now, she's been stoned on pills. I don't even know what she's taking any more. But we all know not to talk to her in the evenings, she can't remember anything anyway."

what this tells us:

An unspecified mental health disorder is playing a major role. And that meds prescribed to treat it have become part of the problem rather than the solution.

Team Preparation: What We Know

From Lydia, about recent changes in her husband Jake:

"Jake got a DWI back when we first dating, about twelve years ago, and he went to counseling then. I can't say the drinking slowed down but he was careful not to drive. Like if we went out, I'd drive home. It stayed like that until about a year ago, when he got laid off and couldn't find another full-time job, just contract stuff. It really got to him. He started staying up late and getting drunk after I went to bed—I had to go to work in the morning. Sometimes I'd find him passed out on the floor at 6AM. Recently he's been spending a lot of time out back in this workshop he built and I'm not welcome there but I think that's mostly drinking. About three months ago our youngest son came to get me because Daddy had fallen down on the back deck and couldn't get up. Getting openly drunk is something new. That's what scares me most."

what this tells us:

Jake's alcoholism is escalating. It'll be difficult for him to rationalize the recent deterioration. He'll no doubt blame it on his job loss. Also, he's likely to point to his earlier experience after a DWI as evidence of his ability to regain control.

From Marvin, on attempts to communicate with his son Philip, 22:

"I've tried talking to him about treatment, that we'd pay for it, support him. At first he pretended to take it seriously but something would come up and it wouldn't happen. After a while I started pushing him about doing something and he just blew up at me. Philip's a big guy and he's explosive. That's a term the doctor used about Philip when he was much younger. A couple weeks ago he put a hole in the living room wall with his fist. He apologized later but I don't know if he meant it. The other thing is he's paranoid. Looks out the window to see if strange cars are parked on the street. He gets phone calls during dinner, like three or four of them, and he always takes them and then later that night, say about 10 or 11 o'clock, he goes out and doesn't come back until 4. Frankly Miriam and I are afraid to ask him about it."

what this tells us:

First, that much of Philip's substance use is hidden from view; things are probably worse than his parents imagine. Second, his major defense is to explode. An intervention should be designed to minimize that possibility.

Team Preparation: What We Know

From Claire, concerning her mother's longstanding pattern of enabling:

"Oh, she's a big-time codependent. I've read all the books. My stepdad gets worse and worse and she will NOT do anything about it. I've talked to her till I'm blue in the face. My aunts have talked to her. Her minister has talked to her. His doctor called her to push for treatment, after his last hospitalization. She says there's nothing she can do if he won't accept help. She says she can't leave him, she wasn't brought up that way. Meanwhile he's been in the ER four or five times in the last two years alone. It's always alcohol. But she's always there to protect him.

what this tells us

Claire's mother needs as much help as her stepfather. That getting through to her (and changing her approach) is as important as reaching the sick alcoholic—not just for intervention, but to his prospects for recovery.

From Wendy, on why her husband won't consider help:

"He's open about it—he figures he's going to die anyway. He's had two heart attacks in ten years and he's already older than his father was when he died of a heart attack. So why quit drinking and smoking?"

what this tells us

The major obstacle we'll face is the alcoholic's belief that death is imminent.

8 Team Preparation: Dealing With Objections

what objections to treatment are we likely to hear from the alcoholic?

Suppose we were to approach your alcoholic tomorrow and urge him to enroll in a treatment program. He'd say no. When we asked for an explanation, what would be his response?

Some examples:

"I don't need treatment, because I don't really have an alcohol or drug problem."

This is a common one. The team members disagree, or they wouldn't have participated in the first place. Just their presence is a strong argument that a problem exists. During the intervention, key members will present evidence to the contrary.

"I may have a problem, but I don't need help treating it."

The alcoholic believes he's managing his life successfully. Once again, the team's very presence weakens this belief. And the members will present evidence that contradicts it.

'My problem is actually [something else entirely]."

Alcoholics routinely attribute substance use to something other than addiction. Stress, depression, marital conflict, grief, anxiety, family or work issue... all may exist, but drinking or drug use just makes them worse.

"This isn't the right time to worry about drinking."

There isn't an ideal time to address addiction. You deal with addiction in part so you can (finally) deal with the rest of the problems in your life.

"It's not really me. It's other people who have the problem."

Drinking alcoholics can be big blamers. They're quite willing to critique everyone else. The team's job is to refocus attention on the alcoholic's behavior.

Team Preparation: Dealing With Objections

"Maybe I'll get help later, if things get bad enough that I need it."

Things are bad enough now. Otherwise why would you have gathered to confront him?

"I can't possibly take the time/spend the money/ devote attention to this problem at this particular moment (other priorities more important)."

Consider such objections a sign of progress. He's no longer arguing about the need for treatment; he's arguing about the logistics. The team should have answers ready, and redouble its efforts to 'close the deal'.

Once we've identified the objections the addict is likely to use, we can prepare for them.

Have team members write down the objections they think you may hear during the intervention.

9 Team Preparation: Converting Enablers

convincing a primary enabler to help the interveners

We should remember that people who've become enmeshed in the enabling role may have powerful emotional reasons for continuing. Families sometimes have to stage a mini-intervention just to earn the support of the codependent. Here's an example:

Winnie's mother Garnet has been protecting her alcoholic son (and Winnie's brother) for more than twenty years. Winnie and her aunt Jeanne (Garnet's older sister) are meeting with Garnet to recruit her to the side of intervention.

Winnie: "Mama, we're going to try to get through to Bruce about his drinking."

Garnet: "I know you are. I hope you succeed."

Winnie: "We need your help."

Garnet: "What can I do? He won't listen to me."

Winnie: "We know that. But we also know you send money to him every month."

Garnet: "Not every month."

Winnie: "Almost every month. Especially this past year."

Garnet: "It's for rent. I don't want him to be homeless, for God's sake!"

Jeanne: "We think most of his money goes to booze."

Garnet: "Maybe so but I still want him to have a safe place to live."

Winnie: "Have you seen it?"

Garnet: "No. I haven't been invited."

Winnie: "There are holes in the carpet from cigarette burns. Empties everywhere."

Jeanne: "It's a dump, Garnet."

Garnet: "I still don't see what you want me to do about it."

Winnie: "Well, we're going to talk to him about his drinking. See if we can't get him into this program we found. We were hoping you would support us."

Garnet: "I can't participate in anything like that."

Jeanne: "You don't have to, honey. We just want to tell him that if he refuses treatment, you won't send him any more money."

Team Preparation: Converting Enablers

Winnie: "He's getting older, Mom. He's got high blood pressure, he's got breathing problems, he looks awful. We're afraid he's going to have a stroke, or die. He has to quit, now."

Garnet (starts to cry): "He was a beautiful person when he was young."

Jeanne: "We're hoping he will be again, baby."

Garnet (through tears): "I'll do it."

Please note that Winnie and Jeanne are careful not to ask Garnet for a commitment beyond what she is capable of making. Their goal is as much to keep her from interfering with the intervention as it is to obtain her active support.

a fallback position

Suppose despite all your efforts, the alcoholic refuses your offer of, for instance, residential treatment. It's common practice to have a fallback option: If you can't achieve your ultimate goal, is there a lesser goal that still satisfies?

Here's an example:

Margaret, a 39 year old drug user, resolutely refuses residential treatment. After exhausting attempts to persuade her, Carla, the moderator, takes over:

Carla: "You know your family has said they'll cut off support if you're not in treatment, Maggie. But they've authorized me to make you one final offer. One last way to maintain their support."

