Family Support and Addiction Management for Long-Term Success

Practical Advice on Achieving High Recovery Rates for Affluent Alcoholics and Addicts

William F. Messinger, JD, LADC

Aureus, Inc.
325 Cedar Street, Suite 700
Saint Paul, MN 55101
Phone: 651.209.7670

National Network of Addiction Professionals

TABLE OF CONTENTS

Practical Advice on Achieving High Recovery Rates For Affluent Alcoholics and Addicts

OVERVIEW **1**

INTRODUCTION **2**

A. SETTING THE STAGE FOR SUCCESSFUL RECOVERY **5**
1. CREATE MOTIVATION FOR RECOVERY BY USING THERAPEUTIC LEVERAGE 5
2. MAKE THE DISEASE REAL BY CREATING CONSEQUENCES 6
3. WHY RECOVERY TAKES MUCH LONGER THAN 28 DAYS 7
4. IMPLEMENT A WRITTEN AND STRUCTURED POST-TREATMENT PLAN 8
5. IDENTIFY RELAPSE PREVENTION STRATEGIES 9

B. WHAT LEADS TO SUCCESSFUL TREATMENT OUTCOMES **11**
1. IMPORTANCE OF THE QUALITY OF THE THERAPEUTIC RELATIONSHIP 11
2. ADDRESS THE CLINICAL NEEDS OF THE AFFLUENT AND PROMINENT 11
3. TREAT THE UNDERLYING DRIVERS OF ADDICTION 12
4. EFFECTIVE TREATMENT: WITHOUT MAJOR CO-EXISTING MENTAL HEALTH ISSUES 13
5. EFFECTIVE TREATMENT: WITH MAJOR CO-EXISTING MENTAL HEALTH ISSUES 15

C. THE IMPORTANCE OF EFFECTIVELY INCLUDING FAMILIES IN THE RECOVERY PROCESS **18**
1. FAMILIES ARE POWERFUL ALLIES IN FOSTERING RECOVERY 18
2. WHY "LETTING GO" OR "DOING NOTHING CAN BE DANGEROUS 19
3. OBTAINING CONSENT FOR RELEASE OF INFORMATION 20

D. RECOGNIZING BIAS AGAINST THE WELL-OFF AND PROMINENT AS A RECOVERY BARRIER **23**
1. "WEALTHISM:" RESENTMENTS BY PATIENTS AND STAFF AGAINST THE WELL-OFF 23
2. FAILURE TO ADEQUATELY TREAT "HIGH BOTTOM" PATIENTS 24

E. CONCLUSION: THE ENORMOUS POWER OF ADDICTION **26**
1. EXAMPLE: BILL WILSON (INVESTMENT BANKER, AND AA CO-FOUNDER)

APPENDIX: ***TWENTY ARTICLES ON IMPROVING RECOVERY RATES FOR AFFLUENT ADDICTS AND ALCOHOLICS*** ***27***

AUTHOR INFORMATION **28**

FOOTNOTES **29**

Practical Advice on Achieving High Recovery Rates For Affluent Alcoholics and Addicts

OVERVIEW

The Problem: Continued Alcohol and Drug Use

Few problems are as vexing and seemingly impossible to resolve for families, advisors and trustees as the active alcoholic or addict, particularly those who continue to use after treatment. While low recovery rates for treatment and subsequent relapse may be understandable in the aggregate, on the individual level the experience is frustrating and unnerving for all concerned.

With addictive behavior being identified more readily these days, the far more challenging problem is recovery:

> *What to do when a family member, client, or an employee is addicted to alcohol or drugs?*

Often the response is "treatment," yet few family members and advisors are familiar with the success rates for treatment or what leads to sustained recovery. The purpose of this article is to provide information about treatment outcomes and to discuss what works for recovery, starting with two key facts:

- **The most common outcome of treatment is relapse.**
- **Pilots and physicians have first time recovery rates in excess of 85%.**

These very important points led us to investigate how recovery rates can be improved for the wealthy and prominent. In doing so, we met with hundreds of affluent alcoholics, learned about their relapses and recoveries, and used our experiences as Hazelden clinicians and interns to understand the pros and cons of treatment for this population. Above all, we drew on personal experiences growing up with and/or living as adults with wealth, prominence, and addiction.

One result of our investigation is this article, where building off the pilot/physician programs, we provide advisors and families with practical information and suggestions on supporting long-term recovery for family members addicted to alcohol and drugs:

- **First, we explain how to set the stage for successful recovery.**
- **Second, we describe treatment components leading to successful outcomes.**
- **Third, we discuss the critical role families can play in the recovery of loved ones.**
- **Finally, we point out how bias against the well-off and prominent is a major barrier to recovery.**

While these topics are discussed separately, it is their integration, individualized for each family and their addicted loved one, which leads to improved outcomes.

The pilot and physician programs are the roadmap to successful recovery. For far too long the wealthy and prominent have accepted treatment failures and continued use as ingrained in the wealth and prominent culture. We reject this view and advocate a far more active and knowledgeable approach, based on what works for pilots and physicians.

Introduction

The Problem: Unresolved Alcohol and Drug Dependence
Few problems are as vexing and seemingly impossible to resolve as the active alcoholic or addict, particularly those who continue to use after treatment. Low recovery rates for treatment and subsequent relapse may be understandable in the aggregate. However, on the individual level, the experience is frustrating and unnerving for families and their advisors. With addiction rates exceeding 20% in many wealthy extended families, alcohol and drug related dysfunctions often underlie problems addressed by advisors and family leaders.

While there are variations to the problem, a common one is alcoholism and drug addiction in offspring of the successful entrepreneur. For example, in 1940, a dinner meeting was held at the Union Club to introduce Alcoholics Anonymous to the Manhattan business community. A.A. founder, Bill Wilson, described an all too familiar situation regarding a "rich man's son":

> *I might start off by giving the experience of a man whom I have not seen for two or three years. His experience so well illustrates the nature of the problem with which we have been dealing. This man was a rich man's son and I can pay him no greater tribute than to say he was very successful in business; I think that is a real tribute. He was a person of dignity, good taste, education. He had a great many friends. Well, he did a conventional amount of drinking, and that went along nicely a number of years, and then he found he began to get drunk, very much to his own consternation, for he had looked down on people of that type before….I have indicated, I think, that he was a person of character, and great force of character. Therefore the question immediately arises in everyone's mind: "Why didn't he stop?" But he did not…[l]ittle by little matters got worse and he began to go from one hospital or cure to another.*
>
> *… That is a typical statement of the alcoholic's dilemma. It describes in a loose way a condition in which we have gone to habit to obsession to insanity. And the very strange thing is that while this is going on, many of us seem to all outward appearances to be sound and able citizens in other matters. Our minds waver, and we wonder what in thunder is the matter.*[1]

This scenario has not changed much since 1940. Although addictive behavior is identified more readily these days, alcoholism and drug addiction continue to plague wealthy and prominent families.

