Family Support and Addiction Management for Long-Term Success

Common Misconceptions About Addiction: What You *Think* You Know Can Hurt You and Your Loved One

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Introduction

A few times a year, we receive a call from a concerned family member (office executive or advisor) about an addict who has been through multiple treatments. Sometimes it's a son or daughter who has been struggling with alcohol and drug abuse from their teenage years on. Sometimes the call concerns a parent who has been through multiple relapses. The person we are talking to will say to us,

> *"We've asked our parent (client) to call you, but they say they have tried everything and think nothing can be done. In any event, they also say they know everything about addiction and recovery from their readings, counselors, and family program attendance and don't want further help."*

To us, this is a tragic situation because the addict has a disease – is sick – and is very unlikely to seek help, particularly after several relapses and treatment failures. Therefore, the family must take the lead in initiating the intervention process.

In our view, treatment has failed the family, but unfortunately, the family gives up based on false beliefs and assumptions. One purpose of this article is to challenge these beliefs by family members about treatment and recovery so that they will continue to seek help for their loved ones. A second purpose is to educate families about barriers to recovery their family members face in treatment.

Ineffective Treatment

When a family member has been through several treatments followed by relapses, the family and the addict often believe that treatment does not work. In talking to family members regarding their views on treatment, they'll say,

> *"Our son or daughter has been to the best treatment programs and failed. We are tired of spending money on treatment that doesn't work. She'll never get it. (Or our child is treatment savvy and won't go again.) We've decided to let go, as advised by the family program or our counselor and allow our son or daughter to face the consequences from using alcohol or drugs."*

However, when we review the facts concerning these treatments we find that treatment was inadequate and at times made the situation worse. That is, the treatment was lacking in certain key elements that lead to recovery and sometimes even was harmful to the patient. Often it is difficult for parents to hear that their certainty is based on false premises or misinformation. They may also have decided not to put more energy into what appears to be a hopeless effort and therefore do not want to take the time to carefully review past experiences to see where errors were made and how it could be different in the future.

In our experience, parents and family members really have little knowledge as to what goes on in treatment and what constitutes effective treatment or the family systems approach to addiction treatment. This lack of knowledge is a major cause of relapse and the repeated cycle of treatment and continued use. Our goal is to improve recovery rates for affluent, prominent, and wealthy alcoholics and addicts. A key factor in doing so is to educate family members about the realities of treatment, treatment philosophy, and family systems concepts so that family members know more about the services their loved ones are receiving in treatment and how they can play an effective role in supporting recovery.

Article Outline

We have been there. We know the good, the bad, and the fear generated by being a patient or intern in a treatment center from an affluent background. As counselors and advisors to families with a loved one in treatment, we know how difficult it is to obtain information and engage treatment center personnel in a cooperative approach to their patient and find competent treatment.

The following twenty-four topics provide information and advice to parents and other family about treatment, what their loved one experiences in treatment, and significant family systems concepts that recognize the importance of positive family engagement in the recovery process.

A. Counseling Quality

- Counselor – Experience and Availability
- Counselor Bias – Anti-Success and Affluence Prejudice
- Attitude: Affluent Patients Must Suffer More to Want Recovery
- Inadequate Patient Time with Counselor
- Failure to Establish Trusting Relationship with the Counselor
- Effect of Inadequate Pay on Counselor's Attitude

B. Treatment Philosophy, Diagnostic, Mental Health and Clinical Knowledge

- Initial Stages of Treatment: Stabilization
- New Concepts about Treatment Undermine Focus on Abstention
- Timing of the Assessment and Planning Process
- Scope of Inquiry Changed Due to Change in Treatment Philosophy
- Inadequate or Unused Diagnostic Information as to Co-Occurring Conditions
- Clinical Needs of Affluent Ignored
- Peer Group Dynamics
- Preferred Referrals (Money Dominates the Referral Process)

C. Family Systems: The Important Role the Family Plays in Recovery

- Recovery Takes Much More than Twenty-Eight Days
- Parents are Part of the Family System and Not Good Evaluators of the Problem or Solution
- Professional Advice
- Using Leverage to Encourage Treatment and Stay in Recovery
- Secondary Issues (Abuse, Neglect, or Mental Health) and Parent Role
- Treatment Center Selection
- Confidentiality, Releases, and Limits on Information Sharing
- Letting Go is a Dangerous Philosophy
- Inadequate and Misinformation at Family Meetings

D. Conclusion

- The Power of Addiction

As we discuss these topics, keep in mind that the resources available to provide high quality treatment for the top twenty percent of the population (the affluent) are very limited. As parents and family members, you must be educated about the realities of addiction treatment in order to be effective supporters for your loved one's recovery.

