

Invitational Intervention: The ARISE Model
For Engaging Reluctant Substance abusers In Treatment¹

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Acknowledgements

The empirical study from which this work has been further developed was supported in major part by the National Institute on Drug Abuse (NIDA–grant No. RO1 DA09402), National Institutes of Health. The authors would like to express thanks to an anonymous reviewer for helpful comments on an earlier draft of this paper.

Abstract

Families are an untapped resource in motivating resistant alcohol dependent and drug addicted individuals to enter treatment. Contrary to popular belief, families maintain a disproportionately close connectedness with their addicted loved ones. In this article, the authors present the underlying functional components of this connectedness; how alcoholism and other addiction initially serves as an attempt at adaptation “helping” the family heal after trauma or significant loss, and how eventually a family member, often generations later, applies the same energy/dynamic that led to the alcoholism and addiction in the first place, to mobilize the family to motivate the addicted loved one into recovery. The authors have named this sequence: Family Motivation to Change (Garrett & Landau, 2006). The process, outlined in this paper, for mobilizing family and friends to form an Intervention Network for the express purpose of getting a resistant addicted loved one into treatment is A Relational Intervention Sequence for Engagement (ARISE). ARISE is a 3 Level, pre-treatment, engagement process based on openness and a commitment to honor and maintain the investment and connectedness of families. ARISE uses an Invitational Intervention method with the family conducting most of the Intervention, thus minimizing the clinician’s expenditure of time and cost. The Invitational Intervention method stops at the first Level where the addicted individual enters treatment. Outcome data on ARISE demonstrates that 83% of addicted individuals enter treatment as the result of families using the Invitational Intervention approach (Landau, et al., 2004).

Key words

ARISE; treatment engagement; Invitational Intervention, Intervention; addiction; alcoholism in the family; substance abuse; outreach; family; breaking the intergenerational cycle; family motivation; motivation to change; Concerned Other; Transitional Family Therapy; resistance; motivation to change; recovery; transitional conflict; Family Link; Link Therapy; resilience; research; co-dependency, enabling, stages of change, Invitational Intervention: The ARISE Model For Engaging Reluctant Substance abusers In Treatment

Introduction

The major problem confronting the field of addiction is the low rate at which alcoholics and other substance abusers enter treatment. In fact, the majority, less than 10%, ever does so (Frances, Miller & Galanter, 1989; Nathan, 1990, Kessler et al., 1994). These statistics are found not only in the United States, but also elsewhere around the world. This low rate of treatment entry causes difficulties for members of the family and extended support system because of how each person is affected by the disease and its accompanying problems.

For instance, a busy primary care physician or nurse practitioner might dread the appearance of a particular patient in the examining room, predicting that s/he is likely to have developed yet another psychosomatic symptom, or be requesting days off work to deal with some minor illness or infection. Many primary care providers have come to realize that the underlying problem rendering the person particularly vulnerable is most likely to be stress. Unfortunately, fewer are likely to realize that there is a high probability that the patient's spouse is struggling with chronic addiction, and that the patient in the office is exhibiting relational symptoms of the disease.

This paper describes ARISE (A Relational Intervention Sequence for Engagement), a manual-driven relational intervention designed to guide family members to get a resistant substance abuser into treatment. It draws on the connectedness, interest and commitment of concerned other members of the extended family and support system to motivate the alcoholic or substance abuser to enter treatment. The ARISE Interventionist collaborates, or "partners," with extended families and their support networks, mobilizing them to act as motivational enhancers to get addicted individuals into treatment.

Overview of Intervention

Those familiar with family therapy understand “intervention” to describe a clinical technique used by a therapist to accomplish a clinical goal. Those familiar with addiction treatment understand “Intervention” to mean a specific technique designed to assist families and significant others to induce an alcohol dependent or addicted individual to enter treatment. This paper will focus on the latter use of the word “Intervention,” with a capital “I” denoting the technique designed to get resistant alcohol dependent or addicted individuals into treatment.

Informal interventions

The basic idea behind any intervention is a desire by family, friends, clergy, colleagues, neighbors, care providers, employers, and other members of the support network to take an active role in assisting another person to change unacceptable behavior. The idea of intervention has been around as long as one person has tried to influence the behavior of another. Everyone has done some form of intervention with others. Perhaps one has tried to help a friend who is chronically late for work get to work on time; prompted someone who was erratic about taking prescriptions to take medication on a regular basis; tried to get a loved one to stop smoking cigarettes; or struggled to persuade a colleague to start an exercise program to help with weight loss. These are examples of simple interventions where one person is working to motivate another to change a behavior. This type of intervention is a frequent, daily occurrence. It is usually informal, focused on one objective, and works through applying the power of the emotional connection in personal relationships towards motivating change.

