CONTINUING EDUCATION (CE) COURSE MATERIAL
Course No. CE1202P2 – Intervention and Referral

COURSE OBJECTIVE
A continuing examination of the intervention process, including the components for developing a Formal Intervention Program.

COURSE MATERIAL
A FORMAL INTERVENTION PROGRAM
In designing a program for groups, consider these key components of the Intervention Program Model developed by the Johnson Institute:

CLIENT FLOW
Remember that the client is rarely the user. Almost always the primary client is the concerned person who seeks help; the one who gets in touch with you. As a group, the other concerned persons are also your clients.

In a formal intervention program, the primary client would generally receive the following sequence of service. Ordinarily the other concerned persons would be brought into the process at step 5, after the primary client's private session with an intervention counselor.

1. Initial contact. The client nearly always telephones the agency. Very few clients are walk-ins. Whoever is on the switchboard must be well prepared to handle the call. A concerned person is generally suffering from fear, confusion, and other painful emotions, as well as from a burden of misinformation. The call must be answered by someone who is competent and understanding and who sounds competent and understanding. This person must be able to tactfully stop the caller from blurting out the whole story. This person must also be ready to answer the caller's questions, support the decision to get help, and make a referral to the appropriate resource-usually to the intake counselor.

2. Intake counseling. The intake counselor listens to the client's story, and then explains the services in general (to the primary client alone or to the primary client and other concerned persons). If the agency/client match seems suitable, the intake counselor makes two appointments for the client: 1) to attend an education session, and 2) to meet privately with an intervention counselor. It's best if everyone at the education session can talk with a counselor immediately afterward.

3. Education session. One-hour meetings are scheduled at set times for groups of new clients to learn more about chemical dependence and what can be done about it. This gives them a chance to know what they're dealing with before deciding to continue. (See the education session later in this course material.)

4. Private session with an intervention counselor. With information from the intake counselor, and in consultation with the client(s), the intervention counselor assesses the need for intervention and each client's readiness to participate. Clients who are ready are assigned to a family intervention class. Those who are not ready are referred to a concerned persons group. (See the private session with an intervention counselor later in this course material.)

5. Family intervention class or concerned persons group. Family members, close friends, and other meaningful concerned persons who appear ready to begin planning an intervention

are assigned to a class for instruction, for preparation of lists or letters to be read to the user, and for decisions contingent on the user's acceptance or refusal of treatment. This intervention class may be intertwined with the rehearsal. (See the family intervention class and the pre-intervention session, later in this course material.) Some clients (whether spouses or teenage or adult children) may not be ready to participate effectively without special help. The intervention counselor and the other concerned persons must decide whether to conduct the intervention session without them. Clients immobilized by fear, shame, denial-and sometimes delusion-are often so enmeshed with the user that they've lost all perspective. They'll not be ready to practice, or even accept, the basic tenets of intervention until they have received the education and support of a concerned persons group. (See the concerned persons group later in this course material.)

Those who are excluded from the structured intervention must be included in other meaningful ways throughout the process. To leave them out can invite sabotage and scapegoating. If the user does not enter treatment, the excluded people may be blamed.

6. Pre-intervention session. This is the practice session. It's a chance to role-play the event and discover what needs to be remedied before the actual structured intervention. It usually takes two or three hours. It may be intertwined with the family intervention class. (See the pre-intervention session later in this course material.)

7. Structured intervention session. Family members and other concerned persons confront the user with statements of their observations and feelings, then present their recommendations for treatment. The user responds and either accepts help or rejects it.

8. Post-intervention session. This is a private meeting between the facilitator and the family and other concerned persons when the structured intervention session is over.

THE EDUCATION SESSION

This general meeting can be scheduled as frequently as necessary to accommodate the number of groups you have. Its content is simple and straightforward. Plan to cover it in a couple of hours, depending on the size of the group and the number of questions you expect to answer. Without going into detail, discuss:

- The disease concept of chemical dependence
- Genetic influences
- The progress of the disease
- How the disease affects people living or working with the user
- Enabling: what it is and how concerned persons get caught up in it
- Treatment: why it is effective and desirable; how to get it
- General information about intervention; policy stating the role of the professional

Even to some clients who are ready to proceed, the details of intervention can be too threatening. Cover the details later, in the family intervention class.

