

A Guide to Intervention

Make a Choice. Take a Step. Find Life.

Eternal Awakenings



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What, Why and How of Intervention

What is Intervention?

In its simplest form, intervention on alcoholism or drug addiction happens each time the dependent person is confronted with his/her use or related behavior. This form of intervention is inadequate and counterproductive. Following such an encounter the addiction worsens and the family and friends of the dependent become angry and frustrated and may avoid further confrontation out of fear of the dependent's reaction.

What is Structured Intervention?

In structured intervention, the family, friends and/or employer of the chemically dependent person are led, as a group, to a point at which they can effectively and constructively confront the dependent and thereby interrupt the progress of their disease. The intervention process requires a strong commitment on the part of the concerned individuals and the interventionists. In effect, a team is formed to intervene ON the alcoholic/addict about his/her problem. The structured team approach is the most effective form of intervention and while there is some risk involved, the process itself and the work that leads up to it are acts of love, courage and hope.

Why Intervene?

Alcoholism is a **progressive, terminal disease characterized by delusion and denial**. Left to his/her own devices, the addicted individual is doomed to continue their downward spiral. They have a disease that makes them think they do not have a disease! We believe that the belief that an alcoholic/addict must "hit bottom" and ask for help is a deadly myth. Studies have shown that the chance for recovery remains the same no matter how the person reaches treatment. An intervention, properly done, serves to raise the bottom, create a crisis, break through the denial system and lead the dependent person to the help that they need to begin recovery. This method also allows him to be a part of the decision to seek treatment, thus relieving anger and promoting cooperation. Intervention works, as does treatment.

How Does a Structured Intervention Work?

In a structured intervention certain elements must be present. The most important of these are a group of two or more caring, concerned people who are willing to confront the dependent with his/her behavior in a non-judgmental and specific way. These concerned people must be well versed on their role in the intervention and willing to take risks necessary to help the dependent person. An intervention, properly done, is a carefully orchestrated and controlled event in which virtually nothing is left to chance.

Intervention Program Description

The Intervention Program is designed to give “concerned others” the skills, knowledge and support necessary to help the “troubled” individual help themselves. **The chemically addicted person attends the intervention session only**, and does not attend any of the other Intervention Program classes or services. Ideally, the Intervention Program consists of an assessment interview, followed by three classes, the intervention, and a follow-up session.

The Assessment Interview: Initially, the concerned others meet with an intervention facilitator for about one hour. The purpose of this session is to collect some information about the concerned others and the addicted person in order to make recommendations about the services which would best meet the needs of all involved. If intervention is determined to be the best approach, the program proceeds.

Class 1: The concerned others attend a group session which includes a lecture on the disease of addiction and the film “The Intervention”. The goal of this session is to teach the concerned others about the disease and to acquaint them with the intervention process. They must know the nature of the disease in order to do an intervention. Many times, Class 1 is combined with the assessment interview.

Class 2: The concerned others hear a lecture on the “Family Illness” concept and enabling. The goal is to learn how their behaviors have sheltered the chemically addicted person from suffering consequences of his/her disease. The concerned others will also learn how they have been affected by the illness.

Class 3: The concerned others meet as a group to proceed with the intervention rehearsal. At this time, the facilitator helps to determine who will be involved in the actual intervention, precisely what each person will say and, finally, set a date for the intervention. Many times, classes 2 and 3 can be combined.

Intervention Session: The concerned others and intervention facilitator meet as a group to proceed with the intervention on the chemically addicted person. The goal of this session is to confront the chemically addicted person with the facts of his/her illness with the intention of helping him/her make a decision to seek treatment.

Follow-up Session: The purpose of the follow-up session is to give the concerned others an opportunity to discuss their feelings about the intervention and to reassure them that they acted in the addicted person’s best interest and that they have no reason to feel either guilty or discouraged.

Rights of Intervention Program Participants

1. You have the right to considerate and respectful care. Your facilitator is responsible for considering your individuality as it relates to your social, religious and psychological well-being and for providing you with those services which will best meet your individual needs. Your facilitator is also responsible for delivering all services in a professional and ethical manner.
2. You have the right to privacy and confidentiality. Your facilitator should make every effort to protect these rights. No information concerning your involvement in the Intervention Program shall be made available to any organization, agency, or individual without your written consent. Only the intervention facilitator and any other Intervention Program Staff shall have access to information concerning your involvement in the Intervention Program.
3. You have the right to request and receive information about the Intervention Program including any services, the charges for any services and the rationale and goals of any services. You also have the right to request an explanation for any and all referral recommendations you may be provided with during your involvement in the Intervention Program. You have the right to the names and qualifications of any and all Intervention Program Staff.
4. You have the right to file a complaint if you feel any of your rights have been violated.
5. You have the right to contact your intervention facilitator at any time during your involvement in the Intervention Program. If any problems do arise and you feel the need to talk, we encourage you to do so.

Responsibilities of Intervention Program Participants

1. You are responsible for attending all intervention classes. You will be expected to be at every intervention class/session and to arrive on time. If you are unable to attend any class/session, you are responsible for calling your facilitator. We ask that you miss only in the event of an emergency.
2. You are responsible for maintaining the privacy and confidentiality of the other Intervention Program participants. You will be expected to discuss class proceedings during class sessions only. You may not share information contained in lectures with anyone at any time. All other information concerning any other person in the classes is not to be shared with anyone at any time. You will be able to learn a great deal from one another as long as this trust is maintained.
3. You are responsible for providing the intervention staff with accurate and honest information. Your facilitator will base all of their recommendations on the information that you provide. If the information is not accurate or complete, the facilitator's recommendations may not be appropriate for your needs.
4. You are requested to refrain from the use of all mood altering chemicals (alcohol and drugs) during your involvement in the Intervention Program. The only exception to this request is the use of drugs that are medically necessary. If you have any questions about any mood altering chemicals you are currently using, please ask. You are responsible for keeping this commitment. We are making this request because mood-altering chemicals do affect learning rates as well as emotional states.
5. You are responsible for completing all homework assignments. If you have problems with or questions about any of the assignments, please feel free to talk with any of the Intervention Program staff. You will not be graded or tested on any of the assignments. The homework is for you and is designed to help you in preparing for the intervention.

