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IN THIS ISSUE

Focus of the Month:
Families and Substance Abuse

Learning Objectives

After reading these articles you should be able to:

1. Identify some of the ways that family dynamics can affect patients with substance abuse disorders as well as their families. **2.** Describe some of the ways clinicians can work effectively with both patients that have a substance abuse disorder and their families. **3.** List the benefits provided by intranasal Narcan for emergency treatment of opioid overdose.

Addiction and Family: What You Need to Know

Alison Knopf is the editor of Alcoholism & Drug Abuse Weekly, *a subscription newsletter published by Wiley that focuses on policy and programming, and a freelance journalist specializing in mental health and substance use issues.*

Ms. Knopf has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

George F. Koob, PhD, director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), doesn't like the word "codependency," and he likes the word "enabling" even less. "Codependency is a pejorative

Continued on page 2

Summary

- Although the term codependency is part of our pop-culture language, it is not a psychiatric diagnosis.
- Rather than using labels such as codependent, or terms such as enabling, clinicians can help patients and their families identify triggering behaviors and negative communication patterns.
- Participating in individual and family therapy sessions, as well as attending support group meetings, such as AA and Al-Anon, can benefit both the patient in recovery and the family.

Q&A With the Expert

Alcohol Addiction: The Role of Families in Treating Patients

Stephanie Brown, PhD

Stephanie Brown, PhD, is a licensed psychologist and expert on the treatment of alcoholics, adult children of alcoholics, and addicts and their families. Dr. Brown is the author of 11 academic and popular books on addiction and recovery, including Treating the Alcoholic: A Developmental Model of Recovery.

Dr. Brown has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Dr. Brown, as a pioneer in understanding the interplay of family dynamics and addiction, I thought we'd start our interview with a patient I recently saw in my practice. This was a woman who presented with depression and suicidal ideation. Over the course of the interview, I learned that she had been drinking more wine over the past few months, from a glass or two to a full bottle per night. She said she was using alcohol to cope with her stressful and unhappy life. She mentioned that she first started drinking a few years after marrying her husband, who has long been a functional alcoholic; he works long hours, comes home late, and drinks two 6-packs every night. Since this was a brief medication evaluation, we didn't have enough time to really get into the nature of their relationship, but it was clear that there was conflict, and that my patient's drinking was related in some way to her husband's addiction. How might I think about family dynamics in a case like this, and how would I go about assessing it further?

Continued on page 4

Addiction and Family: What You Need to Know

Continued from page 1

word, and it implies that someone else is at fault—and one of the major components of Alcoholics Anonymous is to take full responsibility for your actions." However, that doesn't mean that the family doesn't need attention, says Koob. "The fact is that recovery in many cases requires family therapy, having the family help facilitate recovery," he says. "It can produce long-lasting benefits."

While not all clinicians agree with Dr. Koob, the addiction field has clearly become less enamored with terms such as codependency. In this article, I will bring you up to date on some tried and true approaches for working with the families of patients with substance use disorders (SUD).

Codependency and enabling: A history of the terms

The term "codependency" has deep roots in the psychoanalytic theory of self (Horney, Karen. *Neurosis and Human Growth*. Norton, 1950). It is often defined as the unhealthy behaviors exhibited by the person who has a relationship to the alcoholic. Codependency became a household term with the publication in 1986 of "Codependent No More" (Melody Beattie's *Codependent No More*, which sold more than 5 million copies in several languages. The book became especially popular amidst the rising self-help movement because Beattie made observations that seemed so universally relevant to people's lives, whether or not alcoholism was an issue (Beattie, Melody. *Codependent No More*. Centre City, MN: Hazelden Foundation, 1986). In the words of Christine Timko, PhD, who is also consulting professor with the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine, patients who have what is called codependency "take care of other people to the detriment of themselves and maybe even to the detriment of the person that they're supposed to be taking care of."

"Enabling" is a term that is related to codependency in that both are done by the person who has a relationship to the alcoholic. Enabling is more easily defined as actually encouraging the alcoholic to keep drinking. Although codependency and enabling became part of the pop therapy culture of the 1980s, the terms "fell out of favor because the individual with the alcohol problem was essentially blaming someone else, and wasn't taking responsibility" for their own drinking behavior, says Koob. In fact, codependency has never achieved official diagnostic status, remaining more a "syndrome" than a disorder. There is no *DSM-5* diagnosis for being codependent or enabling, and there is no actual pathology involved either. Using *DSM-5*, the closest a clinician can get to codependency is "dependent personality." There is no mention of any related illness, such as a SUD.