This article is one in a series on improving recovery rates for affluent addicts and alcoholics. We use as our model the highly successful recovery programs for pilots and physicians. We

refer the reader to the articles listed on the last page of this paper.[i] In particular, see *Recommendations for Recovery* and *Practical Advice on Achieving High Recovery Rates.*

A. Counseling Quality

When discussing counseling, we are referring to counseling by addiction specialists – counselors trained and licensed or certified in the disease of addiction who believe addiction is a primary disease. One critical mistake parents make is thinking that counseling or therapy by a psychologist or psychiatrist will help their child (adult or teenager) stop using alcohol or drugs. With rare exceptions, it does not. Only addiction treatment is effective. Therefore, the first question a parent or family member must ask is,

> *Does the therapist, psychiatrist, or treatment center believe an addict must be abstinent and in the early stages of recovery for therapy to be effective?*

If the answer is *No,* start right now to find a *Stop the Addiction First* counselor, therapist, or treatment center. However, continue to read on, as this article provides information you need to consider when selecting treatment centers.

1. Counselor – Experience and Availability

A key element in successful outcomes for treatment is the counselor/patient relationship. One of the initial concerns is whether your family member will be assigned to a clinician with years of experience, a clinician with little experience, an intern, or a student. Most people have no choice and have little information regarding counselor qualifications or tenure.

Another factor is whether the counselor will actually be present or on vacation, on leave or otherwise not consistently available while your loved one is in treatment. This is a particular problem in the summer and around the winter holidays when counselors are often not available for one to two week periods.

Counselor experience and availability alone can negatively affect treatment outcomes, particularly for the first time patient.

2. Counselor Bias – Anti-Success and Wealth Prejudice

Counselors bring their own personal attitudes into treatment and these biases often negatively affect the counselor/patient relationship. These biases include negative attitudes about sexual orientation, minority groups, business, professionals, and the affluent, wealthy, and prominent.

Many counselors come from backgrounds where they've suffered economic hardship as children or they've personally lost everything from their use of alcohol and drugs. Due to their personal experience of deprivation, they may resent patients who come from a more affluent background – professionals, business people, trust fund beneficiaries, family business members, politicians, and the prominent. These patients are often looked upon by counselors with disdain because they have it "easy." Additionally, a counselor may have the attitude of, "If I had all of your resources, I'd never be an addict."

This bias may be overtly or indirectly expressed by the counselor to the patient or it may be expressed in patient planning and review meetings. Counselor bias is a significant problem in most treatment centers. Avoiding bias is a very important consideration when selecting a treatment center. It is also a major factor leading to relapse for the affluent and prominent. The advice many wealthy families receive from counselors about *letting go and allowing their loved*

ones to face the consequences of their renewed or continued using can also be grounded in envy and hostility toward the affluent addict. We have heard people giving this advice actually state that they want the affluent addict to lose more money or other resources because they are resentful of the well-off.

3. The View that the Patient Must Suffer More to Want Recovery

Another counselor attitude affecting the affluent is the belief that if a client is not willing to accept the information given by the counselor, the client should leave treatment, use again and suffer more in order to be willing to follow the counselor's advice. (*They must lose everything to "want recovery."*) In our view, this attitude lacks insight into the patient and shows laziness on the part of the counselor in that the counselor is not willing to make the effort to understand the patient's personal circumstances and clinical needs.

An example of this attitude is the lawyer patient who asks a lot of questions in the treatment process and therefore is viewed by counselors as being "resistant" to treatment. Another example is a wealthy patient who is reluctant to discuss his or her personal background due to fear of exploitation or resentment. Both patients will be perceived as unworthy of counselor assistance because they are judged as unwilling to keep quiet and listen (lawyer) or participate adequately in treatment (wealthy patient).

4. Inadequate Time with Counselor

As mentioned previously, the patient's relationship with his or her counselor is a very important component in the recovery process. A good relationship helps establish a positive attitude towards recovery on the part of the patient. However, many treatment centers require only a minimal counselor-client interaction, as low as two hours per week, a portion of which may include group time. Treatment centers have been de-emphasizing the counselor-patient relationship and have started placing more emphasis on the peer group (time spent with other alcoholics) and education (lectures and reading).

This lack of time is particularly troublesome for a patient who is different from the main group of peers, because this patient needs the support, advice and coaching of her/his counselor in order to fit into the peer group. We find that treatment centers that rely heavily on insurance reimbursement place less emphasis on the counselor-patient relationship – just like the rest of the health care industry.

5. Failure to Establish Trusting Relationship with the Counselor

In some treatment centers, interns or other personnel handle the introduction to the treatment unit and initial interviews for data gathering. The patient really does not meet with his/her primary counselor until a few days have passed in treatment. By this time, the ability to establish or form a relationship with the counselor is substantially reduced because addicts have a great deal of trouble trusting people. Patients often feel like they are repeating the same information because no one is listening and they are being discounted. They are already entering treatment with very low self-worth, and thus counselor troubles lead to lost enthusiasm for recovery.