Do acknowledge the courage the participants have demonstrated by seeking help. Assure them that it's normal to feel, ambivalent, angry, fearful, embarrassed, and guilty about the problems they're facing. Tell them they can credit themselves for having the concern and courage to listen and learn-while millions of other people like them around the world will continue suffering needlessly because they won't take action.

At the end of the session, ask the clients whether they already have an appointment with an intervention counselor. (The intake counselor should already have taken care of this. See step 2 of Client flow, above.) Anyone without an appointment needs to make one now.

THE PRIVATE SESSION WITH AN INTERVENTION COUNSELOR

Have this appointment made during intake, so that each client at the education session can talk with a counselor immediately afterward, while thoughts are fresh. During this one-to-one meeting, the intervention counselor will:

- Review the ideas presented in the education session and assess how well the client heard and accepted them
- Help the client verbalize specific concerns about things going on in the client's life
- Help the client identify his or her own role in the situations that are causing concern
- Determine whether the family and the user exhibit behavior associated with the disease of chemical dependence
- Decide whether intervention would be appropriate, and how soon. Is the client able? Is the client willing? Does the client have a sufficient number of concerned persons ready and able to join in confronting the user? Which persons who are meaningful to the user can been encouraged to attend family intervention classes, or at least come in and talk with an intervention counselor (even though they may not be family members)?
- Help the ready and able client develop a plan of action. Out-of-towners who cannot attend this session can be referred to a similar one where they live. They can later join the group for the rehearsal and the intervention session.
- For the client who seems unable to accept – or even hear – the information about the disease process; for the client who is unwilling to try to get other concerned persons involved in intervention; and for the client who appears emotionally immobilized or unstable, suggest referral to the concerned persons group, to Al-Anon, or to another appropriate resource, such as a psychiatrist, psychologist, or clinical social worker.

THE FAMILY INTERVENTION CLASS

This class is for groups of family members,[1] close friends, and other meaningful concerned persons who are emotionally able and ready to participate in a structured intervention. The class provides

- Information about the disease of chemical dependence
- Instruction on the principles and process of intervention
- Support from family members and close friends of other users, assuring everyone in the class that they are not alone
- Guidance in forming an intervention team
- Assistance in preparing for a structured intervention

The family intervention class is ideally three sessions in a single week, but usually it's less than that. The ideal can serve as a guide:

Session 1. In the first meeting, clients learn about the disease process of chemical dependence and how it affects not only the user, but also the concerned persons and others whose lives are touched by the user. Clients also learn to recognize enabling. (Some of this will already be familiar to those who attended the education session shortly after intake.)

[1] Family members should usually be at least ten years old, depending on maturity.

At this stage of the formal intervention program, instruction is geared toward action. Clients are helped to apply their new knowledge as they plan their structured interventions. Content includes-

- The signs, symptoms, and progression of the disease of chemical dependence.
- Denial and delusion. Value conflicts. Enabling. Family dysfunction.
- Large - group discussion in which participants describe how they feel - and hear how others feel - so as to break through denial and feelings of being different from other families, and to lessen the sense of isolation those feelings create.
- Small-group discussion of questions such as: What evidence of denial and delusion have you seen in the chemically dependent person? How have these defenses affected you and your family? What are some of the ways you have enabled the person to continue drinking or using?
- Information on the kinds of treatment available in the area. Examples of people who have received help through treatment and A.A. and other Twelve-Step recovery groups, and how their lives have changed; how the lives of family members, friends, employers, and coworkers have been affected by these changes.
- The principles of intervention. This presentation is more detailed than the one in the earlier education session. Participants start writing their lists (and letters) and start planning just how they will do the intervening.

Session 2. This meeting is almost entirely audiovisual. Participants can view videos such as *Back to Reality; Enabling: Masking Reality*; and *Intervention: Facing Reality*. These videos show how chemical dependence progresses and how concerned persons can address it by effectively planning the use of certain techniques. Participants are asked to watch for examples of enabling and to notice how the techniques of intervention are employed. Discussion helps clarify and reinforce the messages.

