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**The ARISE Intervention: Using family and network links
to overcome resistance to addiction treatment**

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Abstract

An alternative method to the Johnson Institute's "Intervention" is presented which, while incorporating many of Johnson's innovations, is, additionally: (a) less confrontative, thereby avoiding the reactivity in clients and family members that such confrontational approaches have tended to evoke; (b) takes into account both the needs of the chemically dependent person as well as the needs of the larger family and network system; and (c) aimed toward enrolling substance abusers in outpatient (as well as inpatient) treatment, thus placing it more in line with managed care priorities. Principles for treatment engagement are presented, accompanied by case examples. The approach is part of a more comprehensive model designed to maximize successful engagement with a minimum amount of professional time and effort.

The ARISE Intervention: Using family and network links to overcome resistance to addiction treatment

The vast majority of alcohol and other substance abusers are decidedly reluctant to enter treatment or to engage in self-help groups such as AA or NA--and most of them never do (Francis, Miller & Galanter, 1989; Nathan, 1990; Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen & Kendler, 1994). This reluctance has spawned counteractive methods aimed at successfully engaging such individuals in treatment. The most well known and widely applied of these methods is the "Intervention" approach developed by Vernon Johnson and associates in Minnesota (Johnson, 1973, 1986). It proceeds by enlisting and convening as many of a chemically dependent person's (CDP's) significant others as possible in an effort to induce the CDP to enter treatment. The members of the group are coached to, individually, write a personal testimonial (a) declaring their love of the CDP, (b) stating how a CDP's drinking or substance abuse stresses the relationship, and (c) confronting the CDP with a plea or a mandate to change or to get help. The testimonials are practiced beforehand, and a time and venue are chosen for the confrontation to take place. The CDP is informed neither about these preparatory activities, nor of the impending confrontation.

Intervention has brought considerable hope--and a concrete, understandable procedure--to a problem area which, theretofore, had been fraught with ambiguity and despair. Worried, even desperate, family members and friends had finally been given a means, a tool, for taking action toward reversing the destructive process surrounding chemical dependence.

Unfortunately, Intervention's public acceptance has not been buttressed by much empirical evidence--either positive or negative. We have been able to identify only two studies which have examined its effectiveness in treatment engagement: both dealt with alcoholics, were of a "preliminary" nature (Liepman, 1993), and employed (less-than-optimal) quasi-experimental designs. Liepman, Nirenberg and Begin (1989), incorporating an average of four significant others per case, had a success rate of 25% across 24 cases. Logan (1983), using 8-12 individuals per case, had a 90% success rate ($N = 60$).

Obviously, there is a pressing need for more research on Intervention, both as to its efficacy and to the factors which mediate that efficacy. Further, given the lack of conclusive evidence in the literature, the question naturally arises as to whether the Johnson Intervention can be improved upon. Is it, in and of itself, a complete and final method, or is it a way station--albeit an important and pioneering one--in an unfolding process for improving the means by which chemically dependent individuals are shepherded into the treatment fold? Some authors, while praising Intervention's strengths, have been outspoken regarding what they consider to be its shortcomings. For instance, Lewis (1991) has criticized its confrontational nature, which she notes can frighten family members, since it assumes the flavor of an ultimatum: the family may

not be ready for such confrontation, whereas a slower, non-escalating, less distressing induction would be acceptable. Likewise, research by Barber and associates (Barber & Gilbertson, 1996, 1997, in press; Barber, Gilbertson & Crisp, 1995) found that their (female) significant others "were unhappy about employing such confrontational tactics, and most did not comply with the [Johnson Intervention] instructions because they thought that the use of programmed confrontation would be stressful and injurious to their relationship to the drinker" (Barber & Gilbertson, 1997, p. 75). Finally, data by Loneck, Garrett, and Banks (1996b) suggest that the severity of the Johnson Intervention results in a predictable "rebound" in which those clients subjected to it are more likely to relapse than clients with whom less confrontational techniques are applied.