Substance Abuse Interventions

The toll of untreated addiction can be seen in many direct and indirect costs to society, including: health care, criminal justice, child welfare, employment, family/marital functioning

and mental health. For instance, the alcohol dependent or addicted individual uses 4 times the health care dollars used by non-addicted individuals. Concurrently, National Institute on Drug Abuse (NIDA) studies show that of the 2 million admissions per year into addiction treatment facilities, 75% of drug addicts and alcoholics credit their families as the major reason for their getting into treatment (McGrady, 2006): Families are powerful motivators for alcohol dependent and addicted individuals to get treatment.

Combining these two factors, the cost of addiction and the leverage of families, Vernon Johnson, some 35 years ago, popularized the first Intervention method with his publication, I'll Quit Tomorrow (Johnson, 1973). The method was designed to capitalize on the family's interest in getting their resistant alcoholic into treatment. The Johnson Intervention method remained the primary method used until fairly recently. During the past 15 years, several new Intervention methods have developed including: Unilateral Intervention (Thomas & Ager, 1993); Community Reinforcement and Family Training (CRAFT) (Miller & Myers, 1996); A Relational Intervention Sequence for Engagement (ARISE) (Garrett et al., 1997, 1998, 1999; Landau et al., 2000, 2004); Structural Strategic Intervention With Adolescents (Szapocznik et al., 1988) and the (currently unpublished) Systemic Intervention Model (Raiter & Toll, 2006; Maher, 2006).

The common thread through the above-mentioned Intervention methods is the focus on getting a resistant addicted individual into treatment. Some of the methods use a unilateral approach (Unilateral Intervention and CRAFT) and the others employ a systemic approach (Johnson Intervention, Systemic Intervention and ARISE). Of the systemic methods only ARISE uses an Invitational Intervention method. The other systemic methods utilize a surprise approach to reaching the addicted individual.

Why an Invitation?

The historical dilemma, when doing an Intervention, has been how to get the alcohol dependent or addicted individual to participate in a session to discuss an alcohol/drug problem that the individual does not believe exists. The earlier systemic methods thought it best to “surprise” the individual and that way assure having a “captive” audience for the Intervention meeting. The idea of inviting an alcohol dependent or addicted individual to attend a meeting about a problem s/he believes does not exist, would seem an inevitable prescription for failure. Alternatively, not offering the invitation, and proceeding to have a secret meeting without the individual, or springing a surprise meeting on him or her, would almost definitely result in a defiant, rebellious response. The old adage applies, “Tell me what to do and I will do the exact opposite.”

The question of why to invite an addicted individual to attend a meeting where his/her problem of alcohol and drug use will be discussed is based on the principles of family connectedness and the dynamics of Family Motivation to Change (Garrett and Landau, 2006). In the late 1980’s the authors researched this question of invitation thoroughly. They did a retrospective analysis of some 350 individuals admitted to an Intensive Outpatient Program (IOP) for addiction treatment. These individuals met three evenings each week for sixteen weeks. The study sample was divided according to three significant dynamics that had motivated the addicted individual to start treatment: self-referral, court mandate, and Johnson Intervention (Loneck, Garrett & Banks, 1996 a; 1996 b).

This retrospective analysis examined the rates of treatment completion and relapse during the course of treatment. The lowest treatment completion rate (40%) was in the self-referred population. The highest completion rate (91%) was in the court-mandated group. The Johnson Intervention group completion rate was 55 %. It is interesting to note that the group that on the

surface had the best motivation at the start of treatment (self-referred) had the highest treatment dropout rate. The authors further studied the self-referral group in an attempt to understand this apparent discrepancy. They found that the high dropout rate was directly related to the lack of a consequence for dropping out. This self-referred group had no one, other than themselves, to be accountable to when deciding to leave treatment. At the other end of the spectrum, the court mandated group had the most immediate consequence for dropping out of treatment and, therefore, the highest treatment completion rate. The Johnson Intervention group started off strong in treatment, but had high rates of dropping out after eight to ten weeks.