Session 3. Concerned persons gather in groups to role-play a successful structured intervention with simulated information. (Those who are concerned about a particular user need not all join the same group. The important thing is that everyone has a chance to observe and participate in role-playing before the real rehearsal and the actual intervention session.)

The facilitator instructs the leader and other group members before starting to monitor the action.

After the role-playing, the facilitator gives feedback, as will be done after role-playing at the real rehearsal with each private group. For example,

- Did the leader arrange for proper seating?
- Did the leader ask the chemically dependent person not to respond until members had presented their information?
- Did the concerned persons present both observations and feelings?
- Did they avoid gossip and second-hand information?
- Did they use precise words to make clear what they meant?
- Did they sound caring and concerned, rather than angry?
- Did they avoid enabling the user by excusing, minimizing, rationalizing, and so forth?
- Did the leader present the group's recommendation for treatment?
- Was the treatment program prepared to accept the referral immediately?

To improve their own presentations, participants should be invited to give each other feedback too. Their comments can be integrated with the facilitator's or saved until later. In either case, the facilitator must listen carefully to make sure their understanding is correct.

Before the last session adjourns, make sure each group has an appointment for a private post-intervention session with the facilitator immediately following their private structured intervention.

THE CONCERNED PERSONS GROUP

This group is for clients who appear too immobilized or unstable to contribute to - or benefit from - a structured intervention.[2] They're usually drawn from several different groups of clients preparing to intervene with different users. What they all have in common is that they are so enmeshed in their problem that they cannot accept, or even hear, the facts of the matter. Their own denial, other emotional problems, or strong feelings render them incapable of proceeding with an intervention at this time. Some may exhibit full-blown codependence (see below). In any case, they won't be ready until they have dealt with their own problems.

It may or may not be wise to delay intervention until a concerned person is ready. That decision is up to those who are willing and able to proceed, in consultation with the intervention counselor and, preferably, with the person in question.

Whenever a concerned person is omitted from the group, that person and the intervenors must understand the reason. As mentioned earlier, the absent person must also be able to participate in a meaningful way. To shut anyone out is to invite sabotage and scapegoating.

Characteristics of a codependent

For more information about clients who are not appropriate to include in intervention because their dysfunction is typical of full-blown codependence, read *Diagnosing and Treating Codependence,* by Timmen L. Cermak, M.D., published by the Johnson Institute. Says Dr. Cermak, "Power through sacrifice of self lies at the core of codependence."

Dr. Cermak explains how a helping-professional can recognize full-blown codependence:

A. Continued investment of self-esteem in the ability to control oneself and others in the face of serious adverse consequences.

This involves a distorted relationship to willpower; a confusion of identities; denial; and low self-esteem.

Distorted relationship to willpower. Codependents tend to believe they can overcome their own feelings and behavior - as well as the feelings and behavior of the chemically dependent person - by sheer force of will. ("If only we all try hard enough and pull together, we can get your father to stop drinking.") Failure to achieve such control leads to a sense of inadequacy. Ashamed to ask for help, codependents become more and more isolated and dysfunctional.

Confusion of identities. The sense of self is compromised and even lost. Says Dr. Cermak, "The codependent's self-worth rises or falls with his or her partner's success or failure." Enmeshed in a relationship with a chemically dependent person, the codependent feels responsible for making the user happy and for making the user stay sober. The codependent who is not in a relationship feels an internal void.

[2] Members of the group should be at least ten years old, depending on maturity.

Denial. The codependent person either consciously or unconsciously chooses not to see the user's inappropriate behavior – or finds reasons for personal failure to keep the user from using. ("I didn't try hard enough ... I didn't try long enough ... I tried the wrong way.") Says Dr. Cermak, "The denial of the chemical dependent and the denial of the codependent are the same. Both work to preserve the status quo."

Low self-esteem. A codependent tends to give other people power over his or her own self-esteem. Unable to keep the user happy and sober, and unable to see the futility and harm of trying to do so, the codependent determines to try even harder. Repeated failures heighten the person's sense of inadequacy.

Both a cause and an effect of codependence, low self-esteem tends to lead the codependent person into self-destructive relationships and to keep the person stuck there, no matter how painful.