This concern about affluent patients forming a "trusting relationship," while hard to quantify, is an area where the professional counselor working with the family is most helpful by identifying treatment centers that have a commitment to compassionate, supportive counseling.

One puzzling aspect of treatment centers is that they do not identify counselors (or counseling traits) that best fit specific patient sub-groups, but apply a "one size fits all" type counselor to patients regardless of their needs. Therefore, it is through the actual experience of working with specific counselors and treatment centers that the right counselors can be identified as supportive of affluent patients.

6. Low Pay

Another factor in low recovery rates is that the counselors are both under-trained and underpaid in comparison to other medical professionals treating diabetes, cancer or other chronic diseases. The level of expertise and training is minimal, often less than two years of college, if that. Supervisors tend to be promoted up through the chain of command. This is in contrast to physicians treating other chronic diseases, who have many more years of training and experience.

In terms of pay, most clinicians do not earn more than $40,000 to $50,000 per year and are not paid overtime. They also tend to resent the much higher paid professionals in administration who do not provide the direct patient care. These resentments regarding pay and lack of education can be carried over and expressed in minimal care for their regular caseload of patients. Their negative attitude can become focused on the affluent client or any patient earning more than the counselor.

To summarize**,** we have seen all of the above create an atmosphere where treatment simply doesn't "take" for the affluent, wealthy, or even merely employed addict. He/she feels rejected, unheard and neglected. Rather than say, *they treated me badly,* the addict says, *treatment does not work for me.* Before you, as a parent or concerned family member, conclude treatment does not work, you should find out whether your loved one experienced the above. It happens at the "best" treatment centers.

B. Treatment Philosophy, Diagnostic, Mental Health and Clinical Knowledge

Another aspect of treatment that outsiders lack knowledge about is how various centers view alcoholism and drug dependency and the philosophy underlying patient "treatment." Overwhelming evidence supports the view that alcoholism, drug dependency, and the other "isms" are medically based illnesses and must be "treated" in order for the illness to go into remission. Addiction is a primary disease and stable abstention is needed before other co-occurring disorders such as mental health problems or eating issues can be successfully addressed. However, these fundamental concepts are no longer part of the treatment approach or philosophy at many treatment centers (out-patient and in-patient) and one of the reasons for the high relapse rates at these institutions.

One of the cruel ironies of addiction treatment is that families pay $25,000 and more for a 28-day program but they know less about the services given to their loved ones than if they paid a similar amount for a <u>new car</u>. There are no guarantees as to any aspect of the treatment process and little, if any, information on the recovery process. For example, few families are told or know that programs for pilots and health care professionals have very high first time recovery rates (90% and over). Most families would request this option (if available), but since it is more costly and requires sophisticated counseling skills, this type of program is not available in most treatment centers.

As a concerned parent, sibling, child, or advisor, you need to know both the center's treatment philosophy and approach to treatment in order to support your addicted family member in his or her recovery.

1. Initial Stages of Treatment: Stabilization

Treatment can be a mystery to outsiders, but there are recognized tasks to be accomplished in a 28-day program and the weeks following. In-patient treatment begins the process of Stage Two Recovery – Stabilization – and includes five tasks[ii]:

- Recovery From Withdrawal
- Interrupting Active Preoccupation
- Short-Term Social Stabilization
- Learning Non-Chemical Stress Management
- Developing Hope and Motivation

It is no wonder that in-patient treatment is insufficient to assure abstention from use because the stabilization process – Stage Two – takes much longer than 28 days. For some drugs, such as Benzodiazepines (Xanax) or Marijuana, it takes two to three weeks just to complete active withdrawal. Learning new ways of socializing and healthy responses to stress takes months for most people. Assessing the addict's progress through these five stages in treatment and post-treatment is a good indicator of how much support the addict will need to prevent relapse.

2. New Concepts about Treatment Undermine Focus on Abstention

Many treatment centers have changed the focus of treatment from the traditional, holistic bio-psycho-social model to a motivational model. The implication of this change in focus is that it is the patient's current attitude towards his/her addiction and recovery that is important and the patient must experience "trial and error" in order to develop and implement the desire to stop using. In this model, relapse is part of the learning process and the counselor focus is "patient centered." The task of treatment then becomes building up the patient's sense of self-worth, decision-making, and insight so the patient becomes "self-motivated" to stop using.