Margaret (surprised and encouraged): "What is it?"

Carla: "You agree to enroll in outpatient counseling."

Margaret (thinks): "Where? How often would I have to go?"

Carla: "We found one near your apartment. Meets in the evenings twice a week. You don't have insurance, so we'll pay the fees. You can pay us back later."

Margaret (considers it): "I might could do that."

Carla: "You'd have to stay clean. They'd drug test you."

Margaret: "I guess."

Carla: "If you quit the program or flunk out, we withdraw our support. It's entirely up to you."

Margaret: "All right. I'll do it."

Carla: "I'll pick you up tomorrow afternoon. We'll go register together."

After Margaret leaves, one of the intervention team members, Mike, says: "Think she'll be there tomorrow?"

Carla (laughs): "We'll see. She looked pretty happy to have a chance to hold on to the money."

Mike: "She's figuring she can beat those drug tests."

Carla: "Probably. But the counselor said they eventually get caught. Even if it's just the pot that shows up, they'll know if she's relapsed. And they'll have a release to notify us."

Since the problems associated with addiction mount over time, it's always good to hold on to some level of contact with the addict, in case things change. That's the role of the fallback. If Margaret relapses (as she likely will), there's a chance for a second mini-intervention (this time with the counselor's help) to get her to a residential program.

Since the problems associated with addiction mount over time, it's always good to hold on to some level of contact with the addict, in case things change.

10 An Intervention in Action

let's look at a real intervention as it unfolds

Nathan is a 31 year old unemployed auto salesman with a long-standing alcohol problem and recent ventures into pill abuse. Follow along as his family intervenes:

scene one: convincing the alcoholic to listen

The first obstacle in any intervention is simply to get the reluctant alcoholic or addict to participate. Nathan's joked about interventions he's seen on TV and the team believes his first response will be to take off running. They doubt an invitation to a family meeting would work, either; last two times they tried, he never showed, calling later with a feeble excuse. They feel it has to be a surprise. But the challenge is to get around his initial flight impulse. Here's the team (Ben, Mary, and Vance are Nathan's siblings) discussing it:

Ben: "Once he's inside, I could block the door."

Mary: "We're not looking for a wrestling match, Ben."

Vance: "He'd love that. Probably use his i-Phone to call 911, have us arrested."

Mary: "I could invite him over to Mom's under a pretext. Like planning her birthday or something. He always comes to family stuff when Mom's involved."

Ben: "But when he sees us here, he'll know."

Mary: "Yes, but then Mom and I could talk to him. Tell him we're just worried about him and want to explain why. Keep it low-key."

Vance: "Could work. He listens to you two."

Ben: "And he's not going to want to upset Mom. She's the piggy bank now he's out of work."

Mary: "Don't be a jerk, Ben."

Vance: "Sounds like a plan."

The family wisely plans to confine their initial request to simple listening. Nathan likely won't agree to more at this point. Note also that Mary and her mother represent not just a good relationship with Nathan (translation: less conflict) but some actual leverage: Nathan wants to stay on his mother's good side because he may need a loan in the future.

An Intervention in Action

Some interventions are invitational, meaning the subject knows in advance what will be discussed during the intervention. This team had already tried that approach and found it unsuccessful. That doesn't mean it wouldn't work in other situations. If things had been different, the discussion might have gone this way:

Vance: "Nate, the family wants to meet with you to talk about getting some help."

Nathan: "Oh, [censored]. Man, I wish you would stay out of it."

Vance: "I know you do. But the fact is, I'm worried about you too, dude.

Nathan: "Why?"

Vance: "Why not come to the meeting and I'll explain? And the rest of the family, too."

Mary: "We're not planning to argue with you. I love you, Nathan. So does everybody else."

Vance: "It's true, y'know. We're all committed to what's best for you."

Nathan: "Yeah, I know, but Ben's an asshole and Mom doesn't understand…"

Mary: "It'll be different this time. Vance and I will be there. We'd keep it under control."

Nathan: "Just you and them?"

Vance: "Yep."

Nathan: "And I should do this because?"

Mary: "Mom's really upset, Nate. She's so worried she can't sleep."

Nathan: "Dammit. I don't want to upset her."

Vance: "All you have to do is listen. What's to lose?"

Nathan: "I guess so."

Vance: "We'll pick you up on our way. You won't regret this."

Nathan (bitter laugh): "We'll see when it's over."

In this scenario, the team sent out two 'emissaries', both perceived by Nathan as having his interests at heart, to secure his agreement to participate. But what really hooks Nathan is the need to please his mother (and not coincidentally, keep open the potential for financial assistance).

An Intervention in Action

the when and the where of it

You may have heard of professional interventionists confronting the alcoholic in all sorts of weird locales: Airport waiting rooms, the police station, the back room at a Denny's. But if you're doing without the services of a professional, best to confine the location to something more controllable. We use three criteria:

- Quiet and reasonably comfortable—usually a team member's home
- No interruptions anticipated—Sunday mornings are a favorite
- NOT the alcoholic's residence. Better to think of a way to get him out of his comfort zone.

If you're planning on taking the alcoholic to a residential program, you should have the admission arranged and transportation ready. Always accompany him or her to the program (one or two of you is plenty). Arrange if possible to visit the following day. Appoint one team member to act as a central point of contact in case the alcoholic needs anything while in treatment.

In Nathan's intervention, the family chose their mother's home—a place where family meetings traditionally take place, comfortable for all and yet not Nathan's private turf.

An Intervention in Action

scene two: the format (moderator)

Interventions need a moderator, whose main role is to keep the discussion on task. The best moderators are people who have some detachment from the family and any strife that goes on within it. Someone who's already participated in an intervention, for instance, or a family friend who has the alcoholic's respect. The moderator needn't present much in the way of a statement of evidence or concern—his or her role is different.

Nathan's family chose his older brother Vance to moderate. Vance has been less involved with the family of late and Nathan is more likely to perceive him as neutral.

Vance: "Nate, buddy, we're here today because we're all concerned about you. We don't want to talk behind your back, so we decided to be upfront. This is really difficult for some of us, so we'd like to ask just the one thing of you: Wait until all of us are finished talking before you reply. You'll still get plenty of opportunity to share your views on things, and we promise to listen. Once we've finished going around the circle, that is. By the way, we've all turned off our phones. Mind doing the same? We're hoping not to be interrupted."

Nathan: "You can't talk, Ben. You've had your own problems."

Vance: "Nate, we asked at the beginning that you wait to respond until everybody's finished. You agreed. We promised you we'd listen, and we will. But for now, please just let each person finish their statement. It's really important."

It's difficult for alcoholics to sit and listen to this sort of feedback. They've been avoiding it for a long time, after all. So we generally recommend a low-key approach that emphasizes:

No commitment is required beyond listening, and

The alcoholic will get a chance to respond when others have finished.

If the alcoholic is allowed to interrupt, the intervention will quickly deteriorate into squabbling. It's important to prevent that from happening.

That's the moderator's principal job.

An Intervention in Action

scene three: team members present statements

A good statement should be:

- Half a page to a page in length, single spaced
- Based on the worksheet you completed earlier, and
- Requiring about 5 minutes to deliver, ten at the max. There will be other statements to come.