B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.
Codependents carry generosity to the extreme: self-sacrifice. To avoid making the chemically dependent person unhappy, the codependent denies his or her own needs, preferences, and feelings. ("What would you like to do this weekend?" "Whatever you'd like to do.") A codependent wife and mother who won't let her children scream at each other will allow her husband and children to scream at her. At the root of such behavior is the fear of being abandoned. According to Dr. Cermak, "Codependents tend to choose one extreme or another: denial of themselves to keep someone else happy, or compulsive avoidance of others to keep themselves safe."

C. Anxiety and boundary distortions around intimacy and separation.
According to Dr. Cermak, "The codependent equates closeness with compliance and intimacy with fusion. As he or she becomes more involved with another person, the tendency is to take on many of that person's values, wishes, dreams, and characteristics, and eventually much of his or her denial system. The codependent becomes a mirror. ... The codependent involved with a chemical dependent actually feels that person's pain, rather than feeling empathy for the pain. This helps to fill the void which results from not honoring one's own needs and feelings."

D. Enmeshment in relationships with personality disordered, chemically dependent, other codependent, and/or impulse disordered individuals.
The defense mechanisms of rationalization, projection, and denial are typical of adolescents-and typical of adult codependents and chemically dependent people who are not in recovery. Says Dr. Cermak, "When the codependent is confronted with immature defenses in others, he or she responds by mirroring them." There's a mutual attraction that those involved call "chemistry" or "falling in love."

When the relationship breaks up, the codependent copes with the blow to self-esteem by resolving to try harder to make the next relationship work.

E. Three or more of these ten characteristics:
1. Excessive reliance on denial. Both chemical dependence and codependence are diseases of denial-tuning out certain internal and external realities. Denial is largely an unconscious process, employed to achieve a sense of security.

Any chemically dependent person can point to symptoms that she or he does not display. And because symptoms of codependence are also many, no one individual will display them all. The "missing" symptoms may be cited as evidence that no problem exists. The amount of delusion and denial maintained by a codependent can equal or exceed that of the chemically dependent person.

According to Dr. Cermak, "Codependents frequently see the breakdown of their denial system as a sign of their own personal inadequacy, much as chemical dependents view their growing lack of control over alcohol/drugs as a sign of personal weakness."

2. Constriction of emotions. To prove they can maintain at least a semblance of control over their lives, many families in the early stages of treatment believe they must curb their emotions. "Typically," says Dr. Cermak, "the emotions they work hardest to restrict are those normally considered to be immature, dangerous, uncomfortable, or just plain bad: anger, fear, sadness, rage, embarrassment, bitterness, loneliness, etc. Unfortunately, it is impossible to put a lid on such 'negative' feelings without also impeding the expression of more positive ones, such as happiness."

This is one reason that the second half of Al-Anon's First Step is so important to codependents: "We admitted...that our lives had become unmanageable." Codependents are deeply dedicated to "managing" their lives and the lives of others.
Outbursts of pent-up rage and verbalizing every feeling as it comes may appear to contradict the symptomatic constriction of feelings-but their purpose is the same, says Dr. Cermak: to lessen the anxiety of dealing with feelings.

3. Depression. "Anger turned inward, unresolved grief, the chronic restraint of feelings, being identified more with one's false self than one's true self-codependents have plenty of reasons to be depressed," according to Dr. Cermak. "Typically, however, they view their depression as evidence of inadequacy and the failure to stay in control, and for this reason they usually deny its presence."

Also, "admitting that one is depressed means admitting that one has needs, and codependents, by definition, always place the needs of others above their own in importance."
4. Hypervigilance. "The codependent's environment is unpredictable, basically incomprehensible, and highly stressful. ... The only way for the codependent to survive is by being ultrasensitive to subtle shifts in a chemical dependent's behavior and mood," Dr. Cermak says. "Such hypervigilance is a recognized symptom of Post Traumatic Stress Disorder (PTSD), which is most typically seen in combat veterans."

This is related to the codependent's need to control how other people feel and behave-and the need to attend to other people's happiness in order to feel good about oneself.