Outline of the Intervention Process

CLASS ONE

- I Education – The Disease
 - A. The Disease
 - B. Nature of the Disease
 - C. Definition of the Disease
 - D. Progression of the Disease
 - E. Delusional Memory
- II Group Commitment
 - A. Do all participants believe that there is a problem?
 - B. *Screening participants who are inappropriate.***
 - C. *Watch film on Intervention, when appropriate.***
- III Review
 - A. The Intervention Concept and Goal
 - B. Intervention Presentation Guidelines
 - C. Documentation Preparation
 - 1. Suggested Feelings Words
 - 2. Documentation Sheet Example
- IV Treatment Recommendations
 - A. Discuss Treatment Programs
 - B. Discuss Treatment Alternatives
 - C. Discuss Consequences
- V Date and place for Intervention sessions and Intervention
- VI Assignments
 - A. Complete Documentation Sheet
 - B. Make decision on Treatment Program
 - C. *Family to attend Al-Anon***

CLASS TWO

- I Education – Family Illness
 - A. Substance Abuse: A Family Problem
 - B. Symptoms of Co-Dependency
 - C. Enabling
 - D. Enabling Worksheet
 - E. What Goes on in the Family
- II Review Documentation Sheet
- III Complete Intervention Planning Worksheet
- IV Assignments – Arrangements for admission (see Intervention Checklist)

CLASS THREE

- I Intervention Rehearsal
 - A. Practice of Presentation
 - B. Your Intervention Rules
- II Discuss and List Consequences
- III Complete Intervention Checklist
- IV Last Minute Reminders
- V Plan for Follow-up Session

INTERVENTION SESSION

FOLLOW-UP SESSION

The Disease

I. Definition of the Disease

Chemical Dependency is a primary, progressive, chronic, fatal disease of unknown etiology, characterized by the abuse of mood-altering chemicals (alcohol or other drugs) to the point of dysfunction in one or more areas of the person's lifestyle.

II. We are a chemical using society. (*Bayer Aspirin commercial: Life's gotten tough; we've gotten stronger*). We use chemicals:

- A. To relieve symptoms of illnesses.
- B. To relieve stress.
- C. To facilitate socializations.
- D. To feel better.

III. Some people develop the disease of chemical dependency.

- A. Definition of a 'disease' is "any deviation from a state of health with a progressive, identifiable set of symptoms."
- B. American Medical Association defined alcoholism as a disease in 1956.
- C. Chemical dependency is a **primary** disease.
 - 1. It has its own symptoms which are identifiable across the population of its victims.
 - 2. It has a predictable prognosis if the addiction-prone individual continues to use chemicals.
 - 3. It is not a symptom of a more serious problem.

You don't need to want help to get help!

- D. Chemical dependency is a **progressive** disease.
 - 1. A long-term plateau of observable symptoms is not possible.
 - 2. The physical, emotional, and spiritual symptoms become worse when chemical use continues.

- 3. The physiological tolerance for the chemical can increase or dramatically decrease even during abstinence.

E. Chemical dependency is a **chronic** disease.

- 1. There is no known cure.
- 2. The victim is always susceptible to pathologic chemical use even after years of abstinence.
- 3. The symptoms of the disease can be arrested.
- 4. The victim must abstain from using all mood-altering chemicals in order to recover. "*Once a pickle, never a cucumber again.*"

F. Chemical dependency is a **fatal** disease.

- 1. It is a terminal illness unless the chemical use is permanently stopped.
- 2. Chemical dependency deaths are often misrepresented on death certificates.
 - a. Physical deterioration (heart disease, strokes, blood pressure problems, etc.)
 - b. Accidents while under the influence of chemicals.
 - c. Suicides.

III. The disease model holds that:

- A. It is not a willpower issue.
- B. No one caused the disease.
- C. The person with chemical dependency cannot return to controlled use of alcohol or drugs.
- D. Abstinence and recovery -- living a comfortable and responsible life without the use of chemicals -- is presently the most effective long term treatment of chemical dependency.
- E. It does respond well to specific forms of treatment.

Nature of the Disease

We believe ...

- Alcoholism/chemical dependency is a disease that is:

Primary
Progressive
Chronic
Fatal

- In the later stages of the disease the person is incapable of the spontaneous insight needed to seek remedial care, largely due to:

Blackouts
Repression
Euphoric Recall
Their combined delusional thought processes

- Those living with chemically dependent persons often become emotionally distressed to the point where they:

A. Enable the addiction to continue despite best intentions
B. Attempt to manipulate the situation to make it “go away”
C. Show similar symptoms
D. May require remedial care

- Society in general has historically enabled the disease process to continue by viewing it as:

A. A moral issue
B. A matter of willpower
C. Something that will “go away” on its own

- Intervention can remediate the condition on two levels.

Level 1 – Through an educational therapeutic process the concerned others can identify their misunderstandings of the disease process. They can then see it and their own behaviors for what they are and commit themselves to no longer protecting the addicted individual from the consequences of his/her behavior.

Level 2 - The addicted person can be helped to see the love of those around his/her addictive behavior, and thus accept treatment as an appropriate solution.