Here's an example, to Nathan from his sister Mary:

"Nate, you know I've been worried about you for a while now. You and I are closer in age and maybe that's why I always felt closer to you. Remember how much we used to talk? I miss that. But the truth is, phone conversations with you nowadays are frustrating. I suspect you've been drinking, because when we talk later it's like you don't remember anything that was said. You cover it up but I can tell you're faking it. Once I told you a deep dark secret from my divorce—I don't think I'd ever told anybody before—and I know you don't even recall the conversation. I was really angry about that. But then I realized it's a sign of how far things have gone. I'm not the only one who's noticed.

I have a confession to make. I ran into Dave Washington a few months ago, and he told me that you hadn't quit your job, you were fired. He said it was because they smelled booze on your breath at work. On a number of occasions, he said. I didn't say anything to you because I knew you'd get mad at Dave, but I felt like he was telling me the truth. He said the word's out, it's going to be hard for you to get another job. Unless you take care of your problem, he said. You're a great salesman, everyone knows that, but nobody can do well under that sort of handicap.

Nathan, I'm here because I love you and respect you and I want my brother back (begins to cry). I wasn't going to cry (laughs). I don't think I realized how much you mean to me until Mom and I were talking to you before this started. I know we're adults now, but we all need our family when times are hard. We're here for you now, Nate. I guess that's it for me."

It's short and to the point, as most really persuasive statements are, and there's no finger-wagging involved. Note also how Mary refers to feeling angry, but doesn't show her anger during the intervention. A display of anger triggers the alcoholic's defenses, and communication effectively stops.

An Intervention in Action

Now his mother's statement, the last in the intervention and the one with the most leverage:

"Darling, I've been worried about you for the longest time. It's not just what I hear from your sister. I've noticed the changes in you. You're so much more defensive than you used to be. I'm afraid to bring certain things up to you because of your reaction. You were never that way before. Then something happened when you and Bridgette were having your problems last year, and you stayed here for a couple weeks. One day I went to get your clothes for the wash and I found all these pills in your case. I used to be a nurse and I know what those pills were. Painkillers and sleepers. High doses, and there were two different doctors involved. That scared me. It explained why you were so sedated and dopey in the evenings. You had enough meds for three people. And you were drinking a lot on top of it. Every night as far as I could tell. You always liked to drink but I never saw you that affected before. It was really hitting you. I imagine the pills have a lot to do with that.

You know you've been coming to me for money this past year. This problem and that problem, it's temporary, you'll pay it back. You know I don't begrudge you the money, dearest. But I can't help but wonder if it's going for drugs. Do you realize you've borrowed over $3000 and haven't paid back any of it? I think perhaps I've been wrong to give it to you.

This sort of thing runs in our family, dear. Your grandfather. Your Uncle Jeff, who died when you were young. I know we didn't talk about it. We should have, I think.

I can't say it any clearer, Nathan. You need help. This sort of thing runs in our family. Your sister and brothers have found a place for you to get it. If you value my opinion, I urge you to do what they ask. If you do, I'll keep helping out financially to the best of my ability. If you refuse, I don't think I can continue to loan you money. I'm just enabling the problem. And that's not being a good mother—I realize that now."

An Intervention in Action

scene four: the alcoholic gets a chance to object and the team responds

Nathan is visibly moved by the statements of his family members. That's where a lot of the impact of intervention comes from: The sheer force of key people in the alcoholic's life, coming together with a consensus opinion that he needs help. And it makes a difference that they couched their concern in terms of caring and support rather than criticism—much more difficult to dismiss.

It's a powerful 'mirror' they provide for the alcoholic. Still, he's got some arguments left. He begins by attacking his brother Ben.

Nathan: "I can't believe you, man. All the troubles you had when you were a kid, worse than anything I did..."

Mary: "This is not about us being perfect, Nate. We've all had our problems, too. We're just saying that at the moment our main concern is to make sure you get the help you need."

Mom: "If Ben were the one having problems at the moment, we'd all be getting together to help him. And you'd help, too, I know you would."

The natural response would be for Ben to defend himself. But that would short-circuit the intervention by turning it into a one-to-one dispute between the brothers. So Ben remains quiet while the rest of the team intervenes.

This approach prevents Nathan from splitting the team, and reinforces the strength of their united opinion.

Nate moves on to other objections. Turns out there are three:

Nathan: "I appreciate everybody's concern. I really do. But there's a lot going on in my life you don't understand. It's too complicated to get into here, but trust me, this isn't all my fault."

Vance: "I think everybody here knows that. Things are always more complicated than they seem. But we're convinced getting help for drinking and pills is the essential first step to getting healthy again."

Mary: "We have to start somewhere, Nate. And the logical place is here."

This represents Nate's desire to divert attention from his drug and alcohol use. The team's prepared for this defense, too.

An Intervention in Action

Ben: "I know when I was having problems, I kept doing things that made them worse. Like getting drunk and smoking dope. That's why I couldn't seem to get my life together (pause). Remember that time when I was seventeen and I accidentally OD'ed? That was booze plus some pills the shrink gave me. I don't think I ever admitted that before."

Mary: "This is just the first step, we know that. But you can't take the second until you take the first, right? (smiles) I sound like a fortune cookie, but it's true."

Nathan: "You're right, I have been drinking too much. I'm sorry to have let you see that, Mom. And the pills, I shouldn't have mixed them with alcohol. But they're prescriptions, not street stuff. I'm not like a junkie or anything. I can cut back on my own, I promise."

Mary: "I wish I believed that. But I think we're past that point. (briefly tearful)"

Mom: "So do I, Nathan honey. If I thought you could do it without help, I wouldn't be here.

Vance: "I think we're all here today because we feel you need help beyond your own resources. The experts tell us it's an illness. One that requires treatment. That's what we're looking for."

Nathan's second objection involves his desire to solve his problems on his own. On some level this reflects the stigma we talked about. The alcoholic is afraid of the consequences of admitting his addiction.

Nathan's third objection has to do with money and timing:

Nathan: "See, I've got this job interview later this week. It's a place where I think I have a real chance of getting on, at least part-time. And you know I'm broke, I can't possibly pay for treatment at this point."

Mary: "Nate, you've already lost one good job because of this problem. Why risk another failure?"

Ben: "Yep. If it's only part-time, like you say, it'll most likely still be there when you get back. You can tell them it was a family issue you had to take care of."

An Intervention in Action

Mom: "I'll pay for treatment, Nathan. Vance is going to help."

Nathan: "Mom, I don't want you spending your money on me."

Vance: "We believe in you, Nate. It's an investment in you."

Mom: "That goes for me, too. That's how important we think this is."

scene five: applying leverage

When that discussion ends, the team can see that Nathan has been moved by their concern and largely persuaded by their arguments. But his fear of change is strong.

Nathan: "Look, I know you guys are probably right, I should go to treatment, but you have to believe me when I say I just can't. There's too much going on in my life right now, things I can't talk about yet but I need to.... let's just say I can't do it right now. Maybe in a couple months, when things settle down. (pause) I guess I need to think about it first. I promise I will. Really."

Vance: "We appreciate your willingness to listen, Nathan. This must have been as hard for you as it was for us. And I understand your reluctance to make a commitment."

Nathan: "You guys mean the world to me. "

Vance: I think the family still has a couple things to say, however. Mary?"

Mary (tearful): "I knew this would happen, Nathan. But I'm not willing to put this off any longer. If you refuse to go to the program, I'm going to contact those doctors and tell them you've been abusing the pills they give you. And drinking on top of them, to get high. And recommend they notify the pharmacies to watch for you."

Nathan: "You wouldn't."

Mary: "Yes, I will." (Looks him straight in the eye.)