The present paper sets forth an alternative model of Intervention--one that is designed to maximize the probability of treatment engagement while minimizing the sort of reactivity--both in family members and substance abusers--described above. It is the final stage in a three stage, graduated continuum for inducing CDPs (Garrett, Landau-Stanton, Stanton, Stellato-Kabat & Stellato-Kabat, 1997). Termed the "Albany-Rochester Interventional Sequence for Engagement" (ARISE), (Garrett, Landau-Stanton, Stanton, Baciewicz, Shea & Brinkman-Sull, D., 1996) it "starts small" in that the least amount of therapeutic and familial/network resources are initially drawn upon, and these are added to only in the face of increased resistance. In this way, the engagement effort is tailored to a particular client, family and network in terms of their level and type of resistance. In addition, the ARISE approach keeps an eye toward cost effectiveness by predominantly leaning toward outpatient (as opposed to inpatient or residential) treatment (Berlant, Trabin & Anderson, 1994; Frances, Miller & Galanter, 1989; Miller & Hester, 1984). ARISE evolved collaboratively from the authors' experience within a number of treatment contexts, involving more than 1,000 clients, over the past 12 years. Its effectiveness has been examined empirically on a randomly selected sample of 350 cases engaged for treatment over a two year period. These findings have been published in a series of research papers (Loneck, Garrett, & Banks, 1996a, 1996b, 1997). The three-stage ARISE interventional sequence includes "coaching" techniques for (a) the first call from a concerned other person (CO) (b) a series of 3 to 5 intervention network sessions, and (c) the ARISE Intervention. The present paper describes only the third stage of the intervention sequence, the ARISE Intervention, and how it fits into the overall ARISE model. The reader is referred to earlier papers for detailed explanation and guidelines to the first two stages (Garrett et al., 1997; Garrett, Stanton, Landau-Stanton, Baciewicz, Brinkman-Sull & Shea, 1997 in press; Landau, Shea, Garrett, Stanton, Baciewicz & Brinkman-Sull, 1997 in press).

The Changing Nature of Interventions

The ARISE Intervention evolved in part from the Johnson Intervention, with significant influences also from family systems and network therapy (Speak and Attneave, 1973). This evolution of the ARISE Intervention started when the authors noted that there were more

families who refused to do an Intervention than families who proceeded with one. Among the reasons the COs stated for not doing an Intervention were: as noted by other writers, the highly confrontive aspects of the method; belief that support for the CDP was more important than developing harsh consequences; fear that the CDP would "go over the edge" if strongly confronted; skepticism that anything would work due to isolation, confusion and despair from living with the active addiction for a long period of time; inability to get others to join in doing the Intervention; hierarchical respect for a loved one (an adult child for a parent or a younger sibling for an older sibling); and fear of reprisal by the CDP. In addition, research demonstrates that families continue to experience the same, or even a worse, degree of problem functioning even when the CDP gets into treatment following a Johnson Intervention (Barber & Gilbertson, 1996, 1997, in press; Barber, Gilbertson & Crisp, 1995). Consequently, the ARISE Intervention focuses not only on getting the CDP into treatment, but also on the needs of the family and network as well.

The ARISE model has seven operational assumptions which guide each of the stages in the interventional sequence. These assumptions are listed and explained below, using brief case examples.

ARISE Assumption 1. Involving the CDP in the intervention process from the beginning conveys respect for that person while also encouraging openness within the overall system.

By the time most families have called asking for help with the CDP there is commonly a long history of manipulating and lying by the CDP (Stark, Campbell & Brinkerhoff, 1990; Cunningham, Sobell, Sobell, Agrawal & Toneatto, 1993; George & Tucker, 1996). The family often displays an impotence and despair from living with chemical dependency. The end products of this familial adaptation to chemical dependency are isolation, secrecy, guilt and blaming within the system. The natural strengths and resiliency of the system have been compromised (Elkin, 1984; Orford, 1992). The ARISE Intervention supports the family in breaking its accommodation to chemical dependency by opening up the topic for discussion and problem solving. This openness also begins a rebuilding of the trust and respect which have been lost (Galanter, 1993a, 1993b, 1995). Further, the chaos and dysfunction described by the family can be seen to possess pattern and purpose when carefully explored. A substance abuse pattern which seems inexplicable when looked at solely in the context of the nuclear family, can make explicit sense when viewed in relation to two of three generations (McGoldrick & Gerson, 1985; Landau-Stanton & Stanton, 1996).

Case Example A

Parent Intervenes With an Adult Child.

This case exemplifies a situation where the network had decided to set down a consequence and treatment was added as a second condition.