5. Compulsions. Codependents tend to involve themselves in a great deal of compulsive behavior. They might overeat, overwork, gamble, read voraciously, seek sex, rescue others, be intensely involved in religion, or use alcohol/drugs (see #7, below). Some watch television constantly and worry if they miss an episode of their favorite program; others clean the house incessantly-all in an effort to forestall uncomfortable, threatening feelings.

Just as a chemically dependent person must abstain from alcohol/drugs in order to recover, a codependent must abstain from the compulsion.

6. Anxiety. "The anxiety of codependence can take a variety of forms, from free-floating, chronic anxiety to panic attacks, phobias, and existential dread," says Dr. Cermak. The anxiety stems largely from the high level of denial the codependent must maintain.

7. Abuse of alcohol or other drugs. Many codependents develop a compulsive use of alcohol, diet pills, tranquilizers, and other mind-altering substances with addictive potential. Dr. Cermak points out that "denial is necessary to avoid being overwhelmed by feelings, and substance abuse serves as a biochemical 'booster' for one's crumbling denial."

Chemical dependence and codependence are not two distinct problems. "The denial of the chemical dependent and the denial of the codependent are cut from the same cloth." When a codependent is treated for chemical dependence, "the underlying codependence must not be ignored."

8. History of physical and/or sexual abuse. Many codependents have been or are now the victims of actual or threatened physical and/or sexual abuse. Sometimes the abuse takes place during a blackout-which means the abuser has no memory of it and, consequently, no feelings of guilt.

Dr. Cermak notes, "Codependents tend to minimize both the amount of violence in their relationships and the level of stress they live under. They do not see themselves as victims of physical or sexual abuse except in the most extreme cases, and even then they frequently take the blame: either they 'caused' the abuse or they 'deserve' to be treated abusively. Especially if few or no overtly abusive acts have occurred, the codependent's denial system prevents him or her from viewing the situation realistically." ("My husband is good to me. Whenever he hits me, he only uses his hand. He never uses a board or anything that could do any real damage.")

Children who are physically and/or sexually abused are often unaware that it's wrong and that it is not their fault. The feelings stirred by the abuse continue into adulthood.
"One of the most reliable symptoms of codependence," says Dr. Cermak, "is the inability to leave a chronically abusive relationship behind, whether that relationship is ongoing or past."

It may be dangerous, if not life-threatening, for a codependent to attempt intervention with a user who is physically abusive.

9. Stress-related medical illnesses. Like other people who have dysfunctional reactions to stress, codependents have more tension headaches, migraine headaches, asthma, hypertension, strokes, gastritis, peptic ulcers, spastic colon, rheumatoid arthritis, and sexual dysfunction than the general population. Some codependents are so adept at denying the stress of their home lives that physical illness may take decades to appear.

10. Staying in a relationship with an active substance abuser for at least two years without seeking outside help. Dr. Cermak proposes a limit of two years to make sure that failure to seek help signifies active codependence, rather than a normal desire to handle personal problems in one's own way.

Attitude and content of the concerned persons group
The concerned persons group may be structured as a limited number of sessions or left open-ended. It can help its members by

- Creating a supportive atmosphere in which participants are encouraged to gain strength and understanding
- Creating an opportunity for participants to gain insights that increase self-confidence and self-respect
- Providing education about chemical dependence and codependence
- Teaching principles of intervention, and encouraging participants to proceed with an intervention when they are ready and able to do so

In Part Three of *Diagnosing and Treating Codependence,* Dr. Cermak offers many suggestions for working with codependents. Those with full-blown codependence may need months of group counseling and individual counseling to become ready to take even minor steps toward eliminating their enabling actions and participating in a structured intervention. It should be remembered, however, that many codependents can be very effective participants.

The knowledge that change can take a long time may be a danger in itself, for both the chemically dependent person and the codependent. The helping-professional must take care not to enable codependents to stay in unhealthy relationships by expanding the number of counseling sessions. They must stay focused on the primary goal of intervention: helping the user to accept treatment before it's too late.

THE PRE-INTERVENTION SESSION
In this private session, clients concerned about a user make final preparations for their structured intervention.