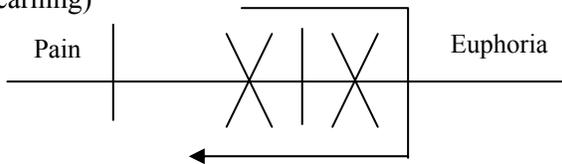
- This disease is successfully treatable with the concurrent approaches to:

A. Attend to physical complications
B. Reduce the symptoms of mental mismanagement
C. Expunge the emotional distress
D. Rebuild family communications
E. Establish a workable spiritual connection

Progression of the Disease

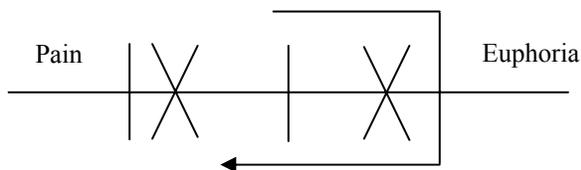
(All or some of these in each area may be present)

Phase 1 – Learning the Mood Swing (Automatic Learning)



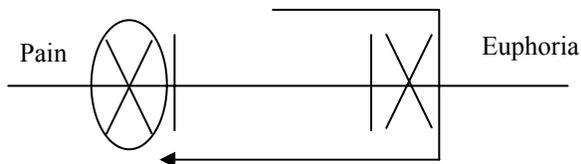
- A. Learns that chemicals can provide a temporary mood swing in the direction of euphoria.
- B. Learns that chemicals will provide this positive mood swing every time they are used.
- C. Learns to trust the chemical and its effects.
- D. Learns to control the degree of the mood swing by regulating the quantity of the chemical intake.

Phase 2 – Seeking the Mood Swing



- A. Applies what was learned in Phase 1 to his/her social, cultural and life situation.
- B. Uses the chemical more or less at the appropriate times and places.
- C. Develops self-imposed rules about the use of the chemical and adheres to them, e.g., "I don't drink until after five o'clock."
- D. May suffer from physical pain (hangover) from an occasional overuse of the chemical, but no emotional pain.
- E. Continues ability to control the times, quantities, and outcome of all chemical using experiences.
- F. Social users remain in this phase. Victims of chemical dependency progress to Phase 3.

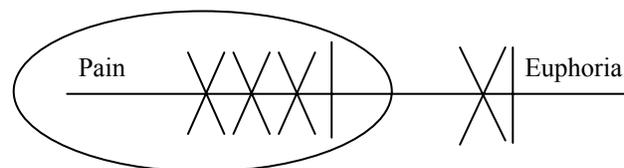
Phase 3 – Harmful Dependency



- A. Begins to experience periodic loss of control or loss of predictability over chemical use. Can no longer predict outcome once chemical use begins.

- B. These episodes result in behavior that violates the person's value system and in turn creates the first emotional pain that the victim experiences.
- C. Spontaneous rationalizations arise and hide these feelings from the victim. The loss of insight becomes a growing delusion.
- D. Negative feelings about self remain unidentified and therefore are unresolved. This results in a growing chronic emotional distress.
- E. Experiences growing anticipation and preoccupation with the use of the chemical.
- F. Lifestyle begins to change and revolve around the chemical.
- G. Specific times for chemical use are not established and rigidly held.
- H. Self-imposed rules that were developed in Phase 2 are now regularly being broken.
- I. Tolerance to the chemical increases causing the victim to develop more ingenious ways to get, use, and keep the chemical, i.e., sneaking drinks, hiding bottles, etc.
- J. Projections of self-hatred onto others begin to occur.
- K. Victim's whole life is deteriorating as health, spirituality, emotional stability and interpersonal relationships become adversely affected.

Phase 4 – Using to Feel Normal



- A. Using chemicals to survive rather than to feel euphoric.
- B. Blackouts occur more frequently.
- C. Tolerance built in Phase 3 breaks down.
- D. Physical addiction can occur.
- E. Paranoid-like thinking is present.
- F. Geographic escapes are made.
- G. Loss of desire to live and a complete spiritual bankruptcy.

Delusional Memory

The dynamics of relationships between a chemically dependent person and his/her memory system:

- A. Almost all persons have a basic trust of their memories.
- B. Current decisions and behavior are often based on our memories of past interactions and decisions. (Example: This is how we came here today.)
- C. Chemically dependent person ends up trusting a memory that, like Swiss cheese, has big holes in it.

These processes combine to give the chemically dependent person a deluded memory system.

I BLACKOUTS: A fundamental symptom of chemical dependency.

- A. **Definition:** A chemically induced period of permanent loss of memory – a physical reaction; “temporary amnesia;” unconscious process outside of person’s control.
- B. **Unpredictability of blackouts:**
 1. When they occur – there seems to be no identifiable pre-existing factor that will trigger a blackout, i.e., time of day, emotional makeup before use, etc.
 2. Quantity of chemical to induce blackout, i.e., sometimes huge quantities will not cause a blackout.
 3. Duration of a blackout – minutes, hours, days.
- C. **Loss of evaluation data:**

Example: Self-destructive behavior that occurs during a blackout cannot be remembered and used by the chemically dependent person to determine that chemicals are causing problems.
- D. **Effects of blackouts on others:**
 1. Persons who observe individuals in a blackout (*and don’t know it’s a blackout*) expect that person to remember the events during that period of time accurately.
 2. This assumption can lead the person to believe that the chemically dependent person is lying when he/she denies behaving in an inappropriate way during a blackout.