Pat was a 28 year old legal secretary. She was engaged to Tom, a 30 year old factory supervisor. The couple had been living together for the past 9 months. Their wedding had been planned for more than one year and was to include a church service and reception with 100 people invited. Two weeks before the wedding Pat's father, Bob, received a call from Tom wondering if Pat was at the parents' house since she had not been home for the past two days. Bob became concerned for his daughter upon learning from Tom that she had also disappeared like this upon three previous occasions. Tom told his future father-in-law that Pat had a problem with crack cocaine and that the earlier disappearances were due to her drug use. Bob called the treatment facility, which had a community reputation for doing Interventions. The therapist followed the ARISE First Call procedures (Garrett, et al., 1997 in press), with the goal of providing options for the family so they could decide the level of confrontation needed to get Pat into treatment. After the initial telephone coaching, Bob agreed to confer with Tom and the rest of the family about the next intervention step. The following day Bob called the ARISE intervention specialist back indicating that the family had decided to postpone the wedding and was willing to set up an appointment for an intervention meeting where Pat would be approached and supported in getting into treatment. The intervention network included Pat's father, brother, grandmother, two aunts and Tom. The intervention specialist developed a strategy with Bob which placed the paternal grandmother as the key person to get Pat to come for the intervention session. Despite Pat's anger, denial and initial refusal to come to the session, this approach proved successful. When the grandmother told her that the family was going to meet regardless of whether she came, Pat understood the seriousness of the situation and the commitment of her family to take whatever action was needed to help her get started in treatment.

ARISE Assumption 2. Intervention is a process that occurs along a continuum.

Families commonly differ from each other in the ways they cope with stressors (Nichols, 1988). The ARISE Intervention avoids the limitations of a "one size fits all" approach by offering a continuum of options. This continuum is designed to empower the family to recognize and utilize its strengths. The therapist is able to convey this message by offering choices to the family. The very nature of choices necessitates a new level of discussion about the chemical dependency (Stanton, 1992). The intervention continuum encourages the family members to have new levels of discussion, taking into account what they believe will work (Imhoff, 1995). The intervention continuum also persuades more families to start the therapeutic process both for their own benefit, as well as the CDP's (Asher & Brissett, 1988). A systemic view of chemical dependency introduces the notion that the family is both affected by the problem and effects the course of the chemical dependency (Steinglass, Davis & Berenson, 1977; Steinglass, Bennett, Wolen & Reiss, 1987).

ARISE Assumption 3. Flexible options maximize potency and minimize resistance from network and CDP.

Families have a multi-dimensional relationship with the CDP. Their loved one with the problem was not always chemically dependent. There has been a significant investment in the CDP by the family prior to the development of this problem. By the time the chemical dependency has progressed to the point of undertaking an Intervention the family does not believe there are any options (Stanton, 1981). Using a model with flexibility encourages the family to work from its strengths. This approach also takes into account the dynamic that family relationships are complex and are rarely defined along the singular dimension of chemical dependency (Bowen, 1978). Options therefore allow the family to approach the CDP with choices, thereby minimizing the likelihood of evoking a rebellious response from being told what to do (Prochaska & DiClemente, 1986; Pickens, Leukenfeld & Schuster, 1991).

Case Example B

Adult Child Intervenes With a Parent.

Ted was a 55 year old man with a 25 year history chronic alcoholism. He had not worked for the past seven years-since being laid off from his factory job when the plant closed . He had been on medical disability for the past four years after injuring his back in an alcohol-related fall. He was divorced and lived alone in an apartment, with his oldest daughter living in the flat above him. In addition, he had two other daughters and a son. (One daughter had a year of recovery from her alcoholism.) Ted had more than 10 hospitalizations for detoxification and had failed in numerous inpatient and outpatient treatment programs. He had cirrhosis, peripheral neuropathy and symptoms of organic brain damage.

The ARISE intervention specialist received a call from the daughter who lived above her father, Ted, indicating that he had been taken to the hospital emergency department the day before after falling on the sidewalk and not being able to stand up. He was admitted to the detoxification unit with a .32% Blood Alcohol Content. The daughter wanted to do an Intervention with her father.