Relapse: The Most Common Outcome of Treatment
Once dependencies are discovered for the well-off and well-known, the far more challenging problem remains sustaining recovery. However, before discussing recovery, we must first confront the reality that the most frequent outcome of treatment is relapse. Stephen Davis, an active member of Al-Anon and a former Arizona State Senator, candidly said:

> *…From all the studies I have read, the success rate for 30-day treatment centers leaves much to be desired. Less than one third of all clients remain clean and sober in the first year after "graduation," much less for the rest of their lives.*[2]

This outcome information contradicts success rates reported by many treatment centers. In this regard a distinguished expert in the field, William White, states:

> ***Some claims of treatment success <u>rest on no scientific foundation</u> and instead represent everything from <u>honest estimates to self-serving fabrication</u>.*** [3]

> *A 2001 review of the largest and methodically rigorous alcoholism treatment outcome study… reported an average one-year continuous abstinence rate of **24 percent**.*[4]

There appears to be more marketing than statistical rigor behind many outcome claims by treatment centers. Misleading assertions may result from the evolution of many treatment centers from community based social service agencies to behavioral health care businesses. The expert quoted above recognizes this change as leading to a focus on profits, and not on vision or community accountability:

> *In this climate, a program director was less likely to be asked about the recovery rate of his or her program than about the census or profit margin of that program. This business and profit orientation has now reached such a state of excess that the non-profit status of some addiction treatment organizations could be legally challenged. In the for-profit addiction treatment community, little motivation exists to respond to community needs…*[5]

This diminished focus on accountability and statistically valid success rates within the treatment community, is one reason why families, concerned persons, and prospective patients, must look elsewhere for constructs supporting improved outcomes.

Another more serious reason is that overly simplistic and exaggerated claims can be damaging to the patient who blames him or herself if relapse occurs, rather than having a realistic idea of the difficulties in sustaining recovery. Misplaced reliance on asserted high recovery rates jeopardizes careers, family businesses and inflicts untold harm on addicts and families who mistakenly believe that simply completing treatment leads to abstention.

When ex-patients return to drinking or drugging (or both), advisors and family members looking for answers to questions or reliable solutions are understandably frustrated by responses such as "alcoholism is a chronic disease" and "relapse is to be expected". Coming to grips with the reality of low recovery rates and lost opportunities for sustained sobriety is often an excruciatingly painful experience for those close to the relapsing alcoholic or drug user. This situation is even more perplexing and disheartening when one learns of the high success rates for pilots and physicians.

Pilots and Physicians: 85% Plus Recovery Rates

In contrast to the relatively low success rates for the general population, pilots and health care professionals have recovery rates in excess of 85%.[6] This disparity in outcomes, led us to investigate how recovery rates can be improved for the affluent and prominent. Our article strives to provide families, and their advisors, with practical information and suggestions about what works to support long-term recovery by building off the pilot/physician programs:

- First, we explain how to set the stage for recovery through leverage, understanding how the disease progresses and implementing structured post-treatment and relapse prevention plans.
- Second, we describe treatment components leading to successful outcomes. These components include looking at the quality of the therapeutic relationship, addressing clinical needs and underlying drivers of addiction, and finding strategies for managing major co-existing mental health issues.
- Third, we discuss the critical role families play in the recovery of their loved ones, why letting go can be dangerous. In addition, we look at the importance of obtaining consents in order to receive information from treatment centers.

- Finally, we point out how bias against the well-off and prominent is a major barrier to recovery, including “wealthism,” and the failure to adequately treat “high bottom” patients (those who have not lost everything and still have intact lives).

Alcoholism and drug addiction is pervasive within the wealthy and prominent culture and needs to be addressed and treated, rather than ignored. In our experience, family members and their advisors can play important roles in combating the disease if they become pro-active and use the pilot/physician models as roadmaps for success.

SECTION A:
Setting the Stage for Successful Recovery

1. Create Motivation for Recovery by Using Therapeutic Leverage
Motivation plays a large role in recovery. Motivation takes two forms: external pressure (therapeutic leverage) from others to change and internal pressure from within oneself.

External Motivation (created by others)
The vast majority of people enter treatment due to external pressure (therapeutic leverage) of some kind. When this pressure is maintained, patients free of co-existing mental health issues tend to do well with support. Addiction specialists, Stephen Jay Levy and Sid Goodman, agree that:

> *Chemically dependent patients, free of co-existing mental illness, with intact jobs and families, tended to do well in rehabilitation programs if therapeutic leverage and support were applied by families and employers.*[7]

The sophisticated and individualized application of outside pressure is key to building and sustaining recovery. Patients who say they entered treatment on their own, on close examination, are in fact entering due to outside influences. Knowing those influences as counselors, aids in understanding what will work for effective leverage over time.

Internal Motivation (created within the addict)
Internal motivation is a more powerful predictor of recovery than external motivation. Moving from external motivation to internal motivation is a long process. Therefore, **it is critical for external pressure to continue** until this transition is fully underway, if not complete. The failure to follow this advice is a major cause of relapse.[8] Pressure can be modified or relaxed over time as recovery progresses by demonstrated behavior and favorable reports from counselors.

Advice on Applying Pressure
External pressure to enter treatment can take many forms, including modifying relationships, employment, and access to funds. Several key points on using pressure are:

Do not wait to use pressure

- While leverage can be very useful, it tends to work the first or second time it is used. After that, the intended patient finds ways to circumvent this effort to influence behavior. Many times, long-term pressure is only applied after several treatments, and by then, it can be too late to be influential.

Keep the outcome in mind, not costs

- Do not turn the problem over to the HR department or the insurance carrier because their interests are in minimizing costs. Your interest as the advisor is the *best* outcome, not the least costly one.

Manage the recovery program

- Do not let the intended patient choose his or her recovery program. Your loved one may not be aware of the degree of the addiction, their individual treatment needs or quality of available programs. Evidence suggests that the decision to enter treatment requires different skills than those needed to maintain recovery.[9]

Treat the occasion as the only opportunity for recovery, by taking charge and finding the right treatment resources. It is difficult for families to effectively apply pressure because of their close relationships with the addict. We advocate finding a knowledgeable and licensed addiction professional that can provide assistance and a clear perspective throughout the process.[10]

The Physicians Program is Open to Everyone
One reason why physicians and pilots have high recovery rates is that they are forced by professional oversight boards to stay in active programs of recovery for several years. The failure to do so leads to loss of employment. These same oversight programs for physicians can be applied to affluent patients after leaving in-patient treatment (if the family or advisor requests that the patient enroll in it).

2. Make the Disease Real by Creating Consequences™
A second influential factor for improved recovery is the severity of negative experience from drinking or using. The more severe the consequences from use, the greater the likelihood of recovery because the addict is more likely to believe he/she has a serious problem. For the well-off, the lack of ordinary, significant external consequences is a barrier to taking recovery seriously.

The Severity of Negative Experience Increases Awareness of the Disease
This information confirms the common understanding in treatment and A.A. that the alcoholic must experience serious consequences to want recovery. Those who continue drinking or "go back out" are said to haven't "suffered enough" and may need to "lose everything" in order to want to quit. Much of what is discussed in this article helps make the disease "real" for the well-off addict.

Creating Consequences™
The lack of severe negative experiences has several implications for successful outcomes:

Treatment must focus more on internal consequences
- Treatment must move away from emphasis on external consequences to focus on the emotional, mental, and spiritual impacts of the disease on the addict and his/her relationships.

Make the disease real by creating consequences™
- The disease can be made "real" by creating consequences™. This is a critical component of the pilot and physician programs where consequences are imposed by oversight boards. In A.A. parlance, this is similar to bringing the "bottom up" for those who have not lost everything (see below).

Find experienced counselors
- Find counselors with the expertise, knowledge base and empathetic willingness to understand and work with the affluent and prominent patient in terms of her or his experience of addiction.

Individualized programming needed
- Standard treatment programs must be individualized, often an impossibility for insurance driven treatment centers.