The dynamics of relapse may explain the timing of the Johnson Intervention group's dropout rate with relapses occurring between the sixth and eighth week of treatment. Dropout rates increased as relapses occurred. During follow-up interviews with the Johnson Intervention group, the authors heard a familiar statement over and over. "At first, I stopped my drug and alcohol use because of the pressure from the Intervention, but then I found myself thinking 'I'm not going to be told what to do!' so I started using again."

This finding led the authors to wonder whether the rebellious response and subsequent pattern of relapse noted in the Johnson Intervention group could be avoided by using a method that started with an invitation rather than by surprise or coercion.

Another study by the authors in the 1980's further bolstered their rationale for starting ARISE with an invitational meeting. Data collected from all calls from family members requesting help to get an addicted loved one into treatment revealed that more than eight of every ten families refused to follow through with a Johnson Intervention (the only model being offered at the time). Following this early study, other research has resulted in similar findings. For example, in 1997, Barber and Gilbertson reported that 100% of the women in their Australian

study refused to do a Johnson Intervention when it was offered.

Based on these findings, the authors did a qualitative study exploring the barriers to participation in the Johnson Intervention. They interviewed a sample of families who had refused to do a Johnson Intervention. Some of the reasons the families gave are listed below:

- Fear that the highly confrontational aspects of the method would destroy the relationship with the addicted individual and/or chase him away forever;
- Belief that support for the addicted individual was more important than developing harsh consequences;
- Fear that the addicted individual would "go over the edge" if strongly confronted, and
- Skepticism that any method would work, deriving from the family's sense of isolation, confusion and despair from living for a long time with active addiction.

The other aspect, that of connection of the alcohol dependent or addicted individual to his/her family of origin is well documented (Stanton & Shadish, 1997). In fact, contrary to the common perception in the field, alcoholics care about their families and their families care about them. They remain very closely connected; in fact more closely connected than the general population. Averaging several studies, it appears that 9% of non-addicts tend to call their families daily while addicted persons maintain daily contact with their families at a rate of approximately 57% in the US, 62% in England, 80% in Thailand and Italy, and 67% in Puerto Rico (Perzel & Lamon, 1979; Vaillant, 1995). One might ask, where did this connectedness originate and how does it relate to addiction?

The authors have found that addictive symptoms originate in families as an attempt at adaptive behavior to cope with transitional conflict arising from migration, rapid or unpredictable transitions, traumatic loss, and unresolved grief (Landau, 2005; Garrett & Landau,

2006; Landau & Garrett, 2006). Other symptomatic behaviors include: depression and suicidality, violence, post-traumatic stress, and risk-taking behaviors, including those that can lead to HIV/AIDS (Landau, 2005; Landau & Saul, 2004). For example, within one year after September 11th, 2001, there was a 31% increase in the rate of substance abuse and addiction in New York City and its immediate surroundings—approximating the addiction statistics of uprooted persons around the world (Johnson, Richter, McClellan & Kleber, 2002). At times of overwhelming grief, families find ways of compensating and staying close together to avoid further loss, often without conscious intent.

Frequently, one member of the family will begin to use alcohol or other substances, or exhibit other symptoms that serve the dual purpose of drawing the family's attention away from the grief and holding the family together to deal with the problems arising from the new problem behavior or symptoms. The result is that the family is unable to process their current transitions, remaining locked in the transitional conflict of the moment. Since this maintains their closeness, the substance use helps to assuage the grief and reduce the pain. When the substance use is reduced, the pain and grief return to the family, reinforcing the need for the problem—increased use or a relapse from recovery results. The addiction cycle is set. It has proven effective in assuaging grief and maintaining family connectedness to prevent further loss. Because it is successful in its purpose, the pattern of substance use, relief of grief, and relapse if the grief occurs when recovery begins, is often transmitted across generations. This continues until the family grieving is resolved, the substance use or abuse has become redundant, and healing of the family and the substance abuser can occur (Landau, 1979, Landau, 1981; Landau & Stanton, 1990; Landau, Garrett, et al., 2000; Landau, 2004a; Landau, 2004b). This pattern is totally subconscious. If the grieving is not resolved within a couple of generations, it is likely to spread

laterally on the family genogram as well as vertically down the generations. Once the grieving is done, generally 3 to 5 generations later if no therapeutic intervention has occurred, another member of the family moves into recovery, often spontaneously.