The intervention specialist described the ARISE Intervention continuum and suggested that the family come to a session while her father was in the hospital, so options could be discussed. She was also instructed to let her father know that the family meeting was taking place. The meeting included all three children and Ted's two older sisters. The first intervention session involved a review of how sick Ted was, with the intervention specialist taking the position that there was a strong likelihood that he might die from his continued drinking. Family issues of loss, anger, mistrust and sadness were addressed, as well. The aims of the first

intervention session were to (a) get a commitment from the family to continue in sessions so they could support each other in the loss of Ted if he continued to drink, and (b) have a plan of action which would be conveyed to him in the hospital.

The family immediately saw the value in continued sessions and agreed to continue. They decided that they would not allow Ted to return to his apartment and that he would either have to go to a long term residential treatment program or live with one of his older sisters for a minimum of six months. He was also to participate in outpatient treatment before he would be allowed to move back into his own apartment.

The family met with Ted in the hospital to convey their decision. The family understood that ultimately it was Ted's decision and that he might reject their love and support. Initially Ted fought his family, wanting to return to his apartment. The family's insistence, unity in approach, and openness about their intent to continue in treatment, even if he choose to reject their plan (because they would then be preparing for his death), convinced Ted about the seriousness of the situation. Giving him two options in the plan allowed Ted to negotiate with his family around which he would choose. He chose to go to his sister's house and to start a outpatient alcoholism treatment which included weekly sessions with his family.

This example demonstrates the potential strength that adult children can have with chemically dependent parents by utilizing the natural succession of problems which develop from untreated addiction. Health problems can often be a powerful motivator to start recovery (Logan, 1983). In addition, the example illustrates demonstrates how this intervention method offers help for family members even if the CDP does not stop using. Finally, it also demonstrates the continuity of the intervention process going from confrontation to support.

ARISE Assumption 4. Pressure from the intervention network needs to be matched to the resistance from the CDP.

The availability of options allows the family to decide what level of pressure is needed to engage the CDP in treatment (Stark, 1992). Most families readily understand and appreciate the gradual escalation of pressure (Callan, Garrison & Zerger, 1975). This approach has a medical parallel of using the least invasive procedure to accomplish the goal. The matched pressure allows for the family to take progressively confrontive steps depending upon how the CDP reacts to the previous approach. Again, the goal of the ARISE model is to utilize the least amount of confrontation to engage the CDP into

treatment. Paradoxically, the design and intent of the overall ARISE model are to avoid having to do an ARISE Intervention whenever possible.

ARISE Assumption 5. Families care about the CDP and CDPs care about their families.

The very nature of a family even making the effort to learn about an Intervention exemplifies their concern and love for the CDP (Cervantes, Sorensen, Wermuth & Menicucci, 1988). Research by one of the authors (Stanton, 1982; 1997) shows the continuous contact CDPs have with their families, despite the problems associated with the chemical dependency. Stanton's reviews of the literature on the regularity of family-of-origin contact concluded that 60-80% of drug abusers either live with their parents or are in daily face-to-face contact or telephone contact with at least one parent. Family patterns of loyalty (Boszormenyi-Nagy and Spark, 1973), power dynamics and hierarchies (Haley, 1980), boundaries (Minuchin & Fishman, 1981), communications (Satir, 1988; Whitaker & Keith, 1981), intergenerational dynamics (Bowen, 1978; Framo, 1976; Paul, 1965) and protectiveness make families more "powerful" than treaters to effect change (Landau-Stanton et al., 1993; Seaburn, Landau-Stanton & Horowitz, 1995).

Case Example C

Parent Intervenes With an Adolescent.

This example is meant to underscore the relative ease of getting adolescents into treatment. Most Intervention calls about adolescents come as the result of problem behavior in school, at home, with the legal system or the discovery of evidence of drug use. The ARISE Intervention method uses techniques researched by Jose Szapocznik, et al., demonstrating a treatment engagement rate of 92% (Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban, Hervis & Kurtines, 1988).

Tracy was a 16-year-old whose primary residence was with her biological mother. While at her father's home for the weekend he found small clear plastic bags of cannabis ("nickel" bags) in her coat pocket. He called his ex-wife to let her know he had found the drugs. He reported that the discussion "opened my eyes to what was going on right under my nose." For the first time, he linked together Tracy's drop in grades at school, her defiant attitude, and her change of friends. Because Tracy had no prior history of problem behavior, and was in advanced course placement at school, he had previously thought the changes he was seeing reflected a "phase my daughter was going through". The parents agreed to confront Tracy about finding the drugs and set up an appointment for a substance abuse evaluation.