Nathan (to Vance, a lawyer): "Can she do that, legally?"

I know what you're thinking here: "Well, that's nice for Nathan. What if we don't have deep pockets?" See "Finding the Right Treatment" for information on low-cost treatment options.

Vance: "Sure. And I believe she means it."

Mom: "And I'm going to go see the doctors with her, Nathan. And there will be no more loans, ever. I'm convinced the money I loan you is just going down the drain. I'll pay for treatment. I'll pay your living expenses when you come out of treatment until you can find work. As long as you're in treatment and I know you're clean, I'll help. But if you're not, then I won't."

Vance: "This is your big chance, Nate. Make the decision now, and have full support from all of us. Not just for the next couple months, but ongoing. Or do it your way and live with the consequences."

Nathan: "I feel like I'm being blackmailed."

Ben: "Tough love, bro. But it's still love."

Nathan: "All right, I'll go tomorrow."

Vance: "Now, Nate. We have the bed waiting. Mary will go to your place and pack you a bag. Ben and I will ride over with you."

Nathan: "Now?"

Mom: "Now or never, Nathan dear."

Nathan (resigned): "Okay."

scene six: the debriefing

That evening, with Nathan safely in treatment, the team gets together to de-brief.

Mom: "I think that might be the hardest thing I've ever done."

Ben: "Worse than me, Ma?"

Mom: "All right, maybe the second hardest." (Laughter.)

Vance: "He seemed to accept it. I told him I'd come by tomorrow to see if he needed anything."

Mary: "I'll come too."

Vance: "Yes, I think it's probably a good idea to work as a team for a while yet. You know how good Nate can be at manipulating us."

Mom: "You mean me."

The team follows three very important rules for successful communication.

- *They don't argue. That alone bypasses many of Nathan's defenses. It's hard to fight with someone who isn't fighting with you.*
- *They keep the tone positive. There are no open expressions of frustration or anger. They know Nathan would just treat these as personal attacks and stop listening.*
- *They support one another. Nathan can't split them. He must confront the consensus of their opinion, and that's much harder to dismiss.*

An Intervention in Action

Ben (reflecting on the earlier discussion): "He's worse off than we knew. You see him jump when you mentioned pills? I bet he's way strung out. I think he was relieved we did this."

Mary: "Really?"

Ben: "Yeah. I've sort of been there, a long time ago. You're floundering but you can't let anybody help you. It's about pride. But secretly you wish somebody would just make you get help."

Vance: "Let's hope you're right."

Ben: "Maybe you guys have never been truly miserable, the way drugs make you. Can't get to work, can't get to sleep, can't enjoy anything without getting high. And when it wears off, you feel like the world's collapsed. In a few days he'll feel better."

Mom: "What if he signs out?"

Vance: "Then we do what we said we'd do. Unless, of course, he changes his mind and signs back in."

Ben: "Make sure you remind him tomorrow."

Mary: "Don't worry, we will. Mom, there's a family meeting we're supposed to attend Thursday night. Vance'll be gone by then, but you and I can go."

Ben: "I'm going too." (They look skeptical.) "We're supposed to stick together, right?"

Ben makes a good point. The intervention's credibility largely comes from group consensus. To preserve that credibility, the team needs to continue working together. Particularly since their work isn't quite finished.

He's also correct when he suggests Nathan's substance problems are worse than they can know. Active addiction is like an iceberg; you can only see the tip. But Nathan has no doubt been working hard to hide how bad things really are.

An Intervention in Action

Nathan doesn't know it yet, but the team will meet again shortly before discharge. Nate and his counselor will be there this time, and the family will lay down some conditions for the immediate future. One will be that Nathan has to continue in counseling as recommended. There's a natural tendency to think treatment ends when the alcoholic walks out the door of the program. That's not true, and it's everyone's job to make sure no one forgets.

summary

This has been an introduction and orientation to the intervention process. Don't stop here. Read the Casebook for more examples of intervention in action. And we've included a brief bibliography of readings on the subject.

It's true that there's no magic bullet when it comes to convincing an alcoholic to get treatment. But the good news is, you don't really need magic. Intervention is about a plan, tapping into the hidden strength of the group, and finding the will to intervene.

11 Finding the Right Treatment

what Is good treatment?

In our humble opinion, good treatment is:

Available—meaning not plagued with an overlong waiting list. The ideal: when the alcoholic is ready to accept help, treatment is ready to provide it. In some areas, finding this can be a real obstacle.

Affordable—we're not fans of the notion that treatment must be costly. It's more important that it meets the needs of that particular alcoholic or addict – once you've determined what those needs are, that is.

Effective—meaning likely to produce the desired results. All treatment is not created equal. There's better treatment, worse treatment, and a wide range in between. But it's not always easy to tell the difference.

Two things to remember:

- There's no magic bullet for alcoholism. The goal of treatment is to improve the chances for recovery, health, and happiness. Good treatment does just that. Poor treatment doesn't.
- Second: to understand how treatment should work, compare it to the challenge of managing diabetes. Treatment means major changes in lifestyle. As the saying goes, you can't do the same things and expect a different result.

With diabetes, those changes mostly involve diet, exercise, and reduced stress. Recovery from alcoholism includes emotional and psychological adjustment as well as lifestyle and behavior. But in both cases, the change is always towards health and away from illness.

And with chronic conditions like diabetes and alcoholism, change involves a learning curve—meaning a succession of experiences, some perhaps quite challenging, occurring over an extended period. Progress may be erratic, as in 'two steps forward, one step back'.

One family complained that they would be willing to commit to treatment if they could just be assured that it would work—that their addict would get well and things would turn out fine. After a few weeks of this discussion, I retrieved a notepad from my desk drawer and composed a document that included a formal written guarantee of success. Dated and signed by me.

The father read it over and was clearly puzzled. "How can you guarantee success?" he demanded.

"I can't," I replied. "That's the point."

Nobody can. But does that mean we shouldn't try?

Of course not.

finding affordable treatment for people without many resources

This is often the real challenge for people who are uninsured or lack the funds to pay privately. And that's an ever-increasing number of Americans, unfortunately.

In some areas, the public sector provides the alternative. But in others, options are scarce.

Start your search. Here (in general terms) is how it's done.

begin by making a list of potential candidates.

First, contact your local Health Department and ask questions about the service you're looking for. They'll tell you what's available locally. You can also search online with the simple phrase "addiction treatment" and the name of the area where you live. That should also get you results. You can also check the Yellow Pages. Winnow through your list using two criteria: first, does it provide the service I need? Second, can they accept your loved one? Some counties restrict services to their own residents.

research the options

When the list has been whittled to a few likely candidates, contact providers and ask questions. Or schedule visits to see for yourself.

Here are some questions to ask:

1. Do you provide the service we're looking for? Whether that's detox, residential treatment, outpatient programming, medication, co-occurring disorders, etc, or a combination of the above.
2. What is your philosophy of treatment? The answer will tell you whether you're comfortable with the program's approach. Mind you, it won't reveal much more than that. But it does provide a hint as to how satisfied your family might be with the services provided.
3. How long do the various phases of the program last? Addiction is chronic and requires ongoing treatment, not a short burst of therapy.
4. How do you decide who needs what? Through an assessment process, of course, but it helps to have that described to you.
5. Last, ask a few questions about important particulars of your case. Easier to do in person than over the phone. For instance, if your loved one has a diagnosed emotional problem, can they handle that? If you live close enough, can you attend family sessions? Do they link up with other services in the community that your loved one might need? How do they approach 12 Step and other support groups?