II. REPRESSION:

- A. **Definition:** The spontaneous defensive reaction that shields the victim from recalling and experiencing specific shameful and painful events. Psychological reaction, not chemically induced. Unconscious process.
- B. **Dynamics of Repression:** It varies in thoroughness from complete amnesic episodes (a war incident, incest, etc.) to impressions of vague feelings of unworthiness, insecurity, and guilt. (Specific events of last night are not remembered.)
- C. **Results of Repression:** Since the specific behaviors and feelings are either lost (total repression) or indescribable, the chemically dependent person is unable to recognize the relationship between the chemical and the harmful dependence.
- D. **Same effects on others.**

III. EUPHORIC RECALL:

- A. **Definition:** It is a perceptual distortion caused by the pharmacological and psychological properties of the chemical which results in the victim not being able to assess accurately, while under the influence or at a later time, the effect of the chemical on his/her behavior. In other words, the victim remembers the feeling response during intoxication, not the behavioral response. Example: He remembers feeling amorous and was misunderstood and rejected by his cold and possibly frigid wife. He is unable to remember the aggressive and demanding advance he made to his frightened and hurt wife.
- B. **Results of euphoric recall:** The distortion of perception becomes so frequent and massive that the chemically dependent person’s judgment becomes thoroughly impaired.
- C. **Same effects on others.**

SUMMARY

The chemically dependent person is trusting and relying on a memory that is totally unreliable because of blackouts, repression, and euphoric recall. Those surrounding the person are certain he is lying or insane.

The Intervention Concept and Goal

Chances are that your Intervention Session will not be the first time you and others have tried to confront the chemically addicted person with the reality of his/her situation. You have probably discussed and presented the facts about chemical use and the harmful consequences of this use before. Some of these confrontations may have included threatening the chemically dependent person with the loss of job or family if change did not occur. Many of these past confrontations ended up in family arguments or apologies or tears or promises. As time passed, however, the promises were broken, the discussions forgotten, and/or the threats were not carried out. In short, the confrontations did not bring about any lasting positive changes.

Structured intervention is different from these past confrontations and it is these differences that make it effective. First of all, **care, concern, and support** are provided during the intervention. The chemically dependent person's defensiveness is reduced because he/she can feel that everyone is trying to help and not hurt. There is no need to respond in anger or hide behind tears or silence. He/she can listen to what is being said and can be assured that the support will always be there. Because the concerned others do not blame, judge or criticize, the chemically dependent person does not feel attacked and does not need a shield from both the people and the words.

The information which is presented during the intervention is all chemically related data. We focus on the harmful consequences of the chemical use and give specific, accurate and true accounts of these harmful consequences. We do not discuss behaviors or weaknesses which are not related to the chemical use.

By keeping the focus on the drinking/drug behavior, we tell the chemically addicted person over and over again that it is the chemicals that are causing the life problems. In essence, we state and document the existence of the disease. We encourage the addicted person to get professional help for the disease. Otherwise, when the focus is not kept on the disease, we end up telling our chemically addicted person that he/she has many different problems, all of which need separate solutions. We overwhelm them with requests for change. He/she is not only confused by all these requests, but honestly doesn't know where to begin or what to change first.

Alternatives for the chemically addicted person and for the concerned others are arranged prior to the intervention session. In past confrontations the chemically addicted person may have agreed to get professional help, but may either have changed his/her mind the following day or hour, or simply never followed through with the commitment. By prearranging alternatives for professional help, we remove the opportunity for the chemically addicted person to have a change of mind or to procrastinate. By making arrangements for the alternatives which we as concerned others select, we also force ourselves to take positive action and to do, rather than to threaten.

Your Intervention Goal is two-fold:

1. To present to your chemically dependent person data about his/her chemical use in a **caring** and **concerned** manner in order to motivate that person to obtain professional help.
2. Define for yourself and all those present what you are going to do for yourself, whether that person gets help or not.

Intervention Presentation Guidelines

Your Intervention Data are the chemically-related facts or events which you are going to present during the Intervention Session. Your data should follow the guidelines below:

1. **Data should be chemically-related behaviors or events.** It is extremely important that all data is chemically-related. If data is not chemically related, you take the focus off the fact that your chemically dependent person has a disease for which he/she needs professional help. For example, *“Dad, last Friday you were drinking and driving. You were arrested and charged with DWI.”* This piece of data is chemically related and tells the chemically dependent person that it is the chemical use which is causing his/her problems and his/her harmful consequences.

If the data had been stated as *“Dad, last Friday you were arrested for reckless driving”* then the data is not appropriate for the Intervention Session because it is not chemically related. The chemically dependent person can deny that this incident was unusual (*“everyone breaks the speed limit now and then”*) and can deny that the chemicals were the cause of the irresponsible drinking behavior (*“I was in a rush – it was a rough day and I was upset.”*)

You have to tell the chemically dependent person with every piece of data you present that it is the chemical use that you are concerned about and which is the cause of his/her inappropriate behavior; it is the chemicals for which the person needs help.

2. **Data should be witnessed or documented chemically-related behaviors or events.** In other words, you have to be sure data really happened and that you are reporting

that data as it happened. For example, *“Mom, Tuesday morning you were shaking, your face was pale, and you looked sick and scared.”* This piece of data was witnessed and was reported as witnessed. A piece of data such as *“I think you are having an affair”* or *“I think you go to a bar instead of working late at the office”* is speculative and is a guess, not a fact. This does not mean that you cannot report incidents which you have not personally witnessed. You can report data which other people have witnessed as long as you can document it. An example of this type of data would be *“Your boss called me last week. He said that you have come into work with alcohol on your breath every day this week”* or *“You have purchased one case of whiskey every week this month. I know this because I balanced our books and have seen the cancelled checks.”*

3. **Data should point out facts about total chemical consumption or usage.** Some of the items of data should focus on the amount of chemicals the chemically dependent person is presently using, such as, *“Mom, you have five prescriptions for Valium, all from different doctors. You take 20 pills a day.”* or *“Dad, you drank eight cans of beer and you were drunk and asleep by 8:00 p.m. every evening this week.”*
4. **Data should specify the date or time when a chemically-related event or behavior occurred.** The more specific you can be about when, where, and with whom a chemically-related incident occurred, the more credible you will be. Also remember that the chemically dependent person was probably intoxicated when these incidents happened and was therefore not perceiving or sensing accurately. The more information you can provide them, the more you will

help them recall these incidents. Data should specify when an incident occurred and can be stated as “*last Friday*” or “*on June 15th*” or “*on our last anniversary*” or “*during this past month*”. If possible, data should be recent. Incidents that happened last week will be easier to recall and have more impact than data that happened ten years ago. If you cannot recall a specific date, specify the time by the month during which an incident occurred or the season.