ARISE Assumption 6. Working from family strengths conveys a belief in their resilience to overcome obstacles.

The family considering an Intervention has functioned before the contact with the therapist and will continue to function after the contact. The goal of the ARISE Intervention is to utilize the inherent family strengths by having the family members do as much of the therapeutic work as possible with minimal involvement from the therapist (Landau-Stanton, 1986). The approach is designed to guide families in recognizing and utilizing their strengths toward stopping the destructive path of the chemical dependency. The ARISE model trusts in the inherent ability of families to heal themselves (Berenson, 1976; Bowen, 1978; Seaburn et al., 1995).

**Case Example D
Spouse Intervenes With a Spouse.**

What makes this case interesting is that expanding the network provided enough support for the spouse to stand firm in her ultimatum for recovery, while backing off from a divorce and remaining isolated. It also demonstrates flexibility of the model, because the intervention sequence can be employed even when the initial request did not ask for an Intervention.

Peggy was a 40-year-old real estate sales woman. She had been married to Roger, a store manager, for 18 years. The couple had two teenage daughters, ages 13 and 15. Roger had a 15 year history of alcoholism and a two year history of using powder cocaine. The current crisis occurred when the police were called to the house by Peggy after Roger became violent. The police took Roger to the hospital because of a hand laceration caused after punching a hole in the wall. Following release from the hospital, Roger went to a motel room at the suggestion of the police. Peggy called the outpatient treatment facility for help with her children, who had witnessed the violence and were emotionally distraught and confused. At the initial meeting with Peggy and her daughters one of the sources of conflict in the home that became clear was the anger the children had about their mother threatening to separate. The children thought their mother provoked much of the violence by her screaming and threatening remarks. Peggy admitted that her resentments and anger towards Roger often surfaced with her threatening him and losing her temper. With the children out of the room, the ARISE Intervention sequence was explained to Peggy. In the ensuing discussion Peggy talked about her love for Roger, how he had changed over the past couple of years, the resulting mistrust that she felt, and how the major source of her anger was the financial problems they were having. She agreed to keep Roger out of the house

until a network meeting was held. Peggy saw this meeting as a last effort for Roger either to get into treatment or experience consequences. She believed a network meeting would help her carry through on the consequence of marital separation because she would have support and have less guilt. She wanted to invite Roger's mother (his father was deceased), both of her parents, the children, Roger's brother and his wife, and his employer. The purpose of the Intervention session was to confront Roger on his addiction and to support Peggy in setting consequences if he continued to use.

ARISE Assumption 7. The intervention network benefits from the process regardless of whether the CDP enters treatment.

Various intervention models are taking into account the well being and functioning of the family (Thomas & Ager, 1993; Sisson & Azrin, 1986; Barber & Crisp, 1995). Recent research shows that subjective reporting by SOs regarding family relationships and marital functioning was no better off one year after a successful Intervention (Barber and Gilbertson, 1996). The ARISE Intervention has a dual focus of both engaging the CDP in treatment and supporting the family members in healing from the damage of living with chemical dependency. The ARISE model is designed to work with the family regardless of whether or not the CDP enters treatment (Paul & Grosser, 1965; Framo, 1976; Haley, 1980; Treadway, 1989). An Intervention is viewed as a therapeutic process, not a one-time event.

Case Example E

Sibling Intervenes With a Sibling.

This case demonstrates the use of a sibling as link in the family in contending with a reluctant parent, and how to deal with a family who want to do a Johnson style Intervention.

Sam was a 24-year-old construction laborer. He was the youngest of 5 children. His oldest brother, a psychiatric nurse, called the outpatient treatment facility to set up an Intervention. He had read about Johnson Interventions and wanted to undertake this style of Intervention with his brother. Sam had borrowed his brother's car the night before and had an accident with it after leaving a bar. Sam had previous legal problems related to drug and alcohol use, including unlawful possession of cocaine, DWI and resisting arrest. The ARISE Intervention sequence was explained to the oldest brother and, although skeptical, he agreed to discuss it with the rest of the family and call back with a decision. The biggest differences between the ARISE Intervention and the Johnson Intervention in this case were: not using the element of surprise, not having severe consequences,

not needing preparation sessions before having the Intervention meeting, and negotiating the level of care with Sam. After discussing the model with the family, the oldest brother called back indicating the family was willing to use the ARISE model as long as there was no negotiating around level of care: the family was insistent that inpatient rehabilitation be used as a starting point with Sam because of the mother's worry about Sam's depression (and potential suicide). The family invited Sam to the intervention session, explained their concerns, dialogued with him about the chemical dependency problem and insisted he go to an inpatient program. He complied within two weeks.