Traditional treatment concepts such as denial, post-withdrawal syndrome, the addictive personality, and the use of outside leverage to motivate change are viewed as counter-productive and even harmful or abusive to the patient. Seeing addiction as a progressive disease with physical, mental, emotional, and spiritual components is viewed as "old thinking." The traditional treatment goal is to find ways for the addict to become open to accepting help and direction in overcoming his/her addiction. This treatment goal is discarded in this new view of how to treat addiction. <u>In our experience, the traditional approach is far better than the new "motivational model" (as described in the previous paragraph).</u>

The traditional approach has two very successful models – the pilots' and physicians' programs with high first time recovery rates of over 90%. Because of this proven success rate, this is the model for treatment centers to follow. Treatment centers should not use the motivational model, which accepts relapse as a given and assumes the relapsing addict will simply try again to stop using. *Just say no*! The idea that a relapsing addict will resume attempts to stop after each relapse ignores experience and the well-documented brain changes that occur as a result of addiction. This philosophy and approach – that relapse is a "learning experience" – also carries with it a high risk of harm to family members and the addict, due to behaviors during active use.

The pilot/physician model is a more expensive one and requires skilled counselors. The motivational model takes the emphasis off counseling and puts the responsibility for recovery

on the addict – who by definition as an addict is unable to stop using. The latter model is much less expensive to operate and requires minimal counseling skills. Our question to you as a parent or concerned family member is:

- Do you know the treatment philosophy of the treatment center your loved one is entering?

Relapse may very likely be a core element of the treatment program.

3. Timing of the Assessment and Planning Process

Assessment information is usually gathered during the first three days of treatment and the treatment plan prepared by the fourth or fifth day. Preparation of the plan takes precedence over assuring data gathering is complete or that all persons with information are contacted and their views included in the process. Examples:

- The psychologist is off for the day and is not available to discuss mental issues – too bad, the plan must be written now.
- Family input? Leaving a voicemail during the day for parents who work is considered sufficient. Document and check the "parent contact box" as completed.

Why is this so? Because computerized record systems used by centers require certain forms to be filled out within specific time frames or the counselor is flagged as failing to conform to system requirements. Therefore it is better to have a bad plan in the record than no plan at all. This type of inadequate planning is rationalized by the idea that it makes little difference what plan the patient is working on as long as he/she is working on a plan.

4. Scope of Inquiry Changed Due to Change in Treatment Philosophy

Many treatment centers limit the scope of their factual inquiry due to the change in treatment theory from the traditional, holistic bio-psycho-social model to a motivational model. This change in theory impacts the fact gathering process:

a.) Past Medical Records

Most treatment centers do not ask for copies of medical records from previous treatments, therapists, or other service providers of the patient. This is true even for in-patient treatments within the past year.

- Rather than building on past efforts and learning from existing diagnostic information, treatment centers believe it is the current situation that is relevant to the patient, not the past.

In our experience, reading records from past treatments is always helpful in understanding a patient's current situation better. In some cases, reading records is critical to assessing underlying causes of relapse. In our view, there is no sound justification for ignoring previous treatments or therapists' reports, even in treatment centers with a "motivational" theory of treatment.

b.) Complete Use History

Information requested from the patient as to substances used may be limited to the last two years or similar time frame due to "relevancy," rather than over the patient's lifetime.

- The traditional approach sees onset and severity of use over a lifetime as key indicators of emotional maturity, progression of the disease, and possible co-occurring disorders.

Gathering lifetime use information is particularly important when heavy use began during adolescence, because it means the scope and intensity of treatment will very likely need to be substantially increased to support a commitment to abstention and recovery.

c.) Family Information About Impact of Use

The treatment center may not want information from family members about their loved one's alcohol and drug use and related conduct such as blackouts. This information is viewed as "negative" and harmful to the patient's newly developing sense of self-worth.

- The traditional approach values this information, as it is often helpful to the patient so he/she has a better understanding of the realities of her/his disease.

Addicts uniformly misjudge the impact of their behavior and emotional demeanor on their close relationships. Learning about this impact, although painful, helps the addict become reality based.

At one well-known treatment center, family members sent information to the patient's counselor about how the patient endangered her children while she was driving in a blackout. These details were shared with the patient who became angry with her relatives for sending in what the patient believed was false information. The counselor supported the patient in cutting off contact with her family members even though the information presented warranted a child protection report (which the counselor did not make). This is an example of a "patient centered" approach to treatment. Needless to say, we no longer make referrals to that center.

5. Inadequate or Unused Diagnostic Information as to Co-Occurring Conditions

Adequately assessing and diagnosing a patient's mental health, learning-related concerns, and past abuse are critical components to the treatment and recovery process. Often we find that relapsing addicts have a secondary condition that is undiagnosed or inadequately treated. Secondary conditions include learning disabilities, sexual or physical abuse, significant emotional neglect, or significant mental issues such as depression or anxiety.