5. **Data should be presented with care and concern.** You need to begin and end each data presentation with a statement which says, “*I am here because I love you, care about you, and I want you to get some help.*” You should present your data in a factual but supportive manner. Many times the data you discuss will be painful for you to talk about and for the chemically dependent person to hear. You should be honest about the fact that these things are difficult for you to say, but that you care too much to leave these things unsaid.
6. **Data should include the consequences you experienced and feelings you had as a result of the chemically-related behavior or event.** Data should include your feelings. “*I was embarrassed by what you did*” or “*I was scared for you or myself*” or “*I called your boss and lied for you*” or “*I carried you out of the bar*” or “*I borrowed money from my parents to pay our bills.*” Be careful not to “**blame.**” Tell the truth in a factual manner and let the chemically dependent person know that you **chose** your own

reactions and responses to his/her behavior or these events. But also let him/her know that you have been affected by his/her chemical problem and that these effects have not been pleasant.

7. **Data must be written.** Bring a written list of the data that you and your facilitator agree upon in the Intervention Rehearsal to the Intervention Session. Do not rely on your memory. You will be nervous during an Intervention Session, and your nervousness may cause you to forget. Therefore, have your data written on a list and have the list in your hand during the Intervention Session.
8. **Data should point out the contradictions and conflicts in values and behaviors that occur during times of chemical influence/intoxication.** You need to point out that your chemically dependent person does not behave “normally” when he/she is under the influence of chemicals. His/her intoxicated self is not the self he/she has been, can be, and honestly wants to be. Data can state this by pointing out that “*Joe, you have been one of the company’s best employees and have always been evaluated as good in customer relations – until recently. This week I received five customer complaints about your rude and drunken behavior.*” or “*You have always been a good, kind and considerate husband but last Monday you came home drunk, we had an argument and you hit me. This isn’t like you. You have never hit me before, and I know you would never have hit me if you had not been intoxicated.*”

Documentation Preparation

YOU CAN LOOK FOR SPECIFIC DATA IN THESE AREAS:

Change in pattern of use:

- a. Uses more
- b. Rapid intake
- c. Hides use
- d. Uses away from home/exclusively
- e. In the home
- f. Denies use
- g. Hides supply
- h. Can't stop/doesn't stop
- i. Increased occasions of intoxication
- j. Uses alone
- k. Increased tolerance/decreased tolerance
- l. Attends more events where chemicals are used/present

Behavior when using:

- a. Becomes angry
- b. Becomes violent/verbally/physically
- c. Becomes loud/shouting/argues
- d. Becomes silent/withdrawn

- e. Becomes friendly/nice/congenial when using
- f. Change in sexual behavior

How is this affecting:

- a. Relationships with significant others
- b. Children's reactions
- c. Communication with significant others
- d. Finances
- e. Physical, medical, sexual functioning
- f. Job problems
- g. Responsibility toward self and others
- h. Legal problems
- i. Accidents (home, car, etc.)
- j. Traffic violations (DWI, tickets, warnings, etc.)

Suggested Feelings Words

Abandoned	Demeaned	Humiliated	Resentful
Afraid	Depressed	Hurt	Rude
Alone	Deprived	Ignored	Scared
Angry	Desolate	Insulted	Shattered
Annoyed	Desperate	Intimidated	Shook up
Anxious	Destroyed	Jealous	Sad
Arrogant	Disappointed	Left out	Stifled
Belligerent	Discouraged	Let down	Strained
Bitter	Disgusted	Lonely	Stunned
Boxed in	Distressed	Mocked	Suspicious
Broken up	Drained	Miserable	Terrified
Burdened	Embarrassed	Mistreated	Terrible
Cheapened	Enraged	Offended	Tricked
Cheated	Estranged	Overburdened	Unhappy
Concerned	Fearful	Pathetic	Unimportant
Confused	Forsaken	Persecuted	Unloved
Cornered	Frightened	Pitiful	Unsatisfied
Criticized	Frustrated	Pulled apart	Valueless
Crushed	Grave	Put down	Vulnerable
Deceived	Grief	Rattled	Worried
Defeated	Helpless	Rejected	Worthless
Degraded	Hopeless	Reprimanded	
Dejected		Repulsed	