On the other hand, for addiction treatment clinicians, the word "codependency" can be useful as a way to reach those affected by the substance use of others, says Michael T. Flaherty, PhD, a Pittsburgh-based psychologist who treats patients with SUDs. The word "confirmed that addiction seldom happens in a vacuum, and that to treat the illness, you had to also get to those closest to it who were often also suffering."

Working with the family

How should we use these terms in our work with families? Austin Houghtaling, PhD, a marriage and family therapist who is clinical director of recovery enrichment programs at Caron Treatment Centers, based in Wernersville, Pennsylvania, frequently hears families use the word "codependent," but he is careful not to use it himself. "We found that when we as practitioners use terms like 'codependency' or 'enabling,' the families tense up," he says. "It feels like labeling, it feels diagnostic, and it makes them feel as if you're assessing them. It's better to align with them from a compassionate standpoint instead of from a pathology standpoint."

However, Houghtaling doesn't correct them if they initiate the term. He'll ask family members who are in therapy with the patient with the SUD patient to describe in 1 or 2 sentences the nature of their anxiety—which can be a major part of codependency. "Most commonly they describe their self-sacrifice and how it detracts from their own self-care," he says. "We will then say something like: 'This is a normal way to respond, of course you're going to invest yourself in helping your loved one, and of course you're exhausted.'" The family member may also worry that if they get too involved with the recovery of their spouse or child, resentment will be the outcome. When this all comes out in family therapy, the patient with the SUD sees what's happening.

Sometimes the SUD patients, in group therapy, will call their families "sick" and "codependent" in ways that are, in fact, meant to blame them. In fact, some families do have their own substance use and other problems—but they are not the ones in treatment.

Continued on page 3

Addiction and Family: What You Need to Know
Continued from page 2

Houghtaling will then point that out to patients: "You have put them [the families] through the wringer, and the way you have coped with stress and anxiety has included drugs and alcohol, and they have their own way."

When Houghtaling has an adolescent SUD patient and a parent—typically a mother—in therapy, the parent frequently expresses feelings of guilt, which is a part of codependency. He tells the parent: "Look at all the ways you tried to help here." The parent acknowledges that he or she got the child into treatment, sometimes multiple times. He then asks how the parents feel, and the response is that he or she is "wiped out and scared to death and exhausted"—to which Houghtaling says, "No kidding." At that point, the adolescent will usually open his or her eyes wide and say they never had seen what "this has done to my [parent]," says Houghtaling. "They get it." Then, when Houghtaling explains that the parent is choosing to go a route that involves self-care, the adolescent is usually immensely relieved. "The kid will say, 'That's a pressure off my shoulders.'" Instead of using fear of disappointing his or her parent as an incentive to recovery, the adolescent uses love, and is happy that the parent will be able to handle his or her own self-care.

Guidance for psychiatrists

Psychiatrists can help patients identify the behaviors that can be triggers to drinking or using drugs, says Brendan Young, PhD, assistant professor of communication at Western Illinois University Quad Cities. A common pattern, for example, is a nagging-withdrawal cycle in which a family member repeatedly confronts the drinker, who then withdraws into more drinking. However, he said it is not correct to assume that all such relationships are codependent. "There are healthy ways of sustaining relationships with people with SUDs," he says. "When it becomes problematic is when they become controlling."

It's also important to recognize that a family member may resent the psychiatrist who has helped the patient with the SUD when the family member has been trying to accomplish the same thing for years, says Young.

"The goal for the psychiatrist is to have the family member be part of the team," says Lorenzo Leggio, MD, PhD, chief of the joint NIAAA-NIDA (National Institute on Drug Abuse) section on clinical psychoneuroendocrinology and neuropsychopharmacology. For example, medications are one of the tools used in treating alcoholism and other SUDs. "We know that it's not easy to comply with taking a medication, so the family member may have to play a key role in that," he says.