As in the use of leverage, this is a second area where persistence, over time, is key. But in this instance, the focus is on behavioral changes so the alcoholic or addict comes to believe he/she has a disease that needs to be taken seriously.

3. Why Recovery Takes Much Longer than 28 Days

Recovery is not complete during inpatient treatment. It takes much longer to treat emotional and spiritual issues and major co-existing mental health conditions.

Addiction Involves Much More Than the Physical Consequences

The hierarchy of recovery is the opposite of the progression of the disease. For example, the disease progresses in this sequence: spiritual, emotional, mental, physical. Recovery on the other hand, starts with the physical and progresses back through this hierarchy. Recent research has shown that recovery is so difficult precisely because recovery goes from the physical to the spiritual. When one becomes addicted to alcohol or drugs, the brain is altered both mentally and physically. Steve Olson, a published author who deals with the issue of alcohol abuse, writes:

> *…for some people, even the thought of alcohol can generate a knee-quaking compulsion to drink. Many researchers believe alcohol doesn't just elicit subjective responses – over time it shapes those responses.*[11]

It takes continuous abstinence over a long period for the responses to return to normal or be managed in healthy ways. This is one reason why time between binge drinking, or episodes of abstention between relapse, is not "recovery." From the brain's perspective, little has changed.

28 Days Addresses the Physical and Mental Components

Detoxification and physical recovery happens within 10 to 15 days for most alcoholics and addicts. Common exceptions are those with severe liver damage, permanent cognitive impairment, or benzodiazepine withdrawal, which can take two weeks or more. During this time, a patient's thinking process improves as well. The addict/alcoholic says to him/herself:

> *I am feeling better. I must be cured. It's time to go home and get back into the swing of things.*

While the feeling may be genuine, the conclusion is incorrect. The patient's decisions on post-treatment activities are made with impaired insights as to his/her true mental status due to partial recovery.

PAWS

This way of thinking is also distorted from PAWS (Post Acute Withdrawal Symptoms).[12] PAWS is a brain dysfunction occurring in 75 - 95% of recovering alcoholics and addicts tested. Its symptoms appear from seven to fourteen days after abstinence and abate in six to twenty-four months. The characteristics of PAWS include:

- Inability to think clearly
- Memory problems
- Emotional overreactions or numbness
- Sleep disturbances
- Physical coordination problems
- Stress sensitivity

The most recognizable symptom is the inability to solve simple problems. Needless to say, the patient in early recovery is susceptible to poor decision making, which is another reason why

participation and oversight by concerned persons regarding post-treatment activities is important.

<u>28 Days Does Little For Emotional or Spiritual Recovery</u>
Family members and advisors know little about the stages of recovery and the corresponding need to continue leverage until the patient's emotional and spiritual condition becomes stable. Premature assumptions regarding the pace of recovery by the addict/alcoholic are another cause of relapse.

4. Implement a Written and Structured Post-Treatment Plan

The clinical and treatment suggestions in this article mean little if there is not a comprehensive and implemented recovery plan after leaving treatment. As mentioned at the outset, the effective use of pressure after leaving treatment is critical to the recovery process (and another reason why the pilot/physician programs are so successful).

<u>Purpose and Goal</u>
The purpose and goals are simple:

Purpose: Behavior Modification
The purpose of a structured aftercare program is to channel behavior into positive activities for recovery and avoid negative behaviors. The word is "behavior," not rationalizations or justifications for failing to engage in recovery activities (in recovery, "trying is lying").

Goal: Develop Internal Motivation
After treatment, the alcoholic or addict must stay active in recovery to convert external motivation to internal motivation and learn new behaviors. This conversion can take up to a year or longer.

Goal: Consequences in Case of Relapse
The written document should also include a plan in case of relapse (consequences for negative behavior).

<u>Content</u>
A comprehensive program of activities after treatment is another reason for the high recovery rates for pilots and physicians. Here is what Chuck Rice, a counselor at Hazelden, had to say about lawyers (another, at-risk population):

> *My experience with attorneys tells me that long-term outcomes are dramatically improved when lawyers can be monitored and when there is an accountability system with a fair amount of external support.*[13]

The same is true for the wealthy and prominent, and, in fact, anyone leaving treatment. The following discussion covers areas to consider in creating an effective plan:

Comprehensiveness
Make sure the post-treatment program includes all activities needed to support and sustain recovery. There is a good chance the program will be comprehensive if there is adequate communication with family members and professionals, and the assessment and treatment plan have been tailored to the individual patient (see below). The pilot/physician programs are useful templates for the plan's core elements.

Accountability
Another question is whether there is an "accountability system" in place. Such a system involves at least one knowledgeable person able to engage in effective oversight to assure the alcoholic or addict in early recovery is following the program. This person must know both alcohol and drug addiction and the particular culture of the patient, whether it is a family business, wealth or prominence.

External Support
External support means counseling support, leverage, and/or pressure to follow through on engaging in identified activities in the post-treatment plan over time. Structure, support and accountability keep the addict engaged in the group and individual therapeutic process long enough to gain insight into underlying drivers of addiction.
Because the addict is used to quick fixes, regular attendance at groups and individual counseling sessions will need to be monitored closely.

<u>Post-Treatment Plan in Writing</u>
Pilots and physicians sign a comprehensive contract after leaving treatment, which promotes accountability and communication between participants. Having the patient sign off on the plan prior to leaving treatment is also useful. Too many times an addict in early recovery will say, "I never agreed to do that!" Written agreements breach this line of defense.

5. Identify Relapse Prevention Strategies
An additional component of post-treatment planning is relapse prevention. Some treatment centers do not discuss potential relapse issues with their patients, believing it is better to think positively. We disagree. The addict's default status is to use, not abstain. Once the physical detoxification is complete, addiction is a disease of the mind. It is thinking and emotions that need to be managed for successful recovery. Without ongoing intervention, the mind will "think it's way back to a drink."

Since relapse is always a concern, the better course is to help patients identify potential relapse issues and work with them on ways to successfully address vulnerable areas. Remaining in remission requires active intervention in the disease. Let's look at two areas where prevention strategies are effective: specific situations and general factors.

<u>Identifying Situations with Potential for Relapse</u>
Knowing how relapse occurs helps identify situations to avoid until recovery is solid.
Relapse Factors by Gender:

- Men who report positive feelings prior to relapse tend to relapse alone and refuse to attend groups (such as therapy).
- Women report negative emotions and personal interactions as preludes to relapse and tend to do so with a romantic partner or female friends.

Paying attention to this information means consciously steering clear of these dangers.

People, Places and Things – Environmental "Cues"
The people, places, and objects associated with drinking or using are triggers at an emotional level for the addict.[14] These triggers operate on the non-thinking level and are conditioned by the connection between the environmental event and the drink or the drug. Again we quote Steve Olson:

After a while, people tend to associate certain places and feelings with alcohol. In fact, social expectations can be so strong that they affect biological processes, in that people can begin to crave alcohol simply when they walk into a bar.[15]

Examples:

- Going to the country club, playing golf, and the "19th hole."
- Socializing after work or at benefits.
- Discussion with parents or spouse about money and past behaviors.

The addict in early recovery must avoid these situations until he/she learns how to change his/her response to these cues or learns coping mechanisms for uncomfortable feelings. Some people are not able to change their responses to certain environments or interactions and therefore, cannot safely be in those situations under any circumstances.