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From the foregoing, it may be apparent that the ARISE Intervention stems from a number of assumptions that differ from those of the Johnson Intervention. For the sake of clarity, these differences are enumerated and briefly summarized in Table 1.

Insert Table 1 here

The ARISE Intervention

There are a number of steps that an intervention network goes through before reaching consensus to do an ARISE Intervention. Parts of the following section are written in the second person and imperative mood so as to make the instructions/guidelines more easily and directly translatable to clinical practice. It should be emphasized, however, that therapists would be well advised to obtain specific Intervention training before undertaking an ARISE Intervention. The steps and procedures in this paper are meant to give a description of the ARISE Intervention and are not a substitute for such training.

1. Review the steps of an ARISE Intervention.

The ARISE model uses graduated levels of pressure which match the resistance from the CDP. The trained ARISE intervention specialist therefore first determines whether or not previous levels of pressure were effective in getting the CDP to engage in treatment.

The overview with the network is meant to make sure all network members understand the escalation of pressure used in an ARISE Intervention. Are they willing to "develop a bottom line" and enforce consequences with the CDP if he/she refuses treatment? Armed with the knowledge that not all Interventions succeed, at least initially, are they ready to support each other regardless of the outcome? Are they ready to face the reality that the chemical dependency may have progressed beyond the point of treatment engagement and the best thing they can do after the offer of treatment is to support each other in the enforcement of consequences and the grieving of the loss?

2. Review "Choice Points" with the network.

Once the network has committed to taking another step, there is an important decision for the group to make. The "choice points" are (a) an ARISE Intervention, (b) consequences without a formal Intervention, or (c) no consequences at this time, while continuing to monitor the CDP. The counselor helps the network discuss the potential risks to themselves and to the CDP in doing or not doing an Intervention. Network fears and ambivalence are discussed by underscoring the assumption that the pressure from an Intervention matches the resistance of the CDP. Are they committed to continuing to meet regardless of whether the CDP enters treatment? This continuation of sessions is important, because it prepares the network to progress from confrontation to support if the CDP starts treatment. In addition, the commitment for continued involvement allows the network members to support each other and to enforce the consequences set forth by the group during the ARISE Intervention process (Landau et al, 1997 in press).

3. Obtain network consensus to do an ARISE Intervention.

The network may choose one of the other choices outlined under number 2, above. If the network does not choose an ARISE Intervention they may want to continue the network intervention sessions (which operate in Stage 2 of the overall ARISE model). In the present paper, we will proceed with the assumption that the network has chosen an ARISE Intervention. The next step is thus to give the network members a choice about who will participate in the Intervention. Some members may not be willing to do so. It is therefore wise to hear their opinions (and respect their decision) in order to understand how their absence will affect the dynamics of the Intervention. They may also be invited to rejoin the network after the Intervention in order both to support recovery if the CDP goes into treatment and to support the network maintaining the spelled-out consequences.

4. Set consequences.

Developing consequences for the CDP is a significant part of the Intervention. The network already understands that the CDP will be given a choice of accepting its love and support in the recovery process or experience some consequence. The network must discuss the range of consequences in order to arrive at the ones which all participants can enforce. The therapist's role at this point is to "stretch" the polarities of the consequences -- entertaining the whole range of suggestions -- in order to assist the network in finalizing its choices. For instance, a discussion of not allowing a grandparent to see his/her grandchildren because of the CDP's unreliable behavior and inconsistent decision-making when drinking can be discussed in the context of what the grandchildren will be missing and what will be said to the grandchildren when they ask to go to the grandparent's home. This type of discussion allows the network to think through the ramifications of the consequences and to understand that their seriousness and possible long lasting implications.

5. Explain the "rehearsed" nature of the Intervention.

To a great extent, an Intervention is a staged activity. This means that deliberate steps are followed in order to minimize any surprises. The reason for the rehearsed nature of the Intervention is to convey accurately and without distraction the consequences the CDP will face if treatment is not accepted.