In addition, family members should not drink, says Koob. "This is just common sense—having a drink in front of an alcoholic is like waving a flag in front of a bull." It's also important to remove all of the liquor in the house, some of which may be hidden.

Finally, family members may need to be encouraged to seek psychological care for themselves. "At some point, someone may need to see the family member as a patient," says Leggio. "With substance use disorders, we are talking about a medical problem as it affects the whole family."

Al-Anon: An adjunct to family work

In addition to individual clinical work, the organization Al-Anon can be quite helpful for families of substance users. Al-Anon was started in 1951. According to lore, Bill Wilson (who co-founded AA in 1935) realized that since AA was attended mainly by men, their wives would wait for their husbands who were in meetings. It became clear that a companion group was needed for family of AA members. The original proposed name was AA Family Group, but AA leadership objected because the sixth tradition of the organization states that the letters "AA" should not be used by an outside enterprise. Thus, the founders decided to use "Al-Anon" (a contraction of Alcoholics Anonymous); the full name is now "Al-Anon Family Groups" (www.al-anon.org; https://www.ncwsa.org/wp-content/library/pages/faqs/FAQ_Name_Al-Anon_20090928.pdf).

"For family members of patients with SUDs, this type of organized support group can be a lifeline," says Timko. I've talked to people who say Al-Anon saved their lives. They came in exasperated, at the end of their rope, not able to solve the problems they are facing. There's a huge sense of relief when they see other people who went through this." Like all mutual support groups, having a community of people who have not only shared experiences but learned how to live with them is very helpful. In addition, Al-Anon "offers activities that get you outside of your life," says Timko.

A recent study by Timko and colleagues found that sustained attendance at Al-Anon improved quality of life, increased self-esteem, and decreased depression. The bonding, goal direction, and access to peers helped to explain these associations. (Timko C et al, *Psychol Addict Behav* 2015;29(4):856–863).

For someone who has a spouse with an addiction, Al-Anon would encourage the person to practice self-care, but not to get a divorce, says Timko. "Al-Anon doesn't say to cut off your relationship with a drinker," she notes. Rather, at Al-Anon, there would be discussion of how to work things out.

There is also Alateen, which is a subgroup of Al-Anon. Alateen is specifically for adolescents who have a family member who is an alcoholic (http://al-anon.org/for-alateen).

How to discuss Al-Anon with your patients

Psychiatrists should be able to briefly describe Al-Anon to patients who have a family member with an addiction problem, says Timko.

"I would probably step back and say, 'This is a hard way to live, to be caring for someone who is engaging in this harmful behavior, so it's important to take care of yourself and stay healthy,'" she says. The psychiatrist could recommend Al-Anon, explaining that it's a resource for someone who has a family member who is drinking or using drugs. "The important point would be to say that Al-Anon doesn't tell people what to do," Timko says. Al-Anon meetings are

Continued on page 5

Expert Interview

Continued from page 1

Dr. Brown: This is a common scenario. The couple is an "alcoholic dyad"—we'd call it an alcoholic family system if they had children. You've learned that your patient's turn to alcohol is related at least in part to the fact that her husband has been drinking every evening for a long time. There is some dynamic at work here in how she responds to his coming home to be with *his* partner—which is apparently his two 6-packs of beer, rather than his wife.

CATR: And this dynamic affects how our patient reacts to her husband's drinking, which in turn affects her drinking?

Dr. Brown: Typically you'll find that the addict, in this case her husband, makes a fundamental attachment to the substance and then your patient reacts to that in some way. Maybe when she met him, he was already a drinker and that was a good fit for her. Maybe she grew up with an alcoholic parent in a family system where alcohol was at the center, organizing all of the relationship and family dynamics. At some point, she starts drinking herself—perhaps reacting to stress, giving up, and finding her own attachment to the substance. Many partners start drinking with somebody who is already alcoholic with the idea, often unconscious, or out of awareness that "we are going to do this together": "I can't fix him; I can't change him so I'm going to join him." This process is enormously common and acceptable in the culture.

CATR: So I'll obviously need to address this issue with her further. Do you have any specific suggestions?