Finding the Right Treatment

Your goal is to learn about the program, while reminding yourself that no program ever meets all your needs perfectly.

If it's true that an informed customer is a smart customer, then this process can make a real difference in your eventual satisfaction with the help you receive.

the 'best' treatment isn't always the right treatment

If you have resources—insurance that covers treatment, or the funds to pay out of pocket—you'll have more choices in front of you.

Not always better choices, but more choices. How do you decide?

To put it bluntly, you need to identify the treatment that best matches the needs of your loved one. And that's not always the most prestigious program.

The question we should ask is: "What treatment is most likely to succeed with this individual at this point in time?" The professional's role is to help you answer that.

inpatient or outpatient?

The issue here is structure—as in, how much external help does this particular alcoholic need in order to get and stay sober?

Apologies again for oversimplifying, but it comes down to a few basic issues.

First, is residential detox required? Or is there some other medical condition that would benefit from an inpatient stay? That depends on the severity of withdrawal symptoms. Perhaps the alcoholic has elevated blood pressure that can't be stabilized as an outpatient.

Second: Is there a mental health disorder that complicates the picture? Depression, mania, panic attacks—these are just a few examples. Depending on the severity, a clinician might decide that a short inpatient stay is indicated.

Third, is the alcoholic motivated enough to remain drug-free in the home environment? Can he control his impulse to drink?

Fourth: If she goes back to drinking or using, is she likely to present a danger to himself or others? The clinician looks at history and current mental status for the answer.

Finding the Right Treatment

Finally, is the environment safe, and is it conducive to an attempt to recover? Maybe she lives with an abusive boyfriend. Or in a drug-infested apartment complex.

For our purposes here, there are three levels of treatment we're likely to encounter:

1. First, detoxification, which can be done as an inpatient or sometimes an outpatient. Meds are prescribed to safely guide the addict through withdrawal.
2. After that might come inpatient rehabilitation—2 to 6 weeks of counseling and education designed to start the alcoholic on the path to recovery. The inpatient environment is used for alcoholics who need additional support and supervision (monitoring) to avoid a crisis.
3. Outpatient treatment—where the alcoholic doesn't live-in—comes in three common forms. Day programs usually operate between 9 and 5, four or five times a week. Intensive outpatient programs are attractive to working folks; they're usually three evenings weekly. Classic outpatient counseling ordinarily means a once a week visit. All can involve group and individual sessions. You might participate in a day program for several weeks, or intensive outpatient for several months, or weekly counseling for half a year or more.

Many programs are phased. The client progresses through several levels.

It's a good idea to ask the program what levels they provide, and how they determine who goes where. The answers will vary but it normally include the use of a standardized assessment such as the ASAM (American Society of Addiction Medicine) criteria for patient placement.

Finding the Right Treatment

Some years back I helped a family with an intervention on an alcoholic who by coincidence, I happened to know. A high-functioning type whose drinking was of considerable worry to his family, but someone who was medically in pretty good shape.

The family had researched the various treatment options and settled on a famous residential program in a distant state. A terrific facility, one everyone's heard of, with some of the best clinical staff anywhere. They had a friend who was a graduate and raved about it.

Still, I had my doubts. The program was openly spiritual in focus; this alcoholic was anything but. The program also had a liberal policy towards smoking, and this particular alcoholic was phobic about tobacco—to the point of leaving a room that smelled of old smoke.

I figured these two facts alone would drive him out of the program before it had a chance to benefit. But the family overruled me. Their argument being that they wanted only the best for their loved one.

If it had been up to me, I'd have sent him to a local physician who ran a solid if unexceptional intensive outpatient program that was more medical and psychological than spiritual in orientation. Plus it had strong boundaries around tobacco use, and actively encouraged people to quit.

You can predict the outcome. The intervention went well and the alcoholic got on the plane in a pretty good frame of mind. That lasted all of three days before he signed out of the famous program, against staff advice, and flew home.

I cite this not as evidence of how smart I am, but to argue that it's helpful to match the program to the patient. Intervention is all about overcoming (at least temporarily) the alcoholic's objections to change. The more objections we leave in place, the more likely it is the alcoholic will use them to justify dropping out of treatment.

Of course, nobody knows whether the program I recommended would have worked any better. We only know that the other one didn't.

Finding the Right Treatment

where to look for lists of providers

Here are some common points of reference that you can check out to see which represents the best fit for your needs. It's best to consult more than one, so you're less likely to miss an available resource.

Free or low cost programs

Your local health department
This'll be in the phone book. If you're in an urban area, they'll have an informational website about addiction treatment services, both residential and outpatient. If you're not, phone them and ask. Two advantages families find with public programs: First, they tend to be free or at least sliding scale. Second, they're usually more familiar with the local court system, which is important if your alcoholic or addict is involved with the criminal justice system. In some instances, there's also a downside: Certain services aren't available, or there's a waitlist. The local health departments can also direct you to private low-cost options that might be available in your area, too.

The National Facility Locator
This is operated by SAMHSA, the principal federal authority. Here's a link: Find a Facility.

On the map, just click your state. It's up to you to contact the various facilities that interest you, and do some investigating.

Your State alcohol and drug administration
Locate this via the State Government listings in the phone book or the State website. In many cases there will be a separate phone for treatment inquiries. Some states offer services that can be accessed by anybody within the state. Other services will be restricted to certain local areas. All the listed programs and providers will have been certified by the State as meeting the required standards.

Twelve Step meetings for families
Many families get info about available treatment resources from visiting these meetings. The ratings and evaluations are highly subjective, of course. Same goes for recovering people of your acquaintance. How do you find the 12-Step family groups? Look here: Meeting finder.

for a more varied list of programs

National Association of Treatment Providers
This will include low, medium, and high-priced programs. They offer a representative list of member providers, near and distant, by name and by state. You can check surrounding states as well. Here's the link: Member Locator. Be sure and visit the websites for each before you call.

12 Intervention Casebook

introduction

The nine examples that follow have two things in common:

First, the families received coaching from a professional, but for reasons that vary—finances, logistics, plain old preference, to name a few—chose not to have an interventionist present when they confronted their loved one.

Second: all were successful -- meaning the subject wound up entering treatment at the appropriate level.

Otherwise, these cases are very different. Some involved a formal sit-down intervention. Some didn't. We include both types to portray the diverse forms that real-life intervention can take.

As to the role of the professional: seems to us that it's of most value during the run-up to intervention. Helping the family make the decision to intervene, for instance. Devising an effective strategy. Learning techniques for getting through to someone who doesn't want to hear your message. Above all, offering an objective view that none of us has, when it comes to our own families. A professional can provide this, and it's worth the effort.

But most of the success or failure of any intervention is determined during the preparation phase—before we sit down to intervene. Let's face it, no alcoholic really cares about the opinion of a counselor he's never met. It's the family and friends who have the leverage and the motivation for intervention.

Here are some examples of how it can be used to convince a reluctant individual to accept help that he needs but doesn't want. By the way, the details have been changed to protect the privacy of the folks who took part.

Case One: Fight or Flight

Here the challenge lay in an adolescent's habit of fleeing the scene and disappearing for days at a time whenever his family confronted him about his drug use—a terrifying (or perhaps a better word would be terrorizing) experience for his parents. After numerous unsuccessful attempts to engage him, they'd resorted to what they considered a compromise solution: he could live in the redecorated basement, with a private entrance that allowed him to come and go as he pleased. At least that way, his mother reasoned, he was likely to be safe at home at night.