You can expect some of the participants to regress during rehearsal. They may feel paralyzed by fear. They may start to doubt that intervention is possible. Old attitudes may emerge. ("It's a moral problem." "It's really my fault." "It's just that she has so many pressures in her life.") If this happens, you must take time for reeducation. Remind the clients of other things group members have said and they've agreed with. Mention facts and feelings they themselves have described. Let them know it's normal to feel like backing off; it would be a rare group that didn't feel doubt and fear at this point. Reiterate how important it is to get help for the user. Be sure to reinforce expressions of hope for changes in their lives.

Let all group members know they're not expected to do a perfect job of intervening. Assure them that you and the other participants will be there to support anyone who feels hesitant or shaky.

THE POST-INTERVENTION SESSION
Whether or not the user accepts treatment, this important meeting takes place with the family and other concerned persons immediately after the intervention. If some of them accompany the user to a treatment program, use your judgment about delaying the session. It should beheld the same day.
With emphasis on the needs of family members, the purposes of the session are

- To help participants process their thoughts and feelings about the intervention
- To help them assess the information presented, identify what was omitted, and decide what still needs to be said and when

- To help them stand by their commitments to their own recovery regardless of the user's response to intervention; to help them identify the difficulties they may encounter and how they will handle them
- To help them analyze what happened as a result of their group effort; to discuss whether to try intervention again
- To celebrate what the family members, the other concerned persons, and the facilitator have accomplished, such as
  1) helping the user accept treatment or at least begin to see the need for treatment,
  2) raising awareness of their power to make effective choices for themselves, whether or not the user accepts treatment, and
  3) learning constructive behavior that will aid their own progress in recovery

Now is the time to remind those who care for the user that intervention is a process, not a single event. It's time to mobilize for the future by highlighting the changes that have already taken place and the changes that need to take place as the process continues.

Contrasting conditions before and after
To show the family members what they have accomplished, use a marker board or flip chart so members actually see where they were before, where they are now, and where they are headed because they cared enough to intervene. Here are some changes family members often cite:

Before: They thought they had few rights as individuals and as members of the family.
Now: They know they have rights and can exercise them without feeling guilty or disloyal.

Before: Their personal boundaries were blurred, or even nonexistent
Now: They know who they are and how to set boundaries within and outside the family.

Before: They judged themselves by external standards (other people's values).
Now: They validate themselves according to their own, internal values and standards.

Before: They perceived that only certain members of the family were important and valued within the family.
Now: The perception is that all family members are equally important and valued.

Before: They often hid the truth.
Now: They can speak out honestly and value themselves for it.

Before: Family members felt hopeless.
Now: They feel hopeful.

The contrast between before and after helps family members feel good about themselves-and appreciate each other-for acknowledging their pain and dealing with it honestly. The family has acted effectively as a unit to solve a difficult problem, and it can do it again and again, because its members have learned to tap their own power and resources.

Bringing a sense of closure
After the intervention, participants need a sense of closure. This does not mean bringing the process to an end. Personal issues raised during the process will not have had time to be resolved.

Urge participants to continue in a recovery program to address these issues, as well as family matters, in order to live comfortably in a healthy family system. Make referrals and provide assistance for a smooth transition to a family counseling program or to psychotherapy, individual counseling, Al-Anon, Adult Children of Alcoholics, or another appropriate service.

An important topic for the post-intervention session is separation. Participants need to be prepared for temporary separation from their chemically dependent loved one-and for separation from the counselor on whom they've come to depend. The counselor needs to explain how his or her relationship will continue with the concerned persons and with the user.

In reaching closure, families will at times credit the counselor for the good things that have come from the intervention process. This is an opportunity for the counselor to give that credit back to the family; to validate their decision to use their rightful power to begin restoring themselves to health.

ADAPTING THE INTERVENTION PROGRAM MODEL

The formal intervention program has been used and refined by the Johnson Institute for more than three decades. It has been used successfully by helping-professionals in thousands of widely diverse counseling agencies, clinics, treatment centers, and other organizations, and in private practice. The program can be modified to suit many different circumstances. Cultural, economic, and logistic requirements can all be accommodated.

SUGGESTED ADDITIONAL RESOURCES

- M Bratton, ***A Guide to Family Intervention*** (1987), Health Communications, Inc.
- VE Johnson, ***Intervention: How to Help Someone Who Doesn't Want Help*** (1986), Hazelden.
- MD Meagher, ***Beginning of a Miracle*** (1987), Health Communications, Inc.
- FL Picard, ***Family Intervention*** (1991), Prentice Hall.