The authors have termed this survival drive of the family “Family Motivation to Change” (Garrett & Landau, 2006). The family does not have to wait until the grieving is done. Intervention is possible and can capitalize on the healing energy of the family to prevent generations of addiction and grief. The motivation of family members to get an addicted loved one into treatment occurs when one or more individuals agree to take action to stop the alcohol or drug use from taking its progressive toll and distracting the family from functioning in a more healthy manner. Family Motivation to Change can best be understood as the combined forces operating within a family that guide it first towards maintaining survival in the face of serious threat, or following major or unpredictable loss and unresolved grief. Secondly, the same Family Motivation to Change guides the family towards health and sustained functioning when threat is removed.

Exploring what happened to families during major disaster, traumatic or unexpected loss, or multiple losses allowed the authors to take a step back into the grief that initiated the problem of addiction (Garrett & Landau, 2006). The authors discovered that the force that drives a family towards health is the same force that drove them to the initial adaptive behavior described above, where a family member becomes addicted in an attempt to keep the family close and to prevent them from feeling the pain of intense loss and sorrow. Eventually, the focus on the problems caused by the individual’s alcoholism or drug addiction slows the process of successfully completing normal family life cycle transitions until the grief is resolved.

Once this has happened, the driving force of health and healing, “Family Motivation to Change,” pushes, frees, or allows a member of the family, a natural change agent or Family Link to lead the family out of grief and addiction and into health and recovery (Landau, 1979, Landau, 1982; Landau-Stanton & Clements, 1993; Landau, 2004a).

Understanding the dynamics related to family connectedness and Family Motivation to Change resulted in the development of an Intervention method that built on the respect and long-term commitment of family members to maintain relationships with one another. The result was the development of a three-level Intervention method that started with an invitation.

ARISE Overview

ARISE is rooted in concepts and methods developed both from addiction theory and from family and systems theory—particularly social network therapy (Speck & Attneave, 1973), Transitional Family Therapy (Seaburn, Horwitz & Landau, 1995) and the network approach to substance abuse treatment (Galanter, 1993). Although ARISE draws heavily from theories used in family and systems therapy, it is a pre-treatment engagement technique and is not therapy. Therefore, professionals using ARISE are not practicing therapy, but are solely focused on getting the addicted individual into treatment and the family as a whole into recovery.

ARISE is manual-driven, and has been formally investigated (Landau et al., 2004)². The ARISE method evolved during the late 1970’s and was formalized in the mid-1980’s. As mentioned earlier, its development was driven by families’ refusing to use the Johnson Intervention combined with the integration of systems theory into addictions treatment. Rather than viewing the families as being “wrong,” or “uncaring,” for not following through on the Intervention method offered, the authors built on their knowledge of family systems, trust in

² National Institute on Drug Abuse–NIDA–RO1 DA09402.

family competence, strength and resilience, and their prior experience of family members' success in getting substance abusers into treatment (Landau & Garrett, 2006). ARISE evolved as a user-friendly and cost-effective Intervention method.

Most families who were initially not interested in participating in an Intervention because of their preconceived notions or prior conceptions, became interested and willing to use the ARISE method because of the openness and lack of confrontation. Families learn that ARISE focuses attention not only on treatment engagement of the individual substance abuser, but on long-term intergenerational family wellbeing and recovery. They also feel hopeful for the future, once they realize that their ongoing relationship with their alcohol dependent or addicted member will be honored and protected.

The following summarizes the 3 Levels of ARISE: **Level 1** uses motivational techniques designed specifically for telephone coaching, but they can also be applied to face-to-face sessions. We help the "First Caller" or "Concerned Other" establish a basis of hope, identify whom to invite to the initial Intervention meeting, design a strategy to mobilize the support group, teach techniques to successfully invite the alcohol dependent or addicted individual to the first meeting, suggest a recovery message and get a commitment from all invited individuals to attend the initial meeting regardless of whether or not the alcoholic attends. **Level 2** follows if treatment does not start during Level 1. Typically, in Level 2, between two to five face-to-face sessions are held, with or without the alcohol dependent or addicted individual present, to mobilize the Intervention Network in developing motivational strategies to attain the goal of treatment engagement. Very few families (less than 2%) need to proceed to Level 3. In **Level 3**, family and friends set limits and consequences for the alcohol dependent or addicted individual in a loving and supportive way. By the time the Intervention Network gets to this point, the

alcohol dependent or addicted individual has been given and has refused many opportunities to enter treatment. Because the alcohol dependent or addicted individual has been invited to each of the Intervention Network meetings in Level 1 and Level 2, this final limit setting approach is a natural consequence and does not come as a surprise. The Intervention Network commits to supporting each other in the implementation of the agreed upon consequences.