While many treatment facilities have comprehensive diagnostic services available as part of their treatment program, in reality their loved one may not receive these services. There are several factors to consider:

- First of all, with payment cutbacks made by insurance carriers and reduced patient populations, many treatment centers (even those with the highest reputation) are reducing the scope of their mental health assessments.
- Secondly, centers are laying off experienced clinicians who know how to ask the right questions. They are also using interns and inexperienced professionals to conduct their assessment programs.
- Another concern is that when screening and other tests indicate the need for additional testing, the treatment center may not have the resources or invest the time into pursuing further diagnostic investigation.

We have found that diagnostic information is very important in understanding the underlying causes of multiple relapses and addiction. In addition, providing this information to the patient helps rebuild self-esteem and confidence. This is because the patient will gain a better understanding as to why he/she struggles with addiction and how to address long-standing educational, learning or communication styles that are perceived by the patient as a self-failure rather than a learning problem.

6. Clinical Needs
Another important factor is whether or not clinicians are trained in the clinical needs of the person they are assigned as a patient. Counselors, as part of their training, are required to learn about "special population groups" such as Latinos, GLBT, and the economically disadvantaged. Few are trained in the clinical needs of the affluent, wealthy, and prominent, although there is now a growing body of research identifying these needs and how they might be breeding grounds for addiction.

Unless clinicians are aware of the very specific set of clinical issues that this population group faces, they will be of little use to their affluent patient as he/she navigates the difficulties encountered in the treatment setting. While it is true that every addict and alcoholic should experience a basic treatment regime, it is also important that their individual needs be recognized and addressed in the treatment process. The failure of counselors to understand and respond to the clinical needs of the affluent in treatment is another major cause of relapse.

7. Peer Group Dynamics
An additional concern is that most of the treatment centers are peer driven. Therefore, the relationship between the patient and the greater peer group needs to be managed carefully, particularly for the affluent client or the client with a job. These are patients who have not lost everything. Peer groups can become very hostile towards their more well-off members.

Peer group relations can be particularly difficult for women who are in need of group support to make progress. Affluent women fear that talking about their life will lead to rejection by the group. For many women, it is difficult to speak honestly in these settings without counselor support. Since honesty is one of the keys to recovery, lack of trust in the group is a barrier to recovery. In contrast, men who are used to dealing with financial conflict are often better able to handle negative peer reaction to money differences. However, for many men – particularly adolescents or young adults who are trust fund beneficiaries or dependent on family money for support – honest peer relations regarding money issues can be an insurmountable barrier to recovery and the source of much dissembling and shame.

Many patients from affluent families will not acknowledge peer group rejection to counselors or family members, although in our one-on-one meetings, it is mentioned as a critical factor in how they feel about treatment.

8. Preferred Referrals
Another factor negatively affecting treatment outcomes is that treatment centers have relationships with specific outside providers to whom they send patients and family members. Or, the treatment center provides its own aftercare services, such as a halfway house or mental health counseling, and patients and families are referred to these services. This system of outside or inside referrals is not disclosed to family members nor are they usually offered other choices for services. Some of these outside providers are not staffed by licensed counselors, but no one tells family members this information. Nor are family members aware of conflicts of interest within programs or the scope of services to be received by their family member.

For example, family members were pleased that their loved one, who was a key employee in the family business, agreed to enter a post-treatment out-patient program with drug testing. But the family was not told that the testing was unobserved because the post-treatment program people

believed it was disrespectful to their clients to observe the collection of urine samples. Only when family members experienced using behavior and asked the program executive how their loved one could be passing drug tests did they learn that the tests were unobserved. This type of nonsense is perpetrated time and again on families who believe they are receiving top of the line services. In reality, they are unaware that service providers are deceiving them.

C. Family Systems: The Important Role the Family Plays in Recovery

Addiction affects the entire family, including trusted advisors, family offices, and businesses. Changing the family system to support recovery is a long-term process. Unfortunately, treatment centers focus on the addict and the 28-day in-patient experience because that is where the money is and it is easier than working with the family. However, addict centered in-patient treatment is not a recipe for sobriety. For example, the highly successful pilot and physician programs are system oriented and long-term (a year or more). Therefore, their in-patient treatment program is focused on making sure the conditions are in place to support the longer-term plan for post-treatment activities and a successful return to the work environment.

In our practice, supporting, advising and counseling families composes at least 80% of our work. Based on our extensive experience, we know how important families and their advisors are to recovery. In this section, we review the reasons why families are important and roles families can play in recovery.