Documentation Sheet Example

DATE	THIS IS WHAT HAPPENED	THIS IS WHAT I DID AND SAID	THIS IS HOW I FELT
<i>April 11</i>	<i>You were drunk during a dinner party with my parents. You insulted my cooking in front of them and even insulted them.</i>	<i>I went into the kitchen and cried alone. I acted as if everything was alright when I returned. I apologized for you the next day and told them you were tired of late and not yourself.</i>	<i>I was embarrassed for myself and for them. I was also hurt and angered by your behavior and insults.</i>
<i>My birthday</i>	<i>You promised to take me to a football game. You came home late and had been drinking. You fell asleep and we couldn't wake you.</i>	<i>I tried to wake you up. Then I realized that you were out for the evening. I went to my room and cried myself to sleep.</i>	<i>I was disappointed about missing the game. I was also hurt because it didn't seem as if you cared about me.</i>
<i>Last week</i>	<i>You were late for work each morning and you smelled of alcohol.</i>	<i>I gave you easy assignments. I also made sure that no one else saw you that morning. I took care of the customers.</i>	<i>I was angry with you and your irresponsibility. I was also concerned as you are a friend whom I care about.</i>
<i>Friday</i>	<i>You came home from work and you were noticeably drunk. You stumbled into the house and fell over the coffee table. You broke a vase.</i>	<i>I picked you up and put you to bed. Then I cleaned up your mess.</i>	<i>I was scared; you could barely walk and you had driven home. I was angry about all the commotion you caused.</i>
<i>Our last fishing trip</i>	<i>You were drinking in the boat. You became too drunk to even talk. You tried to stand up and caused the boat to capsize.</i>	<i>We all ended up in the water. We righted the boat and got you inside. Then we returned to shore. We lost all of our equipment and went home the next day.</i>	<i>I was angry because you could have killed us and angry about the equipment. I was also very disappointed. It wasn't a good trip.</i>

Documentation Sheet
(Bring to Intervention Class II and III)

DATE	THIS IS WHAT HAPPENED	THIS IS WHAT I DID AND SAID	THIS IS HOW I FELT

Substance Abuse: A Family Problem

The Healthy Family:

1. Communicates and listens
2. Affirms and supports one another
3. Teaches respect for others
4. Develops a sense of trust
5. Has a sense of play and humor
6. Exhibits a sense of shared responsibility
7. Teaches a sense of right and wrong
8. Has a strong sense of family in which rituals and traditions abound
9. Has a balance of interaction among family members
10. Has a shared religious core
11. Respects the privacy of one another
12. Values service to others
13. Fosters family time and conversation
14. Shares leisure time
15. Admits to and seeks help with problems

Chemical Dependency is a Disease:

1. The illness can be described. No matter what kind of background a person may have, chemical dependency leads them to similar types of behaviors: compulsive, delusional, unpredictable, etc.
2. The course of the disease is predictable and progressive. The person will get worse. Physical, mental, emotional, and spiritual deterioration proceeds unless disease is arrested.
3. The disease is primary, not a secondary symptom of an underlying cause. Chemical dependency must be treated before other problems can be effectively dealt with.
4. The disease is chronic. Once you have it, you will always have it. Remember, once a pickle, never a cucumber again.
5. The disease is terminal. If not arrested, the person will die.

Families Enable the Chemical Abuser:

1. By covering up to protect them (work, school, etc.)
2. By covering up to protect self through withdrawal from friends and social life.

3. By accepting user's behavior and making excuses for him/her.
4. By refusing to allow the user to face consequences of using.

All of the above are usually done with caring motives.

Roles in a dysfunctional family:*

1. **Identified patient.** Person getting most attention (sickness, drinking, etc.) Usually excused as being unable to cope with life's stresses; needs protection; behavior excused. Has a poor self-image because they are treated as an irresponsible person.
2. **Chief enabler.** Spouse, mother, father, or anyone who takes primary responsibility for thoughts, feelings, and behavior of another. (It is impossible for one to become chemically dependent without a chief enabler.) Enabler ends up angry, resentful, and mirroring the sickness.
3. **Hero.** Sets out to be perfect to gain self-worth for the family. Often are driven people who burn out at an early age. These persons are least likely to become chemically dependent and most likely to marry someone who is chemically dependent.
4. **Lost child.** Quiet child who avoids stress. Because they do not get very involved, they become lonely and feel rejected.
5. **Mascot.** This child sets out to ease tension for the family. Gets a lot of negative attention and usually remains an immature person who clowns around.

*These roles are best identified in families of 6, with husband and wife being the Identified Patient. In other situations, individuals sometimes assume one or more roles at different times in life. Without Al-Anon or some other form of family treatment, virtually all family members stand a good chance of becoming chemically dependent themselves or marrying into a chemical dependency situation.

Symptoms of Co-Dependency

Early Symptoms

1. Embarrassment
2. Confusion
3. Denial – rationalization
4. Fear, anxiety, apprehension
5. Tension
6. False hopes
7. Disappointment
8. Guilt
9. Isolation, alienation
10. Euphoria
11. Anger
12. Disgust
13. Protectiveness
14. Genuine pity and sympathy
15. Preoccupation with chemical dependency or alcoholism

Middle Symptoms

16. Love shift – rejection
17. Rage, panic
18. Constant worry
19. Concern for illness
20. Personal frustration
21. Lethargy – lack of motivation
22. Hostile toward chemical
23. Hopelessness
24. Punish the abuser
25. Self-pity, negative about self
26. Vindictive
27. Distrust of self and others
28. Rigidity
29. Seriously uncommunicative

Chronic Symptoms

30. Decline in independence
31. Role reversal
32. Withdraw from other family/ community members
33. Fighting/nagging, verbal abuse
34. Psychosomatic ailments
35. Sexual problems
36. Avoid social occasions with drinking
37. Lying, covering up
38. Threats
39. Hiding, not being seen, paranoia about seeing others
40. More personal use of chemical, join up with chemically dependent
41. Self-absorbing isolation, no outlets, vacuum

“FAMILIES MUST LET THE ALCOHOLIC TAKE THE CONSEQUENCES OF HIS DRINKING AND FOCUS LESS ON THEM AND MORE ON THEIR OWN FEELINGS.”

Not all co-dependents have all these symptoms nor do they necessarily display them in the precise order listed above.

Enabling

In chemical dependency the term enabling takes on a negative meaning. An enabler is a person around the dependent who steps in to protect him/her from the unhealthy, irresponsible, and anti-social behavior which the dependent exhibits and also protects him/her from suffering the natural consequences that are constantly present in the life of a dependent person. For a time, enabling does prevent the social and financial difficulties the dependent and family would experience. However, by preventing the crisis that might bring the chemically dependent to treatment, his well-meaning family, employer, and friends actually prolong the illness.