The unintended consequence: This arrangement actually made it *easier* for him to continue using and selling drugs. With no rent or food costs, and a safe haven from the police, his profits went straight up his nose.

By nature, his parents were what we might describe as 'conflict-avoidant'—quiet, law-abiding folks who were visibly uncomfortable with expressions of anger, and frightened of any action that might make the situation worse.

The couple also had two grown daughters who were healthy and stable. The last child had been an accident, twelve years younger than his sisters. They took the blame for the boy's problems because both had busy careers and felt they hadn't paid as much attention to him. On some level, they believed his drug use resulted from their neglect.

In the past, they'd recruited the older sisters to help intervene—'you talk to him, maybe he'll listen to you'—and on one occasion had brought in a professional interventionist. The attempt failed. "It was probably our fault," the parents acknowledged. "We just couldn't make him leave home. We couldn't sleep at night for fear of what might happen." After the failed attempt, his sisters had thrown up their hands, refusing any further involvement.

The first question in any intervention is whether or not the subject will agree to sit down and listen. It's not automatic. That's why this family needed a team composed to prevent activation of that fight-flight response.

The solution involved recruiting two (out of six) team members whose main role was to encourage him to stay. One was his former high school basketball coach, and the other a tutor with whom he'd once had a strong rapport. Neither had seen him in over a year and had little to say about his drug use. Nonetheless their appearance as part of an intervention team surprised him and made it much harder for him to bolt—some part of the youth still valued their good opinion. We rehearsed their role at some length and when the time came, their participation made a difference. He stayed and subsequently agreed to 30 days in a residential program.

Both sisters took part, by the way. Turned out they just wanted to make sure their parents really meant it this time, and wouldn't 'wimp out' at the last moment.

If you can get an addict to *listen*, you can usually get an addict to accept help.

Case Two: The Chairman of the Board

People are understandably nervous about confronting the rich and powerful. For one thing, riches and power can be very intimidating. Still, it helps to remember that the rich and powerful have their own vulnerabilities. For instance, they're often:

- More concerned than most about what others think of them
- More likely to use their outward success as a defense against criticism of substance use
- More likely to have surrounded themselves with enablers, and
- More adept at manipulating others (a secret of their success?)

In this case, the alcoholic in question was a noted criminal defense attorney who, now semi-retired, served as chairman of the board of his firm, and a frequent commentator on local criminal matters for TV and the media.

The family expressed the fear that any move towards intervention might endanger his reputation and even bring ruin to his long and successful career. They also mentioned fear of his formidable personality.

'He's a scary guy to cross', as his son put it. As a result, people seldom crossed him.

After some discussion, however, they began to see things differently. There had been a couple recent embarrassing episodes that made it clear that doing nothing wasn't really an option—more public incidents would follow.

The media would inflate future incidents to fill air time on a slow news day. The cat would jump entirely out of the bag.

In that respect, untreated alcoholism would eventually make the decision for them.

And of course, on some level, his grown children had to realize they were still scared of him. Not so hard to understand; he'd built his career on bullying people. Just acknowledging that seemed to empower them.

With those issues out of the way, they began to talk seriously about their real concerns, such as diabetes and high blood pressure. How would they feel if a stroke or a heart attack killed him, without them having ever taken action to intervene? Once that became the theme of conversation, their motivation for intervention increased dramatically.

The intervention team ultimately consisted of his wife of 35 years, his three adult children, one grown grandchild of whom he was inordinately proud, and his original mentor in the law firm, now retired. The team had considerable leverage but never got a chance to use it. The alcoholic simply agreed to whatever they wanted.

I suspect it was because he was so impressed by the fact that somebody, at long last, had been willing to stand up to him.

Case Three: The Complex Case

Temporary working definition of a complex case:

> *Multiple primary disorders. For example: someone who is both alcohol dependent and has bipolar disorder. Or cocaine dependent plus a personality disorder. Opiate addiction and chronic pain. Where this sort of complexity exists, there are usually also medical, social, or family problems to further complicate things; and a history of poor response to treatment.*

Here, the young woman in question had multiple prior treatments at various psychiatric institutions. Along the way she'd been diagnosed as suffering from:

- Bipolar disorder,
- PTSD,
- Panic disorder,
- Bulimia,
- Borderline personality disorder, and of course,
- Polysubstance abuse & dependence.

An intimidating set of problems, huh? There were also many suicide attempts, beginning as a young teen and usually involving an overdose of pills. There was a long period of cutting and burning herself as a teen. She binged and purged. All this had left many scars on her parents. Above all, they feared that any confrontation would cause her to end her life.

And I'm sure that would have been enough to thwart any plans at intervention had her recent condition not begun to frighten them even more. A few weeks previously, she showed up at her parents' home after a long absence, now significantly underweight, openly confused, and quite paranoid. The family attributed this to her having moved in to a crummy apartment with two male drug dealers. They suspected she was a 'mule' for their wares as well as a sexual party favor. They strongly suspected she was HIV positive. Now they were worried about the possible consequences if they failed to intervene.

With any complex case, it's important to gather as much information as we can about the subject's current behavior; to establish what risks and challenges it presents, and to develop a plan to manage those challenges during the intervention process.

Asked to identify the possible risks associated with intervention, the family came up with these:

- We might spur another suicide attempt.
- She'd run away, and they wouldn't be able to find her, and
- Her paranoia and confusion would thwart any attempt to communicate.

I thought this was a pretty realistic assessment of the potential downside. We came up with a strategy to overcome these obstacles.

First, there'd be no attempt to surprise her. Instead, the intervention would feature a formal invitation to a family meeting. We'd take certain steps to increase the chances she was relatively drug free and clear headed for the meeting.

Second, we'd spend considerable time practicing how to deal with a paranoid and confused person.

Our idea was that by modulating and controlling our own behavior, we could temporarily influence hers in favor of a rational discussion of a few essential issues. We knew that if we inadvertently activated her fight-flight response, we were goners.

One other issue: How would we get her to the meeting? Offer the possibility of money, they responded without hesitation. It had been her primary motivation ever since she began using drugs. At one point they'd provided her with a monthly allowance, but stopped once they realized what she was doing with the cash. Suppose they offered the possibility of restoring that allowance, provided she met with some terms and conditions? To be revealed at the 'family meeting', of course.

They selected two emissaries to make the approach: A favorite cousin who happened to be in recovery himself, and her beloved Uncle Max, who would fly in from out of state. These two would extend the invite. Their involvement would impress her.

During rehearsal, the team decided that the mother present but say nothing during the intervention; her relationship with her daughter was just too damaged. The father, on the other hand, had been a passive figure in recent years, and the team felt he should take a very active role in presenting the conditions.

The rehearsals were almost a mini-course in crisis prevention. The consequences the family feared most—running away, another suicide attempt with pills, another dramatic scene—were played out with several endings. Our goal was to build the family's confidence in their own power to deal with their daughter's emotional storms.

In the end, the intervention that wasn't an intervention went quite smoothly. The 'carrot' of a monthly allowance was so strong that the young woman agreed quickly. The conditions: First a residential detox. Then a return to her parents' home while she was in intensive outpatient treatment. Then a stay in halfway house. She was also required to submit to random drug testing at the clinic, with her parents notified immediately in the event of a positive test or if she failed to show. In that event, she agreed in advance to re-enter an inpatient program without protest.