1. Recovery Takes Much More than 28 Days

As mentioned, many people view addiction as episodic and resolvable in 28-day in-patient treatment programs. That is not the case. A recent article in one of our professional addiction journals discussed the developmental approach to recovery and the six stages to achieving stable remission[iii]:

- Transition — *Recognition of Addiction*
- Stabilization — *Recuperation*
- Early Recovery — *Changing Addictive Thoughts, Feelings, and Behaviors*
- Middle Recovery — *Lifestyle Balance*
- Late Recovery — *Family of Origin Issues*
- Maintenance — *Growth and Development*

Most of these stages occur outside the in-patient treatment setting in the context of the family environment, as the time frame often takes two years or more. Needless to say, the main players in the addict's family – parents, siblings, and children – will need counseling, advice, and support in order to grow and change as their loved one grows and changes in recovery.

Some family members are so angry or discouraged with the behavior of the addict that they perceive the addict as fully to blame for all the problems in the family. These family members are usually not open to hearing how they might think differently or change their behaviors to support recovery. If business, financial, or relationship ties remain with the addict, these intractable family members may agree to joint counseling. Otherwise, it can take time to persuade alienated family members to agree to a limited commitment to examine their own behavior or to accommodate the requests of the addict.

2. Parents are Part of the Family System and NOT Good Evaluators of the Problem or Solution Facing their Loved One

We have already made the arguments that family members – parents, in particular – know very little about what occurs in treatment or the treatment philosophy of the treatment center. However, the larger concern is that family members who say they know everything about addiction, treatment, and recovery, seem not to accept the long-established principle that addiction is a family disease. (This can be an even more difficult concept for them to accept when one includes in the "system" family enterprises, trust funds, and family resources.)

These folks often do not accept the disease concept as it relates to the family, that it is in fact a family-wide disease. Rather, they focus solely on the addict as the problem child. In our experience, when a family member says he or she knows all about addiction and recovery, it is actually evidence to the contrary. Such a statement demonstrates lack of understanding of addiction as affecting the whole family.

Because parents, for example, are part of the family system affected by addiction, they are not able to make good decisions about how to help their loved ones. They need outside help to understand their role in the addiction process and their role in the recovery process. This includes how the family resources support using behaviors and how such resources can support recovery (see below). When family members wear two or more hats, one hat being related to the addict and the other hat in another role as family business owner, trustee, family office executive or financier, assuming the role of addiction expert becomes even more difficult to fulfill and usually ends badly.

3. Use Professional Advice

Our arguments for using qualified, licensed professionals to help families and their advisors include the following:

- Families are caught up in problems of their loved one and need independent advice in order to achieve insight and clarity as to how to proceed.
- Families need education on addiction and coaching as to how to respond to the addict.
- Families have trouble understanding the connections between money, affluent culture, and addiction and need the guidance of an expert to help sort through these relationships.
- Families know little about treatment and the challenges the affluent face in the treatment and the recovery community.
- Family members, no matter how dedicated or devoted to their addicted loved one, do not have the time or skills to oversee the stages of recovery discussed in sections B1 and C1 (nor do their lawyers, advisors or family office personnel).
- Families are vulnerable to exploitation by non-professionals masking as intervention, addiction, or post-treatment recovery experts.

The brief summary of reasons for collaborating with addiction professionals to better assist loved ones with a chronic disease is elaborated on in our articles on our website at www.AureusInc.com and listed on page 16.

4. Using Leverage to Enter Treatment and Stay in Recovery

Leverage or pressure put on loved ones to enter treatment is a critical part of the recovery process. This leverage comes from elements within the family system. Why is leverage necessary? Leverage or external pressure is used to encourage the addict to enter treatment. During the course of treatment (in-patient and post in-patient), the addict must learn how to

convert external pressure to agree to go into treatment to internal motivation to abstain and do what is necessary for long-term recovery.

Most parents and their advisors are not able to use leverage effectively over the long term. They are also reluctant to apply pressure until after several treatments and relapses. We find that leverage is most effective when used the first or second time a loved one goes into treatment. Also, when leverage is applied in collaboration with a professional alcohol and drug counselor, the results are better over the long term. Not only does the professional have the sophistication and knowledge about addiction and recovery, but parents or advisors are not in the direct line of fire when their loved one objects to being "bossed around" or otherwise uses anger or despair to fend off pressure to comply.

5. Secondary Issues such as Abuse, Neglect, or Mental Health Issues Cannot be Handled by Parents

Fifty percent or more of women addicts have a history of sexual or physical abuse. Many men do, as well. A significant number of women and men report sexual abuse by a relative or an employee, such as a household servant, gardener, chauffeur or nanny. This is not surprising as child abusers seek work where they have access to children. Wealthy families are easily misled by a clever abuser into thinking that the abuser's primary interest is the welfare of the children when in reality it is access to vulnerable children. Because children blame themselves and are ashamed of being abused, they often do not disclose the abuse to their parents, or if disclosed, many parents dismiss or ignore their children's complaints.