Case examples at each of the Three Levels

Level 1 Case

The First Caller was a mother, Jan, who was concerned about the alcohol and cocaine use of her 29-year-old son, Jude. Jan had learned earlier in the week from her son's wife, Margaret that Jude had spent close to \$6,500 of an inheritance over the previous three months. The concern was that the money had been spent secretly and that Margaret could not identify anything that had been bought. During the First Call, Jan related that her son had a long-standing problem with drinking, but she did not know of any use of cocaine or other drugs.

A section of the First Call Worksheet calls for constructing a preliminary genogram. The purpose of this is to get a family history, list individuals who might be willing to attend the First Meeting and/or be of support during the Invitational Intervention process, and to identify themes and patterns that could be useful in developing the Recovery Message. The Recovery Message is an essential and central component of the invitation that is conveyed to the alcohol dependent or addicted individual.

The genogram revealed that Jude's father, Mark, had been a "dry alcoholic" for the past 15 years. Mark stopped drinking on his own after a series of violent domestic episodes while he was intoxicated. These incidents had

resulted in Jan's divorcing him. Jude and Margaret had been married for 4 years and had a 2-year-old daughter, Samantha. It was also noted that both of Jude's grandfathers were alcoholic. His fraternal grandfather had also stopped drinking later in life and had attended AA meetings for a period of time. Jude's fraternal grandfather had passed away approximately 3 months before the First Call, and Jan stated that her son had spent nearly every day with his grandfather in the nursing home for the two months prior to his death.

When asked who might be willing to attend the First Meeting, Jan constructed the following list: herself (mother); Margaret (wife); Mark (father); Pat (sister); Margaret's parents; and two of Jude's friends with whom he drank and used drugs. When discussing this list in more detail it was decided that it would be best not to invite Margaret's parents to the first meeting, due to recent hostility between them and Jude. It was also decided not to invite the two friends because of concerns about whether they would support Jude's entry into treatment.

One of the key issues in reducing the size of the Intervention Network was that Jan and her ex-husband, Mark, had not been in the same room together since their divorce. Jan thought it would be more productive and provide a better forum for openness if the initial group was smaller, comprising only immediate family who knew the history of violence. She also revealed, "for years after the divorce Jude would sleep in the hallway outside my door because he thought he had to protect me." Jude had no history of violence.

When deciding when and where to meet, it was decided to give Jude a choice of either

meeting at his home, his mother's home, or in the Interventionist's office. The Recovery Message that would be the central component of the invitation was "We know you do not want your daughter to grow up scared and insecure like you did. Let's not let these problems carry over into the next generation."

Jan approached her son two days before the date of the First Meeting and shared with him her concerns, her contact with the ARISE Interventionist, the date and time for the First Meeting, and who was going to attend. She asked where he would prefer the First Meeting to take place and conveyed the Recovery Message. She ended the invitation by letting Jude know that the Intervention Network would be meeting regardless of whether or not he decided to attend.

Jude was 45 minutes late for the First Meeting. The initial time without him was spent with the family discussing the family's history of alcoholism, their inter-generational history of violence, and Jan and Mark's courage and love in being prepared to be in the same room together for the shared goal of getting their son into treatment and breaking the cycle of alcoholism in the family.

When Jude came into the First Meeting, he sat down and looked at his parents and stated, "I'll bet you thought I wasn't coming. I didn't come on time on purpose. I knew you had things to discuss on your own without me." Both parents shared what had been discussed and stated the purpose of the meeting. Jude was asked to listen while each person shared with him his or her concerns. Each person shared what s/he knew of his alcohol and drug use and requested that he get help.

After listening to them, Jude was given an opportunity to respond. He

admitted to his problem with alcohol and cocaine. He talked about how his cocaine use escalated after his grandfather had died, and how he had been having recurrent thoughts of his own death since losing his grandfather. The group supported him, validating how each of them was also having a difficult time with the grandfather's death. Jude agreed to check into a local hospital detox unit the next day and the family agreed to meet again in the detox unit to discuss the next level of care needed.