She last almost two months before she relapsed. The family of course expected a relapse, given their prior experience. They packed her off to a program in another

city. Almost miraculously, she bonded with the staff there and stayed an extra three months. After discharge she got a job as a desk clerk at a mental health clinic and two years later married a young man she met at a 12 Step retreat.

If anybody seemed like a hopeless case, it was this young woman. Just goes to show ya...

Case Four: Dealer's Choice

Devin, the addict in question, was himself a drug dealer of some standing.

He'd begun dealing in college, mostly marijuana, then later on, high-quality cocaine to the affluent twenty- and thirty-somethings in his social circle. Over the years he'd added various designer drugs to his supply chain. At one point he'd claimed to friends that he sold more than a million dollars worth of illicit substances a year—all the while maintaining a legit cover as an investment advisor. But his personal use escalated as well. His oldest friend Terry, newly in recovery himself, was the one who finally brought the problem to Devin's family.

Terry's concern wasn't simply the effects of Devin's drug use, but also the possible reaction of his suppliers. Devin's dad, twenty years sober in AA, decided to confront his son, without success. Devin admitted to dealing drugs but minimized his own use, claiming that it was Terry who was still using, and trying to cast suspicion on Devin.

Devin agreed however that making a fuss could be dangerous if his gang connections found out. "You don't know what these people are like," he informed his father. "If they think I can't be trusted because I'm out of control—who knows what they'll do?"

This argument effectively stopped his family in its tracks. How could they move towards intervention if it put their son in danger? They considered turning him into the police, but feared he would be even less safe in prison. So for the past eight months, they'd remained effectively immobilized. They hoped against hope that Devin would eventually see reason on his own.

Cocaine is not a drug that makes people reasonable. Devin had reached the point where he ate and slept little, was frequently paranoid, and twice had been taken to the ER following seizures. His parents and older sister had come to me for advice.

"We're between a rock and a hard place," Devin's father explained. "We can't decide."

"You talk as if it's your decision to make," I pointed out. "What about giving Devin the choice? You could set up an intervention where you express your fears to your son and then give him a clear set of options. He can choose treatment voluntarily, with your firm support. Or you will contact the police and turn him in."

"But we don't really want him to go to jail," his sister objected.

"Of course you don't. But I doubt Devin does, either. So if he believes you mean it, and we give him the option of treatment, he might just take you up on it."

Which of course he did. It was really Devin who stood between a rock and a hard place. He was scared. Once in treatment, he actually seemed grateful.

Intervention isn't about making the decision for the alcoholic. We can't do that. It's about tipping the balance in favor of treatment, so the alcoholic makes the choice himself.

Intervention isn't about making the decision for the alcoholic. We can't do that. It's about tipping the balance in favor of treatment, so the alcoholic makes the choice himself.

Case Five: Intervention Over the Phone

The challenge in this case was distance—and simply putting together an intervention team.

The family was very small: An alcoholic father in his mid-70's, who lived in a remote section of a rural state, and three grown children scattered around the world (one in Boston, two on active duty overseas.) No other close relatives. This was no doubt in part why Dad's alcoholism had progressed so far—nobody around to interfere.

His drinking followed a familiar pattern among seniors: Lifelong use that now resulted in frequent falls and visits from the ambulance. The alcoholic lived alone, but a housekeeper visited several times a week. The housekeeper spoke little English and was mainly worried about upsetting the man whose continued good will was important to her stay in the US.

The eldest son, a professor of social work, had read up on intervention, then retained a professional interventionist to join him at his father's house. Dad was (fortunately) sober when they arrived unannounced. The three of them spent about four hours discussing treatment. Then the alcoholic politely but firmly sent them packing. "He couldn't wait to get rid of us so he could get drunk", the son stated flatly.

The alcoholic had refused treatment on the following grounds:

First, he disputed the notion that his drinking was out of control. His falls he blamed on age, slippery hardwood floors, and too-thick pile rugs.

Second, he insisted the housekeeper could look on him more often if that would make his son feel better.

Third, his physician had not diagnosed him as alcoholic or told him to quit drinking.

On the way out of town, they stopped off for a quick word with that physician. Who turned out to be ten years older than Dad and smelled suspiciously of alcohol.

That was a year earlier. More incidents had followed. The eldest son determined that he would make one more attempt to intervene. If it didn't work, he'd give up.

There were two main barriers to overcome. First was the lack of a reliable medical evaluation. Second was the absence of sufficient leverage to motivate treatment. The family arrived at this compromise solution: they'd target not treatment itself, but a full medical assessment, performed by a competent physician with a background in addictions. If the alcoholic came up with clean bill of health, the family would accept that. But if there was evidence of alcoholism, Dad would be asked to agree to treatment without protest.

That left the issue of motivation. The son had another concern—after their extended visit, he'd come away with the impression that his father was suffering from impaired cognition, possible related to dementia. Could be alcohol-related, but there was no way to be certain pending a formal assessment. He'd briefly considered commitment but quickly determined that state law made that impossible. Still, he felt strongly enough to maintain that if his father refused the assessment, he'd proceed towards commitment.

After all, the son knew how difficult that would be, but perhaps the father didn't.

The eldest flew back to his father's home and the other two children participated by phone. To make a long story short, the alcoholic was impressed by their concern and agreed to the evaluation. It's a good thing he did, because his new physicians discovered a tumor on his liver that required surgery. The family doc had missed it.

The new doctors minced few words when it came to the need to quit drinking—which the alcoholic subsequently did, without complaint.

Case Six: Evidence

In order to convince someone to seek help, we have to demonstrate need. In other words, provide evidence that a problem exists.

Not the easiest thing to do. The subject of your concern may go out of his or her way to hide the problem from those who care about them. Then challenge you to prove otherwise.

This is complicated by our natural reluctance to recognize the signs of addiction in a loved one. It may scare us as much as it scares them.

In this case, a young woman's parents strongly suspected some type of eating disorder, probably binging and purging, but lacked real evidence. They'd confronted her on several occasions, to no good end. She'd actually become more secretive as a result. Their direct approach had inadvertently reinforced her defenses and made it more difficult to get at the facts.

Which left her younger sister as the only remaining opportunity for real communication. But the sister was reluctant to snitch on her sibling. "I don't want to play detective with my own family," she protested when her parents asked for help. She had a point—this wasn't a criminal investigation.

Turned out the youngest, Helen, was an aspiring biologist. So we reframed the question in terms of the scientific method. Why not gather factual information? The family hypothesized an eating disorder, but would the facts confirm it? If not, the issue could be put to rest, once and for all—and would no longer trouble the family.

Helen approached fact-gathering from a position of neutral disinterest. She correctly thought that any expression of concern on her part would just set off her sister's alarm system.

She made a list of the signs and symptoms based on current diagnostic standards, and began observation. She looked for opportunities to spend long periods of time with her sister, and took note of any indicators of an eating disorder. She promised to make no judgments and take no action. She would simply record her observations and report back in a month.

When the initial period ended, Helen was stunned to realize how much evidence she'd amassed. The situation was far worse than she had expected. And she'd been mobilized to intervene in concert with her parents. The intervention was a success, largely because they were able to provide a concrete basis for their concern, and were unanimous in support for seeking help.

That period of research—notice we do not say detection—is often a big help in establishing the basis for intervention—or in some cases, deciding against it.

Case Seven: An Empty Threat

Here the subject had problems with sex addiction (in real life and via Internet porn) plus longtime heavy use of Ecstasy and other stimulants. He was a successful (to all appearances) psychologist with plenty of money, known for his advocacy of experimental therapies. Several of his former students, including some with whom he'd used drugs, had become very concerned about his conduct. He'd narrowly avoided arrest on two occasions. His fiance had already broken off their engagement, and was out of the picture. His parents were dead, and there were no close relatives to involve.