<u>General Relapse Factors</u>
Post-treatment plans need to take into account three general areas leading to relapse:

Declining motivation after in-patient treatment
After inpatient treatment, motivation to continue recovery activities decreases. Alan Leshner, a former director of the National Institute on Drug Abuse states:

> *Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction.*[16]

Of course, the problem is that many people will not attend continuing care groups, see counselors or engage in other recovery activities.

Resuming Activities
Upon leaving treatment, many patients want to resume normal activities to show they are "OK," simply not drinking or using. Others feel they must make up for lost time by generating as much income as possible. "Workaholism" may become the new addiction.

Stress
Stress can lead to relapse. The generator for stress in the affluent and prominent is often individualized and situational, although there may be common patterns known to the experienced counselor.

The highest priority for at least six months after treatment is to attend recovery activities; limit workloads and social activities; and avoid stressful situations. This is one area where contact and support from addicts in recovery with similar backgrounds is helpful in providing guidance, as their experience is an invaluable resource. However, outside pressure is much more effective as a means to obtain compliance with post-treatment activities and limitations.

<u>Resistance by Treatment Centers</u>
Except for pilots and physicians, our post-treatment and relapse prevention recommendations tend to be novel ideas for most treatment centers so expect resistance. Because treatment is paid for in advance, there is no monetary leverage to use on the center. Rather the leverage is on the patient to agree to a written plan as a condition for receiving funding, returning to work, or otherwise accessing family resources.

SECTION B:
What Leads to Successful Treatment Outcomes

1. Importance of the Quality of the Therapeutic Relationship

Find treatment centers that place importance on the therapeutic relationship. This means choosing centers with experienced counselors who are allowed to spend time in developing a trusting relationship with their patients.

Trust Leads to Change

By gaining confidence in the counselor, the patient is able to listen and on an emotional level begin to understand that a new way of living is possible. Research has found that the counselor/patient relationship is very important to the recovery process. In fact, studies have also shown that:

> *It is through the **patient gaining trust** in his or her counselor that the patient is willing to try new behaviors and to look at life experiences from new perspectives.*[17]
>
> *… research finds again and again that it is the quality of the relationship between client and therapist that emerges as the most primary part of the healing process.*[18]

Some treatment centers support the therapeutic relationship as a significant part of the healing process. Others place more emphasis on an informational approach using educational materials.

Experienced, Empathetic Counselors

Counselors for affluent and prominent patients must be experienced and willing to work with this population group. In addition, they must be able to adjust and match their counseling skills to the learning styles and psychosocial attributes of their patients. Here's an example concerning lawyers:

> *Lawyers need fairly sophisticated counseling…. They don't react well to the old-school, just do it kind of approach. They're pretty detail-oriented. They're trained to analyze. They intellectualize. They tend to come across as argumentative, when in fact that's how they process new information. You need to be more willing to engage in a dialogue with them.*[19]

Finding treatment centers with the right counselors is difficult when low insurance reimbursement results in high staff turnover and low pay. Yet this must be done for recovery to take hold for the well-off/well-known addict. Turning again to the pilots and health care professionals model for guidance, their referents request they be assigned to specific counselors who have the skills, experience, and demeanor necessary to establish a trusting relationship with their patients.

2. Address the Clinical Needs of the Affluent and Prominent

A major flaw in treatment is the failure to validate the clinical needs of the affluent and prominent.[20] Many treatment centers see this group as having service needs – to be treated as special – but not having emotional vulnerabilities unique to their experiences of growing up with or creating wealth. While there are many clinical considerations, two prime examples are whether the assessment includes issues related to money and prominence and whether dual diagnosis issues are addressed in treatment or after treatment.

Comprehensive Assessments Must Include Clinical Factors Unique to the Well-Off and Prominent

The assessment process at some treatment centers overlooks key information regarding economic relationships, family interactions, dependencies, and upbringing. This may be the result of inadequate assessment tools or unwillingness to ask the right questions. For example, when a patient raises a concern involving money, he/she may be told by the counselor not to talk about it. Not only does this response limit understanding of what drives the addiction, but also it reinforces the patient's shame about money.

Normal assessments include social, medical, educational, sexual, vocational, family, substance use, and criminal history. Family members, therapists, and advisors must take the initiative and provide this information on intake, and if needed, throughout treatment. It is common for patients to omit information regarding financial support from trust funds, parents or a family business, instead claiming they rely solely on a job for their income. Another example is reluctance to acknowledge prominent relatives.

Sequencing Therapy For Underling Conditions Driving the Addiction

In treatment, one approach is to stabilize the addiction and work on underlying conditions later on. A second approach is to work on stabilizing the addiction and gaining insight into the drivers at the same time. An article found in the *Counselor* magazine for addiction professions says:

> *A few wise therapists realized that once a patient developed solid recovery tools, they could safely probe more deeply into the patient's psyche. For these patients, a phased type of approach has been useful. For many other patients, the uncovering therapy and acquisition of recovery skills needs to happen simultaneously. These patients require a treatment plan that understands the underlying issues that drive the addiction. They need to understand the secondary gains represented by the addictive behaviors.*[21]

This point is not merely an argument over which approach is better. Many people can't get sober unless underlying conditions are addressed in treatment (since these conditions trigger relapse). If a treatment center postpones looking at underlying conditions until after treatment, a patient needing to do so will experience difficulty in recovery, particularly with a poorly written or implemented post-treatment plan.

Affluent and prominent patients can leave treatment with clinical needs overlooked and untreated. While this can happen for pilots and physicians, their clinical needs are identified and addressed in treatment and in post-treatment plans. In fact, they usually have specialized groups that meet during treatment.

3. Treat the Underlying Drivers of Addiction

Outcomes are improved when treatment centers identify and treat the underlying drivers of addiction along with the addiction in an integrated model:

- Some treatment centers focus primarily on the physical component of addiction, viewing the goal of treatment as reducing or eliminating the use of alcohol or drugs.
- Others segregate addiction treatment and mental health treatment.

In this discussion, the question is if underlying conditions are addressed at all in treatment, and if so, whether they are addressed together with the addiction or separately.

Addiction Has a Profound Psychological Component

While the arguments above may seem technical, they are not. Addiction is more than just physical dependence on a drug. It has a very strong psychological component as well. A noted addiction expert on this issue states:

> *My experience says that addiction to alcohol or any other drug is hardly ever just physical – like a disease – but involves a psychological component as well. What drives the addiction is significant.*[22]

Addiction involves the biological, psychological, and social areas of a person. Experts refer to this idea as the "biopsychosocial model" of the disease. The "drivers of the addiction" are the psychological and social components of this model, as distinguished from the physical need for the drug or drink. In addition, assessments must include clinical issues unique to the affluent and prominent (as they do for pilots and physicians).

Drivers of Addiction Promotes Understanding and Responsibility for Change

Cessation of alcohol or drug use is the first priority for any model for recovery. However, the more comprehensive model incorporating underlying drivers works better for the affluent and prominent. Focusing on the physical element may not result in long-term change. In fact, Dr. Levy, a specialist on addiction, states:

> *One should be wary of models that tease apart the "bio," "psycho," and "social" aspects of addiction to the exclusion of the other parts. This is strategically important for avoiding buying into the patient's delusional system that protects their personal responsibility for change. For example, the media has tended to oversell the biological basis of alcoholism as holding hope for a "cure."*[23]

Knowing which approach is used by a treatment center is a significant step towards treating what originally made alcohol or drugs a "solution for problems" and future relapse prevention strategies. The underlying drivers of addiction approach will identify vulnerabilities and include them in the treatment plan during and after inpatient treatment.