6. Discuss treatment options and negotiation with the CDP.

In the ARISE Intervention negotiation is common when it comes to treatment options. The network may have a certain outcome planned as the result of the Intervention, i.e., inpatient rehabilitation. However, the CDP may not be willing to take the network's choice. The therapist's role in preparing the network members for negotiation is to help them understand that their initial goal is to get the CDP into treatment and then to offer support through the stages of early recovery. Starting off with a request to the CDP to enter the most intense level of care is an understandable starting point, given how destructive the CDP's behavior has been. However, because of the built-in accountability and continuity that the network provides in monitoring the CDP's future behavior, negotiating to a less intense level of care is not a failure. In fact, research on Interventions demonstrates a predictable occurrence of relapse when the CDP does not have some options in the final decisions about treatment (Loneck et al, 1996). The commitment from the group to continue meeting after the Intervention in order to support the recovery process if the CDP enters treatment, allows for future negotiations with the CDP if the less intense level of treatment is not working.

7. Prepare the intervention network for transition from a stance of confrontation to one of support.

The ARISE Intervention is a commitment by network members to continued involvement with one another regardless of whether the CDP enters treatment. If the CDP enters treatment the ARISE model incorporates the network as part of the treatment. In this scenario, the network transitions from its confrontational role to one of supporting the CDP in work within a recovery program. It is common, for instance, for Intervention network members to agree to go with the CDP to self help meetings. If the CDP does not enter treatment the network agrees to meet for a determined number of sessions to support each other in the implementation of the consequences with the CDP.

8. Develop a plan to re-engage the therapist when the CDP "asks for help" in the future.

If the CDP does not enter treatment then the agreed upon consequences are put in place and a monitoring process begins. Due to the chronic and progressive nature of chemical dependency, the therapist is able to predict to the network that the CDP will continue to experience problems. Now that the CDP knows that the network has a concern about the

substance abuse, future problems can be understood as the CDP's bringing new attention to the problem and in that way "asking for help". The implementation of consequences thus requires an ongoing monitoring role of the CDP by the network. When future problems develop with the CDP the network can mobilize its resources and make another attempt to engage the CDP in treatment. In short, then, the therapist's role is to predict the future problems and set up a plan with the network to continue its efforts until treatment engagement is successful.

Once the above procedures have been completed, the next step is to begin planning for a formal ARISE Intervention. The following points outline the preparation for the Intervention session.

ARISE Intervention Preparation

1. Decide who will participate

The counselor/therapist helps the network decide which network members will participate.

2. Write letters

The counselor/therapist instructs each network member to write a letter which will be read at the Intervention. Letters contain the following elements: (a) a statement of love and support for the CDP, (b) a listing of 3-5 instances of the CDP's problem behavior related to drug use and how it has affected the network member, c) a statement of consequences developed by the network, and (d) a request that the CDP get into treatment.

3. Review letters

Each network member reads his or her letter, and the other participants are asked to listen for items that sound angry, resentful, or judgmental. Letters are kept as factual as possible.

4. Role play the Intervention

The network decides on the order in which the letters will be read, placing the most powerful letters at the beginning and the end. The counselor/therapist describes her or his role in the session. Rules are established: no violence, and network members are not to allow the CDP to engage them in dialogue. Seating arrangements are made and other roles for network members are defined. Someone volunteers to play the role of the CDP, and the

session is role-played. When possible, an audio- or videotape of the role-play is made and then critiqued.

5. Finalize logistics

The network decides on date, time, and place for the Intervention. Where possible, treatment arrangements are pre-arranged, including appointments and managed care/insurance pre-certification.

6. Set up a plan to deal with any new CDP problem

The counselor/therapist helps the network prepare for possible crises which may occur between this point and the date and time for which the Intervention is scheduled.

7. Discuss the need for the network members to support each other with consequence enforcement

The counselor/therapist plans sessions following the Intervention for debriefing and group support. Self help meeting attendance, such as Al-Anon, is encouraged. The important point to be made is that the network will continue to meet as long as the group members feel the need for support. Emphasis is placed on the idea that Intervention is a process that will continue for as long as the group benefits from the support. In addition, the group is helped to understand the nature and design of an ARISE Intervention, so that even if the CDP refuses treatment the group can return to a "monitoring" role and prepare for the eventuality of the CDP experiencing another problem in the future.