Dr. Brown: Ask about how she found this partner. Does she see him as alcoholic? Does she believe that she began her own drinking in response to his drinking? You may learn she resists seeing her husband as an alcoholic—"it's just what he does." This is a frequent block: the reluctance to identify that somebody in the family has a bond with alcohol. Family members typically react to the alcoholism of another and then deny it, try to explain it, and hope that it will go away. Or they join in, drinking and denying it, becoming a co-creator of their pathological family system. You need to assess how the family system works and if they deny the reality of drinking while explaining it in a way that allows it to be maintained. This is the central organizing dynamic of many actively alcoholic family systems.

"Family members typically react to the alcoholism of another and then deny it, try to explain it, and hope that it will go away. Or they join in, drinking and denying it, becoming a co-creator of their pathological family system."

Stephanie Brown, PhD

CATR: This is a complicated concept, and not one that I think would be easy to broach with most family members.

Dr. Brown: Yes, it can be tricky. As you are talking with your patient, you are thinking, "What is the role of alcohol as a central organizing principle in this couple, in this family? How dominant is it? Are one or both partners aware of it? Do they acknowledge it? Do they deny it?" What's interesting is that if you were to ask your patient's spouse—the person with the substance abuse issue—"How is your family involved in your addiction?" he might be likely to say, "Not at all. Nobody knows," which is almost never accurate. At the point of early intervention, which is often with a primary physician, many substance abusers and their families truly believe that no one knows—or one or both will resist treatment because they do not want anyone to find out.

CATR: I can see that happening. What do you do in that case?

Dr. Brown: I'll approach this conversation more indirectly by asking the patient to walk me through a typical day or a weekend in their life. That may be how you got the information from your patient that her husband drinks two 6-packs a night in the first place. She has already told you that her husband comes home and takes up with his beer instead of her. So you may want to follow up on this and ask something along the lines of, "How do you feel about that? What happens for you when he walks in with his two 6-packs of beer? Is this something that is long-standing or fairly new? How has that been for you, and what's been your response to it? Is this reminiscent of growing up for you?" Or you might take a slightly different tack with your questions and ask if there was a point where she was OK with her husband's drinking. Did it work for her because they had a bad relationship? Did she find herself nagging him? Is he angry with her all the time? The key thing to remember is that no two individuals or families are the same. It's important to understand, as best you can, how this particular family works. You can cover every possible scenario, and as you gain experience with these families, believe me, you do see every scenario. One person hates the drinking and another can't wait to join in.

CATR: I'm sure there are elements of "codependency" here. Do you use that term? Is it still helpful?

Dr. Brown: Codependency has become a catch-all term—what it really means is sacrificing oneself in service to another. In the addictive system, the codependent becomes complicit, tacitly or unconsciously agreeing to join a system of rationalization, denying that somebody is out of control with an addiction. The codependent, often frightened of a threat to the relationship, initially joins in support of these distortions. Many codependent people come into the office with anxiety or depression, perhaps wanting medication, or relieved when the physician suggests it. Part of what drives the emotional pain is their fear of the realities that exist underneath it. The defenses needed to maintain denial can thus cause anxiety and depression. So addressing the family

Continued on page 5

Addiction and Family: What You Need to Know

Continued from page 3

free and open to the public. The psychiatrist might attend a few meetings to enable the making of referrals. Tips can be gained there for working with alcoholic patients as well.

Houghtaling of Caron says that referring family members to Al-Anon is tricky. If you use Al-Anon as a way to say, "You're sick or codependent, and Al-Anon is your treatment," it wouldn't be accurate, and it wouldn't work. Instead, it's better to say, "You've been exhausted from making all these sacrifices, and now you finally have a chance—you deserve Al-Anon." As for telling the SUD patient to go home and suggest that the family member go to Al-Anon, that's "dangerous," he says. "There will only be more resentment, with the family member saying, 'Now you're telling me what to do?'" Very few patients are grounded enough to be able to tell a family member to go to Al-Anon in a way that isn't "guilt-provoking."

Some psychiatrists do get the spouse to come in so there can be a 3-way conversation, and this would be the right time for the psychiatrist to suggest Al-Anon to the family member. "Everything in addiction treatment is focused on the patient, but this would be a chance for the focus to be on you," the psychiatrist could say.

The bottom line: Supporting the families of your patients with SUD—whether through therapy or Al-Anon, is crucial for effective treatment.