Level 2 Case

The First Caller was the mother of 16-year-old Angela, who had been sexually assaulted at the age of 14 by a 28-year-old man who had plied her with drink and taken advantage of her once she was intoxicated. Angela had been through an extremely painful unsuccessful court case. Despite the statutory rape, her rapist had been found not guilty because the emergency room physician had failed to take the necessary samples at the time of her medical examination. Angela's mother had called to request help because Angela was drinking heavily and using marijuana on a daily basis. She was also failing almost every class in school, playing truant with friends, and whenever her parents tried to discipline her, she would run away, once even running through traffic on a busy highway, narrowly escaping death. During the previous 3 months, Angela had been involved in 4 car accidents of escalating seriousness. Her parents felt that she was depressed and were reluctant to discipline her too strictly in case that put even more pressure on her and drove her further into depression or suicidality. They were beside themselves, but felt helpless to change the situation.

Angela attended all 3 Level I First Call meetings, along with her parents and all 3 of her siblings, but she refused to consider treatment for her addiction and depression. Whenever action was mentioned, she would burst into floods of tears alternating with fury at her father, stating, “You’re one to talk! You always drink when you’re upset! Why don’t you go for treatment?” Her father, after some intense family conflict, agreed to stop drinking if that would help Angela get into treatment and get better. The genogram revealed that Angela’s maternal grandmother, with whom she had been very close, had died recently.

It became clear that both Angela and her mother were still grieving. The parents had lost their first child at 18 months from a congenital illness. This loss was followed by Angela’s mother being diagnosed with malignant melanoma, and years after treatment she now suffered from Chronic Fatigue Syndrome. Angela and the other siblings felt that they had been forced to raise themselves as father buried himself in his workaholicism and mother stayed in her bed.

Once the grief had been identified, and the family was able to work through their extensive losses, it became apparent why the parents were terrified of disciplining Angela. They were anxious about not suffering yet another loss.

After 3 Level I meetings, it was clear that the system needed to be expanded, and friends and extended family members were invited to bring their “Strength in Numbers” at Level II. With some clear consequences set for her behavior, and the other members of the support system not falling for Angela’s threats, the parents became visibly stronger and were able to insist that she go into an alternative school system with intensive addiction program. Clear parameters were set for Angela’s completing the required program, and she agreed to the conditions with clear relief that safe boundaries were being set. She did extremely well in the program, and was able to

graduate from high school with honors and attend the college of her choice. In fact, she chose to attend a college with a dry campus, and is doing extremely well in academics and her social life.

Level 3 Case

The First Caller was the step-grandmother, Sara, who called regarding the problems her 48-year-old step-granddaughter, Julie, was having with alcohol. The problem that prompted the First Call was a school issue that surfaced with Jean, Julie's 17-year-old daughter, and the lack of follow through with a college application.

The participants in the First meeting were: Sara (step grandmother), Frank (father), Jean (17-year-old daughter), Pam (16-year-old daughter), Peggy (friend), and Molly (friend). Sara did the invitation and used the following Recovery Message as part of the inviting: "We know how unhappy you have been over the past few years. You have not been the same since your mother died 10 years ago. Your children need their mother, just like you needed yours. We know how much pain you must be in." Julie did come to the First Meeting and minimized her drinking. She was not willing to enter treatment, but agreed to "cut down" on her drinking. The Intervention Network agreed to continue meeting because they did not agree with Julie's decision and did not think she would be successful at reducing her drinking.

The Intervention Network held 3 additional meetings in the subsequent 5 weeks after the First Meeting. Julie was invited to each of these meetings. She attended the second of the three meetings.

She reported in that meeting about how "successful" she had been at cutting down

her drinking. “I have been able to only drink one or two drinks a night and I don’t even drink every night anymore.” Her reporting of her drinking was contradicted by what others in the Intervention Network had observed. One of her friends, Peggy, reported, “You could barely talk last Saturday night when I stopped over. You had a lot more than one or two drinks.” Her father, Frank, shared how he could identify with her minimizing, “Before I went into AA and stopped my drinking I lied about how much and how often I drank. I went to AA meetings and in the beginning and drank before going and shared with the AA group how well I was doing not drinking.” Julie refused to enter treatment.

In the 3rd Intervention Network meeting (in Level 2) the group shared growing concerns about Julie and how her drinking had continued to be a problem. The group was concerned because Julie told Molly that “I will never go to another one of those meetings again. I don’t have a drinking problem and you are being brainwashed by the rest of the group.” Various options were discussed and the Intervention Network agreed to go to a Level 3 session where a consequence would be introduced if Julie did not enter treatment.

Julie was again invited to the Level 3 session with the agreement that this would be the last meeting the group would invite her to attend. She agreed to come.