The Formal ARISE Intervention

The following steps are taken at the Intervention session itself..

1. Introduction

The counselor/therapist introduces himself or herself and briefly states the purpose of the meeting. The CDP is asked to listen while the letters are read.

2. Read letters

Each network member reads the letter she or he has written, not answering any comments the CDP might make.

3. Choice point

After the last letter is read, all remain silent, awaiting the CDP's decision. The counselor/therapist engages the CDP in a discussion of his or her willingness to enter treatment.

4. Discuss treatment options

The counselor/therapist discusses available levels of care, and helps determine whether the CDP might need medical detoxification. Assist network members are assisted in negotiating with the CDP.

5. Set up a plan to deal with decisions made During the Session

Examples of items to be included in such a plan are: monitoring for physical problems (including withdrawal signs), removing alcohol and other drugs from the house, not allowing drug using friends to visit.

6. Discuss the need for the network members to support each other with consequence enforcement

The counselor/therapist plans sessions following the Intervention for debriefing and group support.

CONCLUSION

The ARISE Intervention is a departure from the Johnson Intervention method. Interventions are a successful method for treatment engagement, and the ARISE model is designed to encourage as many families and concerned others as possible to take constructive action toward the CDP in their lives. Offering an Intervention continuum which matches pressure with the resistance of the CDP allows families and concerned others to feel hopeful in their efforts to alter the destructive cycle of addiction. The ARISE model also takes into account the network needs members regardless of whether the CDP enters treatment.

Table 1	
INTERVENTION PREMISES: A COMPARISON OF THE JOHNSON AND ARISE INTERVENTIONS	
ARISE INTERVENTION	JOHNSON INTERVENTION
<i>ARISE Assumption 1. Involving the CDP in the intervention process from the beginning conveys respect and encourages openness within the system.</i>	
Continuity of contact, open discussion without secrecy, and respect for the CDP as a person reduces the need for surprise.	Surprise catches the CDP with defenses down, increasing the likelihood of treatment entry.
Network's respect for CDP's ambivalence toward entering the recovery process matches confrontation level with CDP's resistance.	Assumes maximum level of confrontation is needed for all CDPs.
<i>ARISE Assumption 2. Intervention is a process that occurs along a continuum.</i>	
Motivation to change is a process, not event.	One-time confrontation is the impetus for change.
Intervention continuum is tailored to CDP's behavior.	Programmed Intervention proceeds regardless of CDP's behavior.
Transition from a focus on treatment engagement to support for recovery.	Engagement of CDP in treatment is the only goal.
Final option in a continuum.	First and only option.
<i>ARISE Assumption 3. Flexible options maximize potency and minimize resistance from network and CDP.</i>	
Negotiation process is encouraged.	Network avoids negotiation to reduce CDP's manipulative power.
Flexible option choices during extended ARISE process reduce fear of proceeding.	Options limited by a one-time intervention.
<i>ARISE Assumption 4. Pressure from the intervention network needs to be matched to the resistance from the CDP.</i>	
Amount and type of pressure is sequenced in response to CDP's resistance.	Singular event combines confrontation and consequences.
Consequences designed to match CDP's resistance over time until CDP enters treatment.	One-time intervention, therefore one set of consequences.
<i>ARISE Assumption 5. Families care about the CDP and CDPs care about their families.</i>	
Negotiation builds on network's past trust, accountability and involvement with CDP.	Network's mistrust of CDP results in avoidance of negotiation.

Sequential process and ongoing monitoring make future Intervention possible.	Process ends with Intervention.
<i>ARISE Assumption 6. Working from family strengths conveys a belief in their resilience to overcome obstacles.</i>	
Outpatient treatment is preferred to maximize continued network involvement.	Aim is CDP's entry into inpatient treatment.
Network strengths are elicited to maintain support for CDP throughout the process.	Letters to CDP convey only initial love and support.
<i>ARISE Assumption 7. The intervention network benefits from the process regardless of whether the CDP enters treatment.</i>	
Builds network support and self care.	Network relationships and self care are not addressed.
Shared stories, strengthened relationships and support result in systemic change, often breaking an intergenerational cycle.	Systemic change is not relevant to singular event.
Parallel goals of getting CDP into treatment and building positive relationship between CDP and network are addressed, ensuring better network function regardless of CDP's actions.	Ongoing functioning of the network is not a primary concern.

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