For further reading:

- Timko C et al. Social processes explaining the benefits of Al-Anon participation. Psychol Addict Behav. 2015;29(4):856–863.
- Timko C et al. Al-Anon Family Groups: Newcomers and Members: *J Stud Alcohol Drugs*. 2013;74(6): 965–976.
- Young LB and Timko C. Benefits and Costs of Alcoholic Relationships and Recovery Through Al-Anon, *Subst Use Misuse*. 2015;50(1).62–71.
- http://store.samhsa.gov/shin/content//PHD1112/PHD1112.pdf (for a patient/family member handout)

Expert Interview

Continued from page 4

dynamic can actually be quite helpful for symptom relief in psychiatric practice.

CATR: I was hoping we could discuss the concept of adult children of alcoholics. How useful is it for practitioners to understand this concept?

Dr. Brown: It is very important. The term "adult children of alcoholics" (ACOAs) means that an individual grew up with one or two alcoholic parents and, thus, an alcoholic family of some kind. The ACOA develops a "defensive self" as a child to cope with traumatic family life, including parental neglect, physical and sexual abuse, and serious attachment problems. These defenses include a strong, unyielding need for control; an exaggerated sense of responsibility for everyone and everything; an automatic reliance on concrete, all-or-none thinking; and denial. While they may serve the child well, these coping mechanisms become maladaptive as the ACOA grows up and attempts to form intimate adult relationships. Claudia Black, in her classic text *It Will Never Happen to Me*, first described these defenses as childhood family roles, including the hero, the lost child, the placater or people pleaser, and the scapegoat (Black, Claudia. *It Will Never Happen to Me*. Denver: MAC, 1981).

CATR: Who is the hero child?

Dr. Brown: The hero child has created a defensive and precocious super self to keep the family from falling apart. As young children, these heroes will rarely show up in anybody's office because they're busy getting straight A's and making the family look good. Maybe they're cooking dinner, maybe they're putting mother to bed, taking care of younger siblings, trying to hold a family together. That child will often do well until leaving home, perhaps for work or college, but the separation from family may lead to depression and anxiety, fueled by survivor guilt, with a fear that the family will go to shambles when that child leaves. The hero often cannot be away from home because of worry and guilt about younger siblings left behind. That's the so-called "parentified" child.

CATR: What sorts of psychological issues might we see in such people?

Dr. Brown: Typically they don't allow themselves to have any needs in a relationship. They feel that nobody ever cares about them; they always have to take care of others. If they're alone, they manage okay; they're not in therapy because they have this sense of tight control over their lives. One of my patients said, "The best relationship for me is to be alone; otherwise I have to give up myself." Things start to fall apart for ACOAs when they don't feel that they are in control. Loads of them are suffering in this out-of-control tech world, especially out here in Silicon Valley where everybody is going so fast, and nobody can really be perfect anymore. Distraught, they seek help for their inability to manage everything. Some will enter your office with the onset of panic attacks, saying, "I just don't know what's wrong; everything was fine; I was managing and now I'm panicking."

Continued on page 6

News of Note

Intranasal Naloxone Product Approved by FDA

The opioid antagonist, naloxone, was first approved for opioid overdose treatment in 1971 and is available as an inexpensive injectable generic. In recent years, emergency responders have been using more easily administered intranasal version of naloxone. However, until now this formulation had to be improvised by attaching a naloxone vial onto a mucosal atomization device. While data support the safety and effectiveness of this type of device, this practice has been an off-label one and depends on "kits" that are not widely available.

On November 18, 2015, the Food and Drug Administration (FDA) granted a fast-tracked (less than 4 months) approval to Adapt Pharma for Narcan nasal spray, the first product manufactured specifically for intranasal delivery. Intranasal use eliminates the risk of contaminated needlesticks and provides first responders and caregivers an easier and less intrusive administration site than the injectable form. The FDA approval will likely bring with it increased awareness of opioid overdoses, which have reached an epidemic level in the U.S. Opioid overdose is now the leading cause of injury-related death, surpassing motor vehicle accident deaths. Hopefully, the easier administration provided by intranasal Narcan will lead to greater use within the community setting.