Overcoming Hopelessness

Without considering underlying causes of addiction, relapsing addicts often feel helpless in the face of their continued use despite their best intentions when entering treatment. This cycle of hopelessness can lead to overdoses or suicide because during the treatment process, the addict has received little or no understanding of the forces driving his/her addiction (one reason for writing this article is to explain why this happens and to help prevent future losses). Similarly, exceptions to the high recovery rates for physicians and pilots are usually those with unidentified or unresolved underlying conditions.

4. Effective Treatment: Without Major Co-Existing Mental Health Issues

Effective treatment can occur once the treatment center has gained an accurate and complete understanding of the patient and identified underlying drivers. Treatment for patients with no major co-existing mental health issues is discussed in this section. The following section then will discuss those with major co-existing mental health issues.

Treatment for Addicts Free of Major Co-existing Mental Disorders

The affluent or prominent patient without significant co-existing mental health disorders, such as trauma, depression, or personality disorders, still needs to engage in a process of changing their addict attitudes and behaviors toward recovery attitudes and behaviors. The problematic

behaviors of alcoholics and drug users without significant, co-existing mental health disorders can be explained as part of their addiction. When solidly sober and following aftercare plans, the addict's behavior changes and they begin acting responsibly and humanely. Research shows that:

> *Employed, middle-class patients…with intact families, jobs, and who were relatively free of mental disorders tended to do well after rehab if they followed their aftercare plans. In these settings, the patient's problematic behaviors were viewed as stemming almost exclusively from the progression of their addictive disease… For the vast majority of addicted people, when they sober up and find a way to stay sober, they change their values and become human beings again. They start using the ethical codes that they should."*[24]

The behavioral and ethical change referred to is a psychodynamic process, although not involving the degree and depth for those with co-existing mental health disorders. In this context, there are four areas to consider regarding treatment for the well-off and well-known:

<u>Sobering Up with Self-Revelation, Awareness and Acceptance by Peers</u>

To assist in gaining self-awareness and changing values, traditional treatment incorporates specific steps to help the patient identify and admit negative actions. In doing so, feelings of remorse, guilt, and shame are common due to the realization that past conduct violated ethical standards, hurt others, or led to economic and interpersonal losses in that:

> *The real cure for shame is a gradual willingness to expose to others what you are most ashamed of, and the discovery that you will not be cast out for making your shameful self known—that you are still a member in good standing of the human community. You are acceptable for who you are.*[25]

Being accepted by peers for who you are, regardless of past conduct, is the outcome from such self-revelation. Often this occurs in telling one's story, or in having heart-to-heart interactions with other patients (peers). This begins the transformation to recovery.[26]

<u>Money and Prominence as Barriers to Self-Revelation</u>

Many affluent and prominent patients find it difficult to talk about money, upbringing, lifestyle, family business, or similar experiences for valid reasons:

- Without doing so, the patient fails to make a genuine connection with others, or if accepted by others, the acceptance occurs under false pretenses, with shame intact. In addition, edited and restrained disclosure limits patient's self-awareness and inhibits new insights as to using actions and attitudes.
- By not talking about an issue for fear of generating resentment, exploitation, or simply becoming a loner within the group, the benefits of honesty and insight are lost, often leading to relapse.

Being open about one's life is an area where the patient's counselor has a key role in helping the patient work through fears and learn protective disclosure skills.

<u>Success and Low Self-Esteem</u>

Even with enormous success, almost all addicts have very low self-esteem, which must be acknowledged, identified, and addressed in treatment. Writer, Sue Erickson Boland, provides personal insight into her experience with her famous father:

> *Fame is not a successful defense against feelings of inadequacy. It only appears to be.*[27]

These inadequacies become glaringly self-apparent during the first few days in treatment, whether it may be fame, money, beauty, or athletic prowess that is the outward manifestation of success.

Being well-off or well-known can create the illusion that money can minimize or cure the addiction, which can then act as a barrier to engaging in recovery activities. This illusion is easily reinforced by the reactions and attitudes of other patients and staff who believe that money and success reflect a life without many underlying problems. Quoting Ms. Boland again:

> *Great talent, then, leads to recognition on a grand scale. And, of course, it is gratifying to be able to command the attention of large numbers of people with a display of one's special gifts and abilities. No matter how successful the performance — the original wound remains unhealed.*[28]

Another counseling task is to help the patient see how success, money, or fame can easily become a self-image, part of whom one is, and relied on in ways that prevent real awareness. In this context, it is authentic interpersonal encounters that lead to real self-esteem:

> *If enormous success like my father's is not a reliable cure for feelings of inadequacy, then what is the road to self-esteem? I would propose that self-esteem is experienced in the context of authentic interpersonal encounters in which the self is revealed and acknowledged rather than obscured by idealized self-images. This is the model of a truly intimate interpersonal relationship…*[29]

With the right therapist and treatment center, the patient can begin to talk about fears and vulnerabilities and connect with other patients in ways that support recovery.

<u>Overlooked Trauma of the Affluent</u>
Growing up and living with money, prominence, good looks, success, etc., can lead to significant trauma.[30] These experiences may then create co-existing mental health issues that are overlooked in treatment, leading to inadequate treatment and post-treatment services. This trauma can be undiagnosed because the patient may not identify or disclose it, the assessment process may not include these areas, or the counselor may not inquire about these complex subjects.

5. Effective Treatment: <u>With</u> Major Co-Existing Mental Health Issues
Over fifty percent of addicts have significant co-existing mental health issues. These co-existing mental health disorders are also described as Axis I and Axis II disorders:

- **Axis I:** *Co-existing Clinical Disorders (Mood, Anxiety, Dissociative, Eating, ADD, PTSD, Learning, etc.)*
- **Axis II:** *Personality Disorders*

Patients with significant co-existing disorders are treatment resistant and relapse prone with poor outcomes. Because the dual disordered are so difficult to treat, this section will outline an approach to treating these patients, which provides hope for their long-term recovery (this section is derived from a paper by Goodman and Levy[31]).

<u>The Psychodynamic Approach Improves Chances of Recovery</u>
Understanding the psychodynamic aspects of addiction improves the chances for recovery. This is why the biopsychosocial approach to treatment is more successful in the long run. For both Axis I and Axis II patients, the emphasis is much more on the psychological and social models

of treatment, as well as the patient's individual experience, rather than a medication, symptom identification approach. Building stable recovery for this population group is much more than finding the right therapeutic drug!

Long-Term Support and Clinical Care is Needed

Addicts and alcoholics with more severe co-existing disorders are often in trouble out in the community and in traditional treatment. Research has shown that:

> *...the treatment resistant, relapse prone patient, with Axis I and II disorders, was unable to thrive outside such a setting and often got himself in trouble while inpatient at rehabs…These patients require much more intense clinical care over a substantially longer period of time…They move easily between "addictive careers" and "rehabilitative careers," precipitating crisis after crisis, usually dropping out of treatment prematurely on repeated occasions.*[32]

In today's insurance driven treatment centers, there is the tendency to turn a blind eye to the implications for recovery of the underlying multiple problems of the patient with the Axis I and Axis II diagnosis, even when identified in the assessment or intake process by facilities purporting to serve patients with co-existing disorders.

Providing Treatment to Resistant Patients

Such patients remain unchanged by a "psycho-educational approach" (be wary of treatment centers that use this approach as a primary component of treatment).

- Psychotherapy is useful, but must take place outside the therapist's office in a group setting.
- And it must occur with appropriately trained staff.