The start of the Level 3 ARISE Intervention meeting is similar to the First Meeting, where the alcohol dependent or addicted individual is asked to listen to the concerns of each person and then respond at the end.

The group members shared their concerns with each statement ending with a request that Julie get into treatment. Julie’s father, Frank, was the last to speak. He was chosen last because he was to introduce the consequence. In this case the consequence was that if Julie did not enter treatment her children would be leaving their home and would be living with their grandparents

until the time that Julie was stable in an alcoholism recovery program. Julie was shocked by the consequence, tried to single her daughter's out to convince them not to leave, and expressed anger over the "threat of taking my children away from me."

Her two friends were able to calmly share the information about the Intervention Network meetings that she had previously been invited to attend and how her plan to reduce her drinking had not worked. The friends were able to tell Julie how the whole group had made the decision and that the group's commitment to the consequence was firm and non-negotiable. The friends invited her to go to Family Court so a judge could hear the merits of her case, hear the history of the alcohol abuse, hear the summary of the Intervention Network meetings and then make a decision. Julie argued for another 5 minutes. The group got up to leave, including her daughters, who said, "Mom we will be in touch from Grandpa's house." Julie began to cry and asked to the group to sit back down because she could not stand to lose her daughters and would enter treatment.

Outcome of the NIDA ARISE Study

ARISE proved successful at helping concerned others to get their resistant loved ones or friends into substance abuse treatment or self-help in 83% of the cases. The 83% level of success was achieved (a) without excluding any cases who asked for help, and (b) with an average of only one session and 1-2 phone calls, totaling 88 minutes of clinician time (median = 75 min., range 5-375). One of the surprising findings was that Invitational Intervention using the ARISE method achieved engagement very rapidly. Fifty percent of engagers entered treatment within one week from the First Call, and 84% within three weeks (Landau & Stanton et al., 2004). One of the reasons that ARISE appears to be so cost-efficient as an engagement method is that the concerned other, family and support network take responsibility for a major proportion of the

work, reducing the time and effort spent by the clinician.

The engagement rate did not differ across demographic variables such as age, gender, or race. Nor did it differ across a number of variables such as preferred substance of abuse (cocaine, alcohol, other drug), current level of substance abuse, length of use, or treatment history (inpatient, outpatient).

(Insert Figure 1 here)

One variable that did reach significance was the extent to which concerned others deemed their addicted individuals to be in need of treatment: The greater the perceived need, the more likely were they and their network to get the addicted individuals engaged in treatment or self-help. Both these variables can be attributed to the concerned others' level of motivation and their frustration at dealing with the addicted individual's ongoing denial and resistance to treatment. This combination is most likely to lead to the concerned other devoting effort to contacting other network members, convening meetings, and working hard toward getting the substance abuser into treatment.

There was no significant difference among different types of concerned other-addicted individual relationships. However, in line with Meyers et al. (1998) and Miller et al. (1999) finding that parents were more likely to get addicted individuals engaged than spouses, we did find improved results with cases in which at least one parent *was involved as a participant*, whether or not that parent was the actual concerned other (Landau & Stanton et al., 2004). This also matched the research that addicted individuals are closely involved with one or both of their parents. This supports the findings of Meyers et al. (1988), Miller et al. (1999), and Szapocznik et al. (1988) suggesting that parents can be a powerful resource for inducing addicted individuals to seek help.

Engagement at Level I

By the end of Level I, 55% of these cases had been engaged in treatment, requiring only one or two telephone conversations between the clinician and the concerned other and one face-to-face session. We believe this success rate can be attributed to four primary factors:

(1) *Immediacy*. ARISE capitalizes on the timeliness of the concerned other's choosing to call on that particular day. Barriers are minimized and the ARISE Interventionist supports the concerned other's decision to call at that particular time, and translates the situation into reasons why the concerned other should act now, rather than later. A similar rationale has been employed with the Community Reinforcement Training approach to engagement: the clinician attempts to see the concerned other on the day of the first call (Azrin, 1976; Sisson & Azrin, 1986). Further, the immediacy of a program's response has been shown significantly to increase the rate at which substance abusers, calling in for initial appointments, will actually show up (Festinger, Lamb, Kirby & Marlowe, 1996; Stasiewicz & Stalker, 1999). In addition, the crisis intervention literature demonstrates the benefit of an immediate response in people faced with crises (Lystad, 1988; Rapaport, 1977)

(2) *Sharing the responsibility* by network support for the concerned other. This starts from the moment of the First Call, when the ARISE Interventionist reassures the concerned other that s/he does not need to handle the situation alone any more, and that help from others breaks the isolation, provides needed support, and dilutes the negative power of the addicted individual who is most likely to "win" in a one-on-one situation. Expanding the system by bringing in additional members of the support network is critical in this process (Landau, 1981; Landau-Stanton & Clements, 1993; Landau, et al., 2000).