Narcan nasal spray is approved for the emergency treatment of known or suspected opioid overdose, generally presenting as severe respiratory depression. The nasal spray requires no assembly and provides a 0.4 mg dose per spray which has been shown to reach similar, or higher, levels as intramuscular injection in about the same amount of time (2–3 minutes). It works similarly to other types of nasal sprays you might be familiar with, such as allergy or cold remedies. Similar to the injectable form, the nasal form of naloxone may require repeated doses and may result in opioid withdrawal symptoms (diarrhea, runny nose, goose bumps, sweating, yawning, body aches, irritability, cramps, and increased heart rate and blood pressure).

This new product hit pharmacy shelves last month at a cost of $70 for a box of 2 nasal sprays; many insurers will likely provide coverage. We recommend that you discuss the possibility of opiate overdose with your substance-abusing patients, and educate them about the availability of rescue treatment and the importance of family members or friends having access to naloxone rescue. As we've said before, "Naloxone rescue saves lives. Prescribe it."

—Talia Puzantian, PharmD, BCPP, deputy editor, The Carlat Report

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Expert Interview

Continued from page 5

CATR: So these children defined themselves as people who had to control an alcoholic and an out-of-control family system, but in their adult lives they get into a work situation or a relationship that they can't control.

Dr. Brown: Right. They knew how to please others in the world, how to be a hero, and then that system collapses, and they are scared. Hopefully, these people seek help, begin therapy, and see how much they sacrificed themselves to be a hero.

CATR: So what's the therapeutic statement, then, for someone like that? Is it something like, "You learned that you had to be a hero when you were a child, but you don't have to do that any longer. It's OK not to be in complete control."

Dr. Brown: You might say that, depending on the context and the person's readiness to hear it. But many newly identified ACOAs would not be able to absorb or act on your permission, and they would likely be terrified of the idea that it's okay to relinquish some control. You might say something like, "One day you won't have to give up yourself anymore." It is vital to recognize the complexities of "diagnosis" and treatment in working with all aspects of addiction. While types are immensely helpful, it's important not to assume that all "heroes" are alike.

CATR: Thank you for your time, Dr. Brown.

Note: For further information, check the website for the National Association for Children of Alcoholics (nacoa.org), which can be beneficial for both doctors and patients.

References:

Brown S. *Treating Adult Children of Alcoholics: A Developmental Perspective.* New York, NY: John Wiley and Sons, 1988.

Brown and Lewis V. *The Alcoholic Family in Recovery: A Developmental Model.* New York, NY: Guilford, 1999.

Stephanie Abbot (Ed.), *Children of Alcoholics: Selected Readings.* Rockville, MD: National Association for Children of Alcoholics, 1995.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. According to the book *It Will Never Happen to Me* by Claudia Black, what is the name of the childhood family role played by an individual who grew up in an alcoholic family that is characterized by making the family look good and trying to hold the family together? (Learning Objective #1)

   [ ] a. The scapegoat
   [ ] b. The placater, or people pleaser
   [ ] c. The hero
   [ ] d. The lost child

2. Which outcome for families of patients with substance abuse disorders has been shown to result from sustained attendance at Al-Anon meetings? (LO #2)

   [ ] a. Increased self-esteem
   [ ] b. Increased rates of depression
   [ ] c. Decreased rates of divorce
   [ ] d. Decreased secondary drinking

3. What dose per spray of intranasal Narcan has been shown to be as effective as an intramuscular injection of Narcan? (LO #3)

   [ ] a. 0.2 mg dose per spray
   [ ] b. 0.4 mg dose per spray
   [ ] c. 0.8 mg dose per spray
   [ ] d. 1.0 mg dose per spray

4. True or false: According to the *DSM-5*, family members of patients with substance abuse disorders who are substance abusers themselves can be classified as codependent. (LO #2)

   [ ] a. True
   [ ] b. False

5. According to Stephanie Brown, PhD, adult children of alcoholics (ACOAs) often develop a "defensive self" as a child to cope with a traumatic family life. Which of the following is not a typical coping mechanism you'd see in an ACOA? (LO #1)

   [ ] a. A strong need for control
   [ ] b. An exaggerated sense of responsibility
   [ ] c. Reaction formation
   [ ] d. Denial

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Families and Substance Abuse

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