These patients require much more intense clinical care over a substantially longer period of time.

Assuming these conditions exist, families can expect stable recovery:

> *...the higher functioning patients with personality disorders and co-existing clinical disorders there is hope for a stable recovery when family, vocational, educational and peer pressure are applied.*[33]

The goal is to uncover the psychic pain and maladaptive patterns of thinking, feeling, and behaving that are at the core of the addict, and lead to repeated relapses and failure of self-care. These patients may do better in treatments with open-ended stays, rather than fixed time periods. In doing so, they must be active in recovery in order to graduate to less intense levels of services.

Suggested Treatment Approach

It is critical to consistently implement the "cardinal rule in dealing with addicts": i.e., judge them based on their actual behavior and not what they say. Program concepts include the following:

- Trust must be demonstrated and earned, not assumed.
- There must be consequences, both positive and negative, in order for addicts to learn from their experiences.
- Continuous feedback among and between patients and staff is essential.
- The value of honesty is fostered at every turn.

- Peers in treatment learn to become responsible for confronting another's negative behavior. The goal in identifying negative behavior is to understand the forces driving it.

Both feedback and consequences need to be immediate. In this setting, the patient learns to connect thoughts, feelings, and actions so that fundamental emotional deficits can be understood before they lead to relapse.

Unity Between Family, Treatment Center and Family Advisor

Feedback between staff and families should be continuous to prevent the patient from splitting them. The treatment center must view family members and their expert advisors as part of the treatment process. The well-off patient may try to access resources from the family in order to avoid consequences for his or her behavior or to leave treatment. The patient can do this by exploiting his/her disabilities as well as their long-established interactions with parents and others. This means the treatment center must be pro-active regarding family input, not merely passive recipients.

Stand Firm with Help

The family advisor plays a significant role in making sure the family is standing firm on agreements made with the patient and withholding access to resources. This role involves being available to the family to work through their feelings and fears. The advisor also plays a role in identifying and maintaining pressure on the addict to follow the recovery plan. Drs. Levy and Gordon advise:

> *The more that can be put in place to forestall the repetitive compulsion of past failures and aborted treatments the better.*[34]

The more therapeutic leverage, the better. That is the rule to follow for these patients.

SECTION C:
The Importance of Effectively Including Families in the Recovery Process

1. Families are Powerful Allies in Fostering Recovery
Another factor in the success rates of pilots and physicians is the active and constructive involvement of their employers regarding treatment and post-treatment. Similarly, for the affluent and prominent, effective communication by treatment personnel with key family members, advisors, and addiction professionals is critical to sustaining recovery. In fact, as Susan Cheever observes in her book about Bill Wilson, co-founder of Alcoholics Anonymous:

> *Families neither cause nor cure addiction. However, they can be powerful allies in fostering recovery.* ***It is an essential part of the clinical mission*** *to draw these families into treatment planning and execution.*[35]

Families and other influential people in the life of the patient can only be "powerful allies" if they are incorporated in the process. Families are resources for assessment and treatment planning, particularly as to information the patient may be reluctant to disclose. They also must be included in post-treatment planning when they are funding recovery, controlling access to resources, reemployment, or in a relationship with the patient.

Successful Families: Like The Balance of a Tightrope Artist on a Bicycle
Here is how Susan Cheever describes the family's role in her biography of Bill Wilson:

> *The balance that* ***creates*** *a successful family around an alcoholic is trickier than the balance of a tightrope artist on a bicycle. Families of alcoholics must both separate themselves from the alcoholic and involve themselves intimately with the alcoholic, and they must do so at the same time.*[36]

Substitute the words "advisor," "family business" or "trustee" for family and the same prescription applies. The key word here is *create,* because the sought after balance is a learned phenomena, on-going and evolving. What is needed at day one is different at day 10, 20, 30, 60 and so on. Ideally, learning occurs with support by a therapist specializing in addiction as well as interactions with the patient's counselors.

Few Treatment Centers Include the Family in Treating the Addict
Another problem is that while every treatment center says it promotes family involvement and communication, few actually perform as promised. The following comment reflects contemporary practice:

> *Alcoholism/addiction has been characterized as a "family disease" since the mid-20th century.* ***That rhetoric continues today, but there is little evidence that such beliefs permeate clinical practice.*** *If we really believed that addiction was a family disease, we would not assess, treat, and provide continued support services to individuals in isolation from their families, we would instead deliver family-oriented models of engagement, assessment, treatment, and continuing care.*[37]

Communication with family members, employers and even outside therapists is often perfunctory and when it does occur, has almost no influence on treatment planning, which happens within three or four days of entering treatment. To address this treatment defect, one expert suggests assigning a staff member as advocate for families:

> *It is useful to consider having a skilled and sensitive staff member whose sole responsibility is to act as family advocate.*[38]

We couldn't agree more, as we have spent countless hours attempting to communicate with counselors and administrators. Adding insult to injury, one would think centers would be more responsive to those paying the bill, but this is not so.

Pilots and Physicians Programs' Oversight Communication

Counselors at centers treating pilots and physicians must communicate with employers and oversight professionals. Families and their advisors need to be more assertive in fulfilling this role in recovery of their loved ones. Families need to be aware of how vital it is to use treatment centers that clearly articulate their commitment to communication and are willing to set up specific times to do so, such as phone dates. If communication is poor, families and advisors can call marketing representatives and the administration to complain.

2. Why "Letting Go" or "Doing Nothing" Can be Dangerous

Our advice regarding the active and constructive involvement of family members flies in the face of information given by treatment centers, therapists, Al-Anon, and other well-meaning people. Families and advisors are often told that they are "powerless" over their loved one's addiction and must "let go". Similarly, concerned persons are told their loved one must "hit bottom" before wanting to stop and enter treatment or attend A.A. This advice can lead to at least three negative results:

It takes too long to hit bottom and is dangerous

- The concerned persons do nothing in regard to their loved ones' or beneficiaries' alcohol and drug use, simply hoping for the consequences of such use to lead to the "bottom".

Waiting can take a very long time for someone with money or other resources.

Support systems continue when they should be cut off

- The passive monetary support and other resources enabling use continue to be in place with no changes.

This passive system must be terminated.

Harm to self, others, and wasted assets

- The failure to intervene at an early stage in the disease decreases the ability to recover, hurts others (such as children), and wastes resources.

Take action before the progression leads to economic and personal harm and decreased ability to grasp the emotional and spiritual elements of recovery.

Distinguish Between Emotional Enmeshment and Tangible Leverage

One common theme throughout this pamphlet is an explanation of how and where "power" can be appropriately and effectively exercised when intervening in the disease process. We recognize the importance of decreasing emotional enmeshment with the alcoholic/addict when using or in early recovery. We wish to contrast this lessening emotional enmeshment with using tangible leverage, consequences, and rewards. Because "riding this bicycle on the tightrope" is so difficult, we firmly believe in the active involvement of a knowledgeable outside professional to assist family leaders and advisors throughout treatment and recovery.

We believe an important goal of recovery is to transform unhealthy relationships and dependencies into healthy ones. What we suggest in this article are techniques to do so, not the

end game or ultimate results of recovery. The transformation occurs in the context of core concepts that seem to govern addicts within wealthy family systems.[39]

3. Obtaining Consent for Release of Information

A common reason given by treatment centers for the failure to communicate is the patient's unwillingness to sign a release of information. While the treatment center is obligated not to communicate without a release, the lack of one can be overcome by using outside pressure or through persuasion by the patient's counselor to sign a release.