In addition to abuse, many addicts from well-off and prominent families report that their parents neglected them, leaving them to the care of nannies, thereby preventing strong parental bonds from forming. The end result is detachment disorders. These affluent addicts have trouble connecting with people to establish affirmative relationships and often suffer from depression or anxiety disorders. Yet they feel they can't complain because they grew up with wealthy or well-known parents. Attachment disorders, as well as other effects of inadequate parenting (divorce, focus on money), result in increased vulnerability to alcohol and drug use as a way of feeling better about themselves. Needless to say, this is the type of information few parents can receive without professional help.

For example, sons and daughters of politicians pay a heavy price for the success of a parent. Almost all politician parents are too busy with their careers to pay any meaningful attention to their children. Several years ago I suggested to a politician that it would be helpful to form a sons and daughters of politicians' support group. The resulting look of horror said much more than any words could as to the level of denial and rationalization. Many parents do not want to hear anything about their inadequacies regarding their children, yet this may be a key part of the recovery process for their children, particularly those who start using at a young age. The situations described in this section are one of the reasons why we keep emphasizing that alcoholism and drug addiction is a family disease – although many parents would prefer this were not the case.

6. Treatment Center Selection

Addicts are very poor evaluators of what they need for treatment because they have an illness. The illness leads them to misjudge the severity of their problems. This results in the addict's selecting inadequate treatment and misjudging the type and length of treatment that he or she

will need for stable recovery. Therefore, we find it is best for family members, in conjunction with professional advisors, to select several treatment center options for their loved one.

A related problem is that families sometimes wait for their loved ones to express their desire to enter treatment on their own. In our experience, this happens when the alcoholic or addict experiences a life-threatening scare or some other major disaster. They are scared into getting help. Unfortunately, when the addict has reached this stage, his or her disease has progressed to such an extent that it compromises the ability to recover and impairs the ability to make good choices. Not only is this an argument for early action by the family but another reason why the addict should not pick his/her treatment facility. Most addicts, if given a choice, will prefer an out-patient program or a cosmetic 28-day program which may or may not treat addiction as a medical illness.

7. Information Sharing

Information sharing with treatment centers and the interaction between families and treatment centers is another problematic area.

First, most families have no idea what information is important to treatment centers, when it is needed, or how to interact in productive ways. For example, most treatment centers do their assessment and program planning in the first two or three days of treatment, well before most family members have any contact with the treatment center.

Second, regarding releasing information, often the patient will restrict information to family members and tell the family member that a release of information has been signed but not indicate the restrictions. Most family members are not aware of these limitations and do not realize they are getting limited information.

A third issue is that treatment centers will not send complete copies of records or sensitive information to family members and nonprofessionals out of fear of the information being misused and misinterpreted. Therefore, family members need to have a licensed professional ask for the information. This leads to another concern, which is that family members usually do not even know what to ask for, so they don't know if they are receiving the correct information.

A fourth point is that family members who call or use institutions for intervention help do not realize they are receiving help from people who are unlicensed or have narrow chemical dependency professional training and are only interested in doing the intervention. Thus, these people are not useful or helpful in interacting with the treatment center in a meaningful way.

To summarize this section on information sharing and confidentiality, parents are easily misled and ill informed about what is occurring in treatment. Therefore, parents are not good judges of what services are actually being provided or the progress made at the treatment center.

8. Letting Go is a Dangerous Philosophy

Family members who do attend family programs are often told to let go and not do anything regarding their loved one's addiction. They are told that their loved one is responsible for his/her own recovery. This information is easily misinterpreted by family members when there are resources involved or other leverage points that can be used to encourage a loved one to enter and stay in treatment. As we argue here, addiction is a family systems disease, and

resources and leverage present within the system must be used to support recovery – not be passive, or worse, continue the status quo.

Another example of this "letting go" philosophy is that it also tends to protect treatment centers from being scrutinized as to the treatment quality for the patient. These days, most family members will not allow a loved one to navigate the medical or hospital system for major surgery or other severe illnesses on their own. However, treatment centers tell family members to pay for treatment and then refrain from asking any questions because they need to "let go," or such questioning is characterized as improper interference with the patient's treatment.

9. Inadequate Family Meetings

Family members often meet with the patient in treatment centers for family meetings with the patient's counselor present. However, the patient frequently limits the information his or her counselor can share with the family members. This information includes post-treatment recommendations or concerns regarding progress in treatment. The patient has the right to limit the information his or her counselor can communicate to family members. Often family members do not know the right questions to ask, or because of "letting go" philosophies, simply listen and do not ask such basic questions about whether there is a relapse plan and whether the plan is in writing.