Paradoxically, the enablers act out of a sincere sense of love, loyalty, and concern. One cannot be an enabler without caring for the dependent. Sometimes enablers are motivated out of shame or fear. This is especially true with supervisors in the workplace as their own self-esteem and respect are involved. These people see no other alternatives. As it does with family members, enabling begins imperceptible and ends just like it does for the dependent – in denial.

Consequently, covering up for the dependent person, making excuses, doing his or her work, overlooking the shoddiness and inconsistency of the work, and becoming more responsible for the dependent are all making it possible for the dependent to go on drinking or using. This is a sure sign that the concerned person is caught up in the illness.

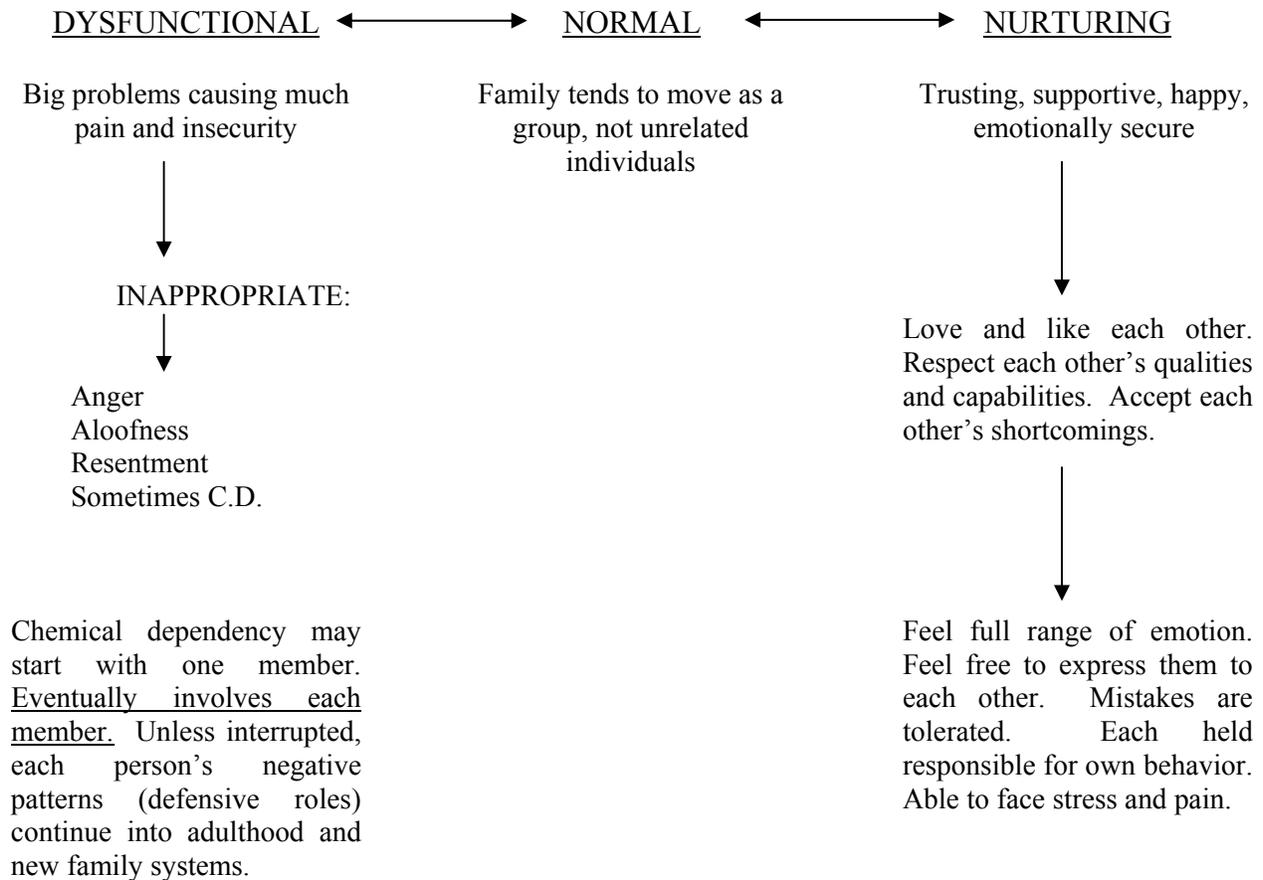
Enabling behaviors:

1. Denying that the person is abusing drugs or is chemically dependent.
2. Keeping your feelings inside.
3. Avoiding problems – keeping the peace, believing lack of conflict will solve problems.
4. Minimizing, “It’s not so bad, things will get better when ...”
5. Protecting the chemically dependent person from pain.
6. Lecturing, blaming, or criticizing the chemically dependent person.
7. Taking over his responsibilities.
8. Feeling superior – treating the dependent person like a child.
9. Controlling.
10. Enduring – “This too shall pass.”
11. Waiting – “God will take care of this.”

Enabling Worksheet
(Complete and bring to Intervention Class III)

DATE	THIS IS WHAT HAPPENED	THIS IS HOW MY ENABLING SELF WOULD RESPOND	THIS IS HOW MY NON-ENABLING SELF WOULD RESPOND

What Goes on in a Family?