Parents and advisors have legitimate, therapeutic reasons for open communication between each other and the patient's counselor.

- **Reverse the Pattern of Secrecy and Misinformation**

Because addiction, secrecy, and dishonesty go hand in hand, concerned persons must insist that their relationship with their loved one in recovery be based on honesty and disclosure. Being truthful and open is of utmost importance when a profession, children, money, or other resources and relationships are involved.

- **The Patient is a Vulnerable Adult and May be Otherwise Dependent**

People in treatment for alcohol or drug use are vulnerable adults. As such, concerned relatives need to be aware of how treatment is progressing for oversight purposes. Moreover, there may be other dependencies warranting communication. Economic dependence is common. For example, the patient may be an adult in age and appearance, but from an economic (and likely psychological) perspective, the patient is not self-sufficient.

- **The Pilot and Physician Experience: Quid Pro Quo for Access to Resources**

Pilots and physicians must sign consents to release information from the treatment center to their employers and oversight boards. These consents allow communication as to treatment progress and post-treatment requirements with the family and/or employer. Failure to do so results in continued license suspension and employment termination. Similarly, for the affluent in treatment, consents for the release of information must be signed as a condition for receiving funds, access to resources, or employment, or participation in family related enterprises. A signed consent is a non-negotiable item, but as mentioned above often leads to resistance by counselors.

Are Requests to Sign Releases Coercive and Counter-Therapeutic?

Counselors may say that because the patient is an adult, she/he should not sign a release as such information sharing promotes dependency. Furthermore, it has been suggested that conditioning money, employment, etc. on releases is a form of "blackmail" or inappropriate control. One parent, when hearing his adult child take this position said, "Fine, let your counselor pay your bills, but I am not authorizing any more distributions." Some counselors go so far as to say that requesting releases interferes with therapy, recovery, and/or triggers childhood trauma. This usually results in the therapist and patient aligning against the family. While this alignment may make the therapeutic relationship in treatment more convenient for the counselor, it can jeopardize the prospects for abstention because of unresolved family conflict about money or other issues.

Counselor Awareness About Money

In our experience, few counselors are comfortable talking about money and prominence. Fewer still understand how intimately they are tied up in the addiction and other dysfunctions of the

well-off or well-known patient. It is far easier to reject the conversations as “anti-therapeutic” or “controlling,” than to use the situation as an opportunity for the patient to gain a better understanding regarding his or her relationship with money. Becoming familiar with the patients financial status gives the therapist an opportunity to gain insight into the family system and to begin the conversation in family therapy about separating economic/prominence issues from relationship issues (for most wealthy families these are intertwined). To aid families in communicating with treatment centers and counselors, we offer the following points concerning the therapeutic benefits of requesting releases:

- **Same Rules Apply to the Wealthy as to Others**

First, when money or other resources are transferred to another person, there is the expectation of accountability as to their performance in handling the money. No employer, airline, or hospital would continue to employ an identified addict without knowing information about treatment. It should not be any different for a parent or trustee that is supporting their loved one. The choice for the addict is to accept or reject the money. This is a reality check for the patient who is now being governed by the same rules as employees. The therapeutic task is to help the patient with his/her reactions (anger), not to reinforce an attitude that says the patient does not have to function under the same rules as the rest of society.

- **Continuing to Write a Blank Check is a Definition of Insanity**

Second, family members have legitimate concerns about the behavior of the addict. Given their pre-treatment activities, attitudes, and dysfunctions, no responsible parent or trustee would continue to support a loved one without information about treatment and post-treatment recommendations. The therapeutic task is to help the patient identify these behaviors and understand why parents would be worried and unwilling to continue funding. When the family says, “We can no longer support you in your addiction and we want to know about your recovery as a condition of funding,” this signifies sanity, not pathology. Continuing to sign a blank check without accountability perpetuates the addiction and fails to change the relationship between the addict and the supplier of funds.

- **Ending the Mishandling of Money**

Third, usually addicts are unable to manage their spending habits. Spending in excess of income, supporting people whom make using and other dysfunctional behavior sustainable, and lying about requests for advances, loans or extra distributions are commonplace. The threat to terminate funding is a good opportunity for the therapist to suggest that the patient look at how he/she has spent money in the past and how it might be improved in the future. The threat of cutting off access to money is also useful because it is likely parents or trustees will ask the patient to prepare a budget, be accountable for expenditures, or limit funding as a condition for continued support. These requests can be shocking to patients who are used to spending freely with no oversight.

- **The Role of Money in the Addictive Process**

Fourth, counselors may be ignoring the role of money in the addictive process and in supporting dysfunctional behavior. In our experience, the threat to terminate or limit funding is an opportunity for the patient to see how having and spending money is either a mood altering experience or intimately connected to using. It can be a stimulant or a depressant for the addict. This subject is too complex to thoroughly address here,[40] but counselors should encourage rather than object to termination of funding since money and addiction are a deadly

combination. It's time for the patient in early recovery to start developing a new and healthier relationship with money.

- **The Opportunity For Spiritual Growth**

The final observation for counselors is that the threat to terminate funding is an opportunity for the patient to explore his/her attachment to money and the material world. The progression to sobriety is about changing the focus from material to the spiritual.[41] If the patient's existence is tied to money, it is a sign that money is more important than recovery. By identifying the role of money or other material attributes in the life of the patient, the counselor has a good understanding of impediments to sobriety.

Our goal is for counselors to view requests for releases of information as benefiting and not hurting early recovery. In our experience, treatment center administrators must place a high priority on communication in order for it to be implemented by staff.

SECTION D:
Recognizing Bias Against the Well-Off and Prominent as a Recovery Barrier

1. "Wealthism:" Resentments by Patients and Staff Against the Well-Off
When it's not safe to talk about what is really going on, men and women will find ways to protect themselves by isolating or accommodating to group norms. Their focus is on survival, not taking risks to develop the intimacy skills and relationships needed to recover. Patients leave essentially untreated, but tell themselves they have been through treatment. Let's look at four areas concerning bias:

Wealthism
While most populations are off limits in terms of jokes and negative comments, targeting the affluent seems to be open game. This is termed **Wealthism**.[42]

- Prejudice towards wealthy people. It includes actions or attitudes that dehumanize or objectify wealthy people. Common expressions of wealthism are awe, envy, and resentment.

While in open society, the affluent expect negative comments and are usually well guarded (although often reinforced by alcohol or drugs). However, in treatment, feelings are exposed and bias by peers is hurtful and reinforces defense mechanisms. Some well-off patients may have negative views regarding their wealth and/or status. Patients with this self-directed bias may be reluctant to acknowledge or discuss money and prominence concerns with their counselors or peers.

Resentment from Counseling Staff with Unresolved Money and Prominence Issues
Some counselors have unresolved issues around money and are unable to effectively counsel patients who are successful or come from money or prominence. This inability to be therapeutic includes the withholding of counseling skills to intercede in expressions of bias in groups and peer settings.

- Helping the affluent set boundaries with peers is a crucial part of the counseling process. This becomes a heightened concern when other patients are asking for loans of money, clothes, or other benefits from the well-off.

Without the affirmation and support of an empathetic and supportive counselor, the patient feels isolated, alienated, and afraid to ask for help.