In our view, this is a particular concern for families attending family programs. When families attend these patient/counselor meetings without the presence of a family counselor to support them, it is difficult for them to ask the right questions and express their concerns. We have seen instances where deliberately misleading or false information has been given by patients to their families with no corrections or comments made by the patient's counselor to indicate to family members that the information they are receiving is not accurate. This is unconscionable and reason enough to refuse to refer patients to these centers.

D. CONCLUSION The Power of Addiction

The theme of this article is that parents really do not understand or know everything about treatment and recovery. In this final section, we emphasize that parents also have trouble comprehending the emotional and physical power of addiction. Parents (and other family members) have little understanding of what it is like to lose control of the ability to choose whether or not to drink or use drugs. This loss of control is very difficult for the addict to admit to him or herself, let alone describe it to their often successful parents who became so using willpower. The emotional states of addicts and non-addicts are so different that parents really cannot bridge the chasm and thus misjudge the recovery needs for their son or daughter. If a parent is in recovery and does know addiction's power, the tendency is for that parent to apply his or her recovery program to the child, not accepting that every addict's path to sobriety is unique.

In addition, when identifying the underlying drivers of addiction is fundamental to the recovery process, parents need to be supportive and not judgmental or wearing their *quasi-professional, we know everything about addiction* hat. Discussing these drivers and addiction-related behavior is very difficult for a young adult to do with his or her parents, assuming the young adult has insight as to what they might be.

A related concern is that every addict faces their own **"dark night of the soul"** when they come to grips with the reality of their use and its impact on self and others. This emotional bottom can almost never be empathetically received and heard by family members in a helpful way for the addict and can be ammunition (self-admissions) for the next round of conflict. (Another reason why your son or daughter needs the help of a counselor who understands both addiction and the clinical needs of the affluent, prominent, and wealthy.)

Our concluding note for parents is to say that we understand how painful and disheartening it can be to have a child who struggles with addiction. Please do not give up. We have seen many situations that have been turned around with persistence, patience, and effective partnership between families and professionals.

Related Articles

In this article, we refer to our other articles in the **Addiction in Wealthy Families** series on:

Families and Advisors

- *Practical Advice on Achieving High Recovery Rates For Affluent/Prominent Alcoholics and Addicts*: *What Every Family and Family Advisor Needs to Know (Based on Highly Successful Programs for Physicians and Pilots)*

Recovery Recommendations, Systems Changes, and Governance Practices

- *How We Help Families and Advisors Address Addiction in Affluent, Prominent, and Wealthy Families: Recommendations for Recovery, Systems Changes, and Governance Practices*

Families, Wealth, and Addiction

- *A New Clinical Approach to Addiction, Treatment and Recovery for Wealthy Families*

Advisors, Trustees, Account Managers, and Family Offices

- *Solutions for Dealing with Alcoholism and Drug Addiction in Affluent Families: What Advisors, Account Managers, Trustees, and Family Offices Need* to *Know*

Financial Managers and Dysfunctional Clients

- *Financial Managers and Dysfunctional Clients: Addiction's Effect on Staff Morale and Fiduciary Responsibilities in the Family and Wealth Management Office*

Trustees and Beneficiaries

- *The Demise of Trustee Discretion and Ascertainable Standards as Effective Controls on Dysfunctional and Underperforming Beneficiaries*

Law Firms

- *Achieving High Recovery Rates for Addicted Attorneys, What Every Law Firm and Lawyer Needs to Know (Based on the Highly Successful Recovery Programs for Physicians and Airline Pilots)*

Core Needs in Wealthy Families

- *The Advisor's Role in Helping Wealthy Families Meet Their Core Needs*
  - *Part 1: A Developmental and Experiential Model for Advisors and Consultants*
  - *Part 2: An Alternative Model for Planners and Consultants*

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The National Network of Addiction Professionals, LLC
Established by William Messinger, we specialize in working with families and their advisors facing alcohol, drug and other addictions in loved ones. We model our program after highly successful programs for pilots and physicians. Our extensive experience and training translate into unique and individualized consulting and case management services that ensure our client families receive the highest standard of care available and have the best opportunity for positive change.

We provide our clients with comprehensive support thorough assessment services, selecting and utilizing the right interventions, referral and placement with the treatment providers, and post-treatment care and monitoring. Our clients include law firms, family businesses, family business advisors, and family offices. We are available 24 hours a day to respond to your questions. Please visit our web address to review our articles for family advisors, trustees, attorneys and family leaders.

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Footnotes

[i] We refer the reader to the *Recommendations* and *Achieving High Recovery Rates* articles for citations to support information presented in this paper.
[ii] Recovery From Addiction, A Developmental Model, Part One, *It's All in the Journey,* Sept. 2008, p 8.
[iii] Ibid., p 8