Four Phases in Progression of the Illness of Family Members Who Are Not Chemically Dependent (Called "Co-Dependency"):

Development phases of defenses that help them meet their emotional needs:

1. Learning Phase: They develop awareness of stress and changes (increasing arguments, tensions, less communication, or strained spouse and parent/child relations). They begin experimenting with defensive behaviors that are not healthy.
2. Seeking Phase: They attempt to find solutions. The defensive behavior becomes manipulative. They believe they can control the person's use -- delusional. As they meet frustration they become an angry, resentful, emotionally-tangled person – enabling the illness. Four patterns of enabling behaviors: "Too Good," Rebellious, Apathetic and Joking Defenses.
3. Harmful Phase: The defensive behavior becomes compulsive. A denial system about their own pain may develop. They suffer harmful consequences of the defensive behaviors.
4. Escape Phase: Separation, desertion, suicide. Hope for change is lost; they look for escape from their pain.

Intervention Planning Worksheet

(Complete and bring to Intervention Rehearsal)

Your Facilitator is: _____ Phone # _____

Your Intervention Leader is: _____ Phone # _____

1. The treatment alternative we have selected for our chemically dependent person is: _____

2. The treatment alternative will be financed by: _____

3. The secondary alternative ('what if?') we have selected for our chemically dependent person is: _____

4. The alternative(s) we have selected for ourselves if the chemically dependent person selects the treatment alternative is (are): _____

5. The alternative(s) we have selected for ourselves if the chemically dependent person selects the secondary alternative is (are): _____

6. The alternative(s) we have selected for ourselves if the chemically dependent person rejects both the treatment and secondary alternatives is (are): _____

7. The best time of day during which to do the intervention is: _____

8. The best day of the week during which to do the intervention is: _____

9. The best place at which to hold the intervention is: _____

Practice of Presentations

A. Do's and Don'ts

1. Do present with love/concern/caring.
2. Do state specific facts – what – when –where – with whom.
3. Do not be judgmental.
 - a. Discuss a problem
 - b. Do not accuse a person of being an alcoholic or addict.
4. Do not ask questions.
5. Do ask the person to accept help – do not ask him/her to stop drinking/using.

“I care _____.”

Or

“I'm concerned _____”

Because

“you did _____ (describe behavior specifically) _____.”

Or

“_____ when you were (include chemical involved).”

And

“I want you to get help.”

Or

“I want both of us to get help.”

B. Strategy to cope with reaction of the addicted person.

1. Getting addicted person to intervention.
2. Remind them of contract to listen.
3. Move to next intervener.
4. Be prepared for reasons to “wiggle out”.
5. Be prepared for “crocodile tears” and promises.
6. Listen for capitulation.
7. Consequences!

Your Intervention Rules

1. The facilitator will open the session by introducing himself/herself. He/she will then tell the chemically addicted person that everyone is here today because they are concerned and care. The facilitator will then ask the chemically addicted person to agree to spend some time with the group. The facilitator will explain that the concerned others have things which they want to tell the chemically addicted person, and they would simply like this time to say these things. If the chemically addicted person is hesitant or resistant to making a commitment, the request can be repeated. After a verbal commitment is made and the rules are explained, the facilitator will request that the first person present his/her data. Allow the facilitator to take control, follow the facilitator's cues and directions.
2. The facilitator will explain the "rules" to the whole group. The rules are simply that each concerned other will be allowed to present his/her data without being interrupted. The chemically dependent person will be allowed to respond to each data presentation after it is completed. Again, rely on your facilitator to control the length of this response.
3. Do not argue with the chemically dependent person or become angry. If the chemically dependent person disagrees with your data, simply restate the data, restate your concern and restate your feelings relating to each incident. Again, watch your facilitator for cues and direction.
4. Allow the facilitator to present the alternative you have selected for the chemically dependent person. The facilitator will answer questions like "What is treatment?" and "How long will it take?"
5. If the treatment alternative is not selected, the facilitator will present the secondary alternatives. The chemically dependent person may not readily accept the treatment option. This means that you and the facilitator will have to give encouragement. Also, allow the facilitator to make the decision as to when the secondary alternative is necessary. You do not want to pursue the secondary alternative unless you absolutely have to.
6. If you, as concerned others, have selected alternatives for yourselves, you will be asked by the facilitator to explain these alternatives to the chemically dependent person. Again, the facilitator will directly request you to do this. Follow the guidance of the facilitator.
7. Present only the data on your list and present it as you presented it in your rehearsal session. Do not give any data which your facilitator has not heard and/or approved.
8. Do not use the words "alcoholic" or "drug addict." These will be taken as accusations. You are presenting data, not making a diagnosis.
9. Do not blame, criticize or judge. Present your data in a caring, concerned manner.

Intervention Checklist

(Complete this before your Intervention Session)

1. Have we made arrangements with the treatment program we selected for our chemically dependent person?
_____ a. Checked space availability with treatment facility.
_____ b. Checked out insurance coverage and treatment financing.
2. Have we made arrangements in order that the chemically dependent person can go into treatment immediately?
_____ a. Packed a suitcase?
_____ b. Arranged for the care of any children, pets or plants, etc.?
_____ c. Made arrangements with the dependent person's employer/school?
_____ d. Made arrangements for the care of any apartments or property, if necessary?
3. Has everyone concerned been informed of the time, date and place of the Intervention Session, including:
_____ a. The Intervention Facilitator?
_____ b. All the concerned others who will be participating?
_____ c. The chemically dependent person (*at the appropriate time*)?
4. Have arrangements been made for:
_____ a. Transporting the concerned others to the Intervention Session?
_____ b. Transporting the chemically dependent person to the Intervention Session?
_____ c. Transporting the chemically dependent person to the treatment center?
5. Have arrangements been made for the alternatives the concerned others have selected for themselves?

Last Minute Reminders

1. Remember to bring your written Documentation Sheet.
2. Remember to follow your facilitator's direction during the Intervention.
3. Remember that Interventions are highly successful. You have worked to prepare for this Intervention, and can trust your Intervention will be successful.

**God, grant me the serenity
To accept the things I cannot change,
The courage to change the things I can,
And the wisdom to know the difference.
Amen.**