As for his former students, he'd kept them at bay with threats. Principally, that if they 'betrayed [his] trust' by revealing anything about his drug use or sexual conduct, he'd ruin their reputations in the field. "He's a really well-known guy," one of them said. "We're nobodies. They'd take his word over ours. He said he'd make sure we never got a good position again."

They were ashamed of their cowardice, but cowed nonetheless. The real barrier to intervention lay in the effectiveness of this threat.

"Suppose you were to let it be known that he was a regular user of Ecstasy and other drugs," I asked them. "What would happen?"

"He'd sue us. We'd be hauled into court," came the answer, without hesitation.

"And then you would most likely be called to the stand, to testify under oath that he was using drugs and participating in orgies—right? And you'd witnessed this."

"Right," they agreed.

"And this is going to make YOU look bad?" You could see the light bulbs go on—it would mean the end of his career, not theirs.

These individuals, well-schooled and bright, had allowed themselves to be bullied by an empty threat.

Case Eight: The Relapser

Here the subject was someone who had already undergone many treatments for addiction. Sometimes she'd relapse a few hours after discharge. Other times she'd seem to do well for a few months, before falling back into old patterns. Never longer than four or five months, however.

She'd picked up a number of co-diagnoses along the way, as people tend to do—depression, bipolar disorder, borderline personality.

Her husband seemed detached from it all, making no move towards divorce, but not supporting recovery, either. He lived his life around his wife's problems. As if he'd given up and was simply waiting for events to run their course.

Their insurance paid for therapy, she had her own substantial income from a trust fund, and as long as her behavior wasn't too much of an inconvenience, he didn't seem to care what she did. She suspected he had a girlfriend or two on the side.

Her parents weren't at all sure an intervention would be worth it. Even if she completed treatment, wouldn't she just relapse?

Like many Americans, they conceived of treatment as a sort of washer-dryer—goes in dirty, comes out clean. Goes in wet, comes out dry. But of course it doesn't really work that way.

It's more like heart disease. Do we feel we haven't got our money's worth when someone comes out of the hospital with a warning that he still has heart disease? No. Because we didn't expect a cure. We understand that.

Relapse, even multiple relapses like this woman's, aren't really evidence of treatment failure. Diabetics relapse, but we don't see that as a sign of hopelessness. We simply acknowledge that change is difficult, and many people struggle with it.

Addiction isn't a 'problem' that you 'solve' the way you correct an error on your tax return. It's a disorder that affects a whole range of behaviors, including the personality itself. The pattern can be broken, but the mystery isn't why so many relapse—it's why, given the challenges, so many succeed.

If the relapser's family was discouraged, imagine how she felt. Not just scared to fail—heck, she expected to fail—but of getting her hopes up once again, only to fall flat on her face.

The task here was to give the family an injection of renewed faith, so that they could in turn pass it on to the alcoholic. Maybe if they believed, she could allow herself to believe, too.

This intervention was about love and support. A level of family commitment that despite all their previous attempts, they'd never really achieved. In return, they asked more of her—not a thirty day program, or three months in a halfway house, but a year in a therapeutic community. They didn't just ask her to make that commitment, they challenged her.

She stayed two years. But hey, it worked.

Case Nine: 'Already in treatment, but…'

Treatment wasn't working. This alcoholic was on his third outpatient program and yet continued to drink—trying to keep it secret, but somehow people always found out.

He was getting a lot of support from others. Sometimes it seemed that those around him—counselors, psychiatrist, probation officer, 12 Step sponsor, wife and family—were working harder at the alcoholic's recovery than he was. In fact, that was the problem. This alcoholic wasn't really trying to stop drinking. In a weird way, he used treatment to perpetuate his use.

If he was going to meetings and participating in group, then he couldn't be accused of failure, could he?

But of course, that's exactly what he was doing—failing.

So when the alcoholic's wife finally came to see us, we turned the question around. To ask: What is it that is blocking his motivation for change?

The family came up with several answers:

First, he still saw himself as in control of his drinking—to some extent, a 'successful' drinker. His network of excuses for various alcohol-related problems had so far not been penetrated.

Second, he still associated alcoholism with a down-and-out drunkard, not a solid citizen like himself. He continually 'compared out' with other alcoholics.

Third, despite multiple relapses, he was getting away with more drinking. His superficial compliance with treatment staved off the most feared consequences—jail and the loss of his family. In that sense, treatment had become part of the problem rather than the solution.

The intervention was designed to break this pattern. Family, counselors, fellow sufferers—a total of eleven people participated. More than ordinarily recommended, but we couldn't fight off all the folks who volunteered to participate. Seemed like everyone had something to tell this alcoholic.

As in the case of the relapser, the interveners asked for a commitment to recovery well beyond what he'd done in the past. That included extended residential treatment. He quickly agreed, awed by the force of their conviction.

Of course, this alcoholic had known all along that he could lose his family and even his freedom if he continued relapsing. I suspect he was just putting recovery off as long as he could get away with it.

Reminded me of the longtime sober alcoholic who described the moment his own life turned around. He was on a stretcher in the Emergency Room for the umpteenth time, following yet another binge. A young foreign-trained resident approached him with the usual warning. "Mr. ——," the doctor pronounced, "If you don't quit drinking, you are going to die!" Yeah, yeah, heard that before, the alcoholic remembers thinking. But then the doctor added: "Soon!"

"It was the 'soon' that did it," the alcoholic later confessed. "I guess I never thought it could be soon."

Addiction isn't a 'problem' that you 'solve' the way you correct an error on your tax return. It's a disorder that affects a whole range of behaviors, including the personality itself. The pattern can be broken, but the mystery isn't why so many relapse—it's why, given the challenges, so many succeed.

13 Intervention Bibliography

It's Not OK To Be A Cannibal: How To Keep Addiction From Eating Your Family Alive,

Andrew Wainwright & Robert Poznanovich (*Hazelden, 2007*)

The authors are recovering addicts and cofounders of a leading national provider of intervention services, Addiction Intervention Resources. The book is aimed at the family; a significant part is the authors' own stories of addiction. Paperback, 156 pages.

Love First: A New Approach to Intervention for Alcoholism and Drug Addiction

Jeff & Debra Jay (*Hazelden, 2000*)

A husband and wife intervention team based in Michigan. Debra specializes in intervention with seniors. Also aimed at the family, and includes a lengthy appendix of helpful materials. Paperback, text is 205 pages.

Addiction Intervention: Strategies to Motivate Treatment-Seeking Behavior

Robert K. White & Deborah George Wright, Editors (*Haworth Press, 1998)*

An academic review containing articles by various authors. Aimed at therapists and other professionals. Paperback, 140 pages.

Heart to Heart: The Honorable Approach to Motivational Intervention

Ed Storti (*self-published 1990, reissued in 2006, available through author's website.*).

Storti is a West Coast interventionist associated with the Betty Ford Center, who developed a somewhat different technique called Motivational Intervention™; . Paperback; aimed at families; about 160 pages

Intervention: How to Help Someone Who Doesn't Want Help

Vernon Johnson (*Hazelden, 1986*)

Dr. Vernon Johnson describes the process that has successfully motivated thousands of chemically dependent people to accept help. In simple terms, this book shows how chemical dependency affects those around the addicted person, and teaches concerned people how to help and how to do it right. Paperback, 132 pages.