When the Interventionist works only with the concerned other-addicted individual

relationship, he or she is necessarily confined to the dynamics of that relationship. If there is tension or a stalemate, or the relationship has escalated into open conflict, the Addicted individual is unlikely to want to hear the demands or wishes of the concerned other. The most stressed dyad is also likely to have the least energy and capacity for change. Sharing the responsibility, and getting the concerned other out of the middle, allows other network members with greater leverage to intervene, bringing additional resources and “strength in numbers” to the Intervention (Landau, et al., 2000).

(3) *Instilling confidence in the Concerned Other.* The clinician starts building confidence by assuring the concerned other that there is a method designed particularly for the situation s/he has just described. This leads to hope where previously there may have been frustration, despair and anger. In addition, the reassurance by the ARISE Interventionist that a Herculean effort may not be required to engage the addicted individual appears less daunting and therefore more achievable. The concerned other is motivated by the knowledge that only the amount of time and effort necessary to effect engagement will be required. Finally, spreading responsibility among other network members both relieves the concerned other of a considerable burden and fortifies the notion that the contributions of these others may increase the chance that something constructive will result. As Miller et al. (1999) state: there is a “direct message that family members *can* do something to instigate change” (p.695).

(4) *Respect for the addicted individual* is shown by including him or her in the process from the very start. As mentioned earlier, the Addicted Individual is informed about the First Call and invited to the first ARISE session. The Addicted Individual is also told that, since the discussion will revolve around her or him, s/he may want to attend in order to provide input and have her/his views considered. This alone often succeeds in getting him/her to attend because

most people do not like to be talked about without both hearing what is said and having a voice in the discussion. Should s/he not attend that meeting, constant efforts are made to encourage her/him to join the process.

Consequently, there is neither loss of face nor embarrassment if s/he later is persuaded to come in as is likely to happen when the approach has involved secrecy or strong confrontation.

Prevailing Addiction Myths.

As with most of the other published engagement studies, these findings challenge the widespread view that Addicted individuals must "hit bottom" and be self-motivated to enter treatment. Along these lines, Loneck, Garrett & Banks (1996a; 1996b), found that self-referrals (i.e., those Addicted individuals who sought admission on their own after hitting bottom) had the lowest treatment completion rates by comparison with criminal justice referrals and family-type intervention referrals.

Concerned others in the NIDA study often indicated to the ARISE Interventionists that they had tried other agencies without receiving much encouragement. Many mentioned the anger they experienced at being labeled "co-dependent," "controlling," a "victim" or an "enabler," and the helplessness they felt at being told that there was nothing they could do until their loved one "hit bottom." They were relieved and felt supported and encouraged by this Invitational Intervention.

Conclusion and Practical Clinical Implications

Invitational Intervention, and the ARISE protocol, can be applied to a number of non-substance related addictions and dependences that, in their own way, are as disruptive to individual and family life as substance abuse. These tend to fall into three main categories: (a) other addictions and behavioral compulsions; (b) chronic and/or life-threatening physical or

psychiatric disorders, and (c) physical or emotional problems that threaten primary relationships, but are not severe enough to warrant psychiatric referral.

The authors have used Invitational Intervention in the areas listed above. They have not yet done empirical studies, but on an informal basis the ARISE Intervention appears to be effective in engaging resistant patients and clients in treatment in these instances. In addition, where the primary problem is, for example, resisting regular testing of blood, urine, or blood pressure, attending regular doctor's appointments, or complying with prescribed medication, an Intervention Network coached by an Invitational Interventionist can bring about a remarkable change. When approached by a concerned other member of the support system about any of these problems, the Invitational Interventionist proceeds in much the same way as s/he would in dealing with a substance abuse issue. However, in each of the categories and sub-categories there are likely to be differences, ranging from subtle to blatant. It is useful to be aware of these differences and the need for specific training prior to offering one's services in any of these areas that may be less familiar to the Interventionist.

The authors hope that studies in the areas mentioned above will follow since they believe that the resources and resilience of families can be brought to bear on many of the problems that are currently costing significant and unnecessary mortality, morbidity, and expense to our population.

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