ACKNOWLEDGEMENTS

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CONTINUING EDUCATION (CE) EXAMINATION QUESTIONS

Course No. CE1202P2 – Intervention and Referral

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

QUESTIONS

Questions 1 through 10 omitted.

11. The primary client in an intervention is usually:
    a. The user.
    b. The abuser.
    c. A concerned person.
    d. None of the above.

12. The general education session should include a discussion of which of the following topics.
    a. The disease concept of chemical dependence.
    b. What "enabling" is and how concerned persons get caught up in it.
    c. Why treatment is effective, and how to access the treatment.
    d. All of the above.

13. A private session with an intervention counselor should take place immediately after the general education session, and should include all of the following except:
    a. Helping the client verbalize specific concerns about things going on in the client's life.
    b. Helping the client identify his or her role in the situations causing concerns.
    c. Helping the ready and able client develop a plan of action.
    d. Discussing with the client payment for service to make certain that the service is paid for before the intervention takes place.

14. The family intervention class:
    a. Should include only family members.
    b. Should include everyone but family members.
    c. Should include family members, close friends and other meaningful concerned persons.
    d. None of the above.

15. The first session of the family intervention class should include:
    a. The signs, symptoms and progression of the disease of chemical dependence.
    b. The opportunity for the participants to describe how they feel.
    c. Information on the various kinds of treatment available in the area.
    d. All of the above.

16. Indications of codependency, according to Timmen L. Cermak, MD, include all of the following except:
    a. Distorted relationship to willpower.
    b. Confusion of identities.
    c. Denial.
    d. High self-esteem.

17. The concerned persons group may help its members by:
    a. Creating a supportive atmosphere in which participants are encouraged to gain strength and understanding.
    b. Create an opportunity for participants to gain insights that increase self-confidence and self-respect.
    c. Provide education about chemical dependence and codependence.
    d. All of the above.

18. During the pre-intervention session:
    a. Some participants may regress during rehearsal.
    b. Some participants may doubt that intervention is possible.
    c. It is normal for participants to feel like backing off the intervention.
    d. All of the above.

19. The post-intervention session:
    a. Should only take place if the user does not accept treatment.
    b. Should be held regardless of whether the user accepts treatment.
    c. Both A and B above.
    d. Neither A nor B above.

20. The purpose of post-intervention session includes all of the following except:
    a. Help the participants process their thoughts and feelings about the intervention.
    b. Help them identify the difficulties that they may encounter in their own recovery, regardless of the user's response to the intervention.
    c. Help them analyze what happened as a result of their group effort, and, if applicable, whether to try intervention again.
    d. Help them criticize the mistakes made by family members and other concerned persons during the intervention.

21. Contrasting conditions before and after the intervention, changes often cited by family members include which of the following:
    a. Their own personal boundaries were blurred before the intervention; but they are better able to set boundaries after the intervention.
    b. The judged themselves by internal standards before the intervention; but they are better able to validate themselves by utilizing external standards after the intervention.
    c. Both A and B.
    d. Neither A nor B.

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

Breining Institute
COLLEGE FOR THE ADVANCED STUDY OF ADDICTIVE DISORDERS

CONTINUING EDUCATION (CE) ANSWER SHEET

SECTION 1. Please type or print your information clearly. This information is required for CE Course credit.

First Name

Middle Name

Last Name

Address (Number, Street, Apt or Suite No.)

City

State (or Province)

USA Zip Code

Country (other than USA)

Country Code

Primary Telephone Number (including Area Code)

Facsimile Number (including Area Code)

E-mail Address

SECTION 2. Credit Card Payment Information (if paying by credit card): Circle type of card: **VISA** or **MasterCard**

Credit Card Number

Expiration Date

Full Name on Credit Card

Authorized Signature

Breining Institute is authorized to charge Twenty-nine dollars ($29.00) to this card.

SECTION 3.
Course Title: **CE-1202P2 / INTERVENTION AND REFERRAL – PART 2**
Answers (circle correct answer):

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

Signature: _____ Date: _____

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