Safe Spaces are Needed to Allow Change
Successful recovery is dependent on talking about personal experiences and feelings. According to numerous studies:

> *A vital part of the therapeutic process is the admission of past behaviors for which one carries guilt and shame, and facing both the facts and the painful emotions associated with them. This is the spiritual part of recovery and is practiced by most addiction programs whether they make use of 12-Step recovery principles or not.*[43]

For alcoholics and addicts, this process first occurs in treatment with counselors and members of his/her treatment group (peers). However, if the patient does not feel the environment safe to reveal information, he/she will be reluctant to be fully forthcoming and only partially disclose or make up an acceptable story line. Creating a supportive environment is particularly important, as research shows that a positive therapeutic milieu promotes recovery.[44]

Being Accepted for Who You Are

A low bias setting is critically important for the well-off and other exceptional patients such as the prominent and the beautiful. Being accepted for who you are is the beginning of recovery:

- The essence of recovery is telling deep, personal experiences with alcohol or drugs to other alcoholics/addicts and being accepted for who you are. These experiences are primarily internal, emotionally based, but occur within the context of each person's life.

The relationships needed for strong recovery depend on intimacy:

- The ability to talk freely creates intimate relationships, which lets others know what is going on inside. A creative pun on the word "intimacy" is "in-to-me-see," which describes the previous thought perfectly. Self-revelation lets others know what is going on inside.

A common A.A. slogan is that this is a "We" program. The first step says:

> *We admitted we were powerless over alcohol, that our lives had become unmanageable.*

Alcoholics and addicts recover together, not by themselves. This means being able to identify with and become integrated into a group that is recovering.

Look for Treatment Centers that Work Well with the Affluent and Prominent

While this seems like a straightforward concept, finding centers that treat this population is difficult. The ideal setting is one where bias is acknowledged as a valid concern by program supervisors and counselors, and patients receive support regarding clinical issues relating to disclosures and patient reaction.

2. Failure to Adequately Treat "High Bottom" Patients

Not only is there potential for bias against the affluent addict, there may be prejudice against those in treatment and post-treatment who still have lives partially or fully intact. When A.A. first started, the thinking was that alcoholics had to lose everything in order to want to stop drinking. Only when people who had not lost everything joined A.A. did the founders realize this was not always the case.

They Stopped in Time

The result was a second edition of the Alcoholics Anonymous book, with an additional set of stories, and a preface with the heading *"They Stopped in Time"*. The preface for these stories reads:

> *Among today's incoming A.A. members, many have never reached advanced stages of alcoholism, though given time, all might have... Why do men and women like these join A.A.?...*
> *They saw that they had become actual or potential alcoholics, even though no serious harm had yet been done. They realized that repeated lack of drinking control when they really wanted control, was the fatal symptom that spelled problem drinking. This, plus mounting emotional disturbances, convinced them that compulsive alcoholism already had them; that complete ruin would only be a matter of time.*
>
> *Seeing this danger, they came to A.A. They realized that in the end alcoholism could be as mortal as cancer; certainly no sane man would wait for a malignant growth to become fatal before seeking help. Therefore, these seventeen A.A.'s and hundreds of thousands like them, have been saved years of infinite suffering. They sum it up like this,*

> *"We didn't wait to hit bottom because, thank God, we could see the bottom. Actually, the bottom came up and hit us."*[45]

Before alcoholics reach the advanced stages of alcoholism, they are referred to as "high bottom drunks". However, treatment protocol does not often distinguish between degrees or stages of alcoholism. Rarely is the quoted text given to patients nor is counseling directed at what it means "for the bottom to come up and hit us."

Counselor-Patient Disconnect

One reason for inadequate treatment for "high bottom" addicts is that some counselors did indeed lose everything and are biased towards those who still have a job, a house, and family. Attitudes may be expressed that the affluent or prominent patient needs to "suffer more," with the result being a withholding of assistance. Even when not biased, some counselors do not have the personal experience or professional training to know how to assist the patient in "seeing the bottom," i.e., what elements in the patient's life would help make the disease real. Both circumstances make it difficult for the affluent and prominent patient to feel heard and be helped by treatment staff.

SECTION E:
Conclusion: The Enormous Power of Addiction

1. Example: Bill Wilson (Investment Banker, and A.A. Co-founder)
Many family members and advisors underestimate the power of alcohol and drugs over the addict. A helpful reminder is Susan Cheever's description of Bill Wilson's drinking history:

> *In the years between his first and last drink, the years between when he was a twenty-year-old army officer and 1934 when he was a down-and-out drunk, Bill cycled through an entire alcoholic career, from the first euphoric moments to the last desperate beers. If the story of these years has a theme, it is the enormous power of alcohol over an alcoholic. Most alcoholics can't stop, ever. Most alcoholics die of alcohol-related accidents and diseases. Bill Wilson was an extremely intelligent man, a man with a great deal of personal experience with alcoholism and its path of destruction. He knew at first hand what drinking could do, and as a result, he had often said he would never drink. Yet he drank. When he began drinking, he saw almost at once what a toll it took on his young marriage. In a family of doctors, he was often told what the effects of alcohol might be on his brain, his liver, and his ability to hold a job. He lost job after job. Yet he drank.*
>
> *His wife's misery, her heartbreaking ectopic pregnancies, his mother-in-law's death, the Great Depression – all came and went as he promised again and again to stop drinking, and yet went on drinking. Bill knew as well as anyone can know how insidious and fatal one stop at a speakeasy could be. Yet he kept on drinking. His pledges in the family Bible became a joke; his morning-after promises were laughable. He did everything he could to hold a job. His work in the stock market had become his identity. Even after he had signed a contract with partners promising that if he drank he would lose everything, he reached for that jug of Jersey lightning.*[46]

"Most alcoholics (and addicts) can't stop, ever."
But look at the recovery rates for physicians and pilots!

> *We have seen far too many members of affluent families suffer unnecessarily from the disease of addiction. It is time to take a new approach to addressing addiction in our families, an approach based on the highly successful programs for pilots and physicians.*

You, as parent, sibling, advisor, trustee, family leader or business owner have the power to collaborate with professionals to insist your family members afflicted with alcoholism and drug addiction start down the path to recovery.

You can make the difference. It takes persistence, knowledge, professional cooperation, and skilled, willing treatment centers, but it can be done. We encourage advisors and family leaders to use the information in this article to become increasingly active in addressing addiction in family members and related enterprises.

Improving Recovery Rates for Affluent Addicts and Alcoholics

TWENTY ARTICLES

Introduction

A. *Our Family/Advisor Recovery Management Program For Affluent Alcoholics and Addicts*

1. Leverage First: Using Family Resources as a Positive Influence for Recovery

- Describes our Recovery Management Program, based on the medical board and airline programs. Contrasts the high success rates for pilots/physicians with the low (and misleading) outcomes rates promoted by treatment centers. Discusses addiction as a statistically probable disease to be anticipated and planned for by families. General overview of our ideas.

B. *Encouraging and Inducing Change*

2. Using Leverage to Support Sustained Recovery

- Explains how we modify the pilot/physician program when applying leverage to affluent alcoholics and addicts to improve outcomes. Describes fifteen differences between programs for pilots/physicians and programs for the affluent.

3. Change Strategies For Advisors with Low Leverage or Low Interest Families

- Advice on change strategies for advisors facing reluctance in client families to address difficult problems. Strategies range from education and risk protection to using the momentum generated by addiction related incidents to promote change.

4. Building Leverage into Governance Documents for Earlier Intervention and Stable Recovery

- Discusses a problem solving approach in dealing with family members exhibiting addictive or other dysfunctional behavior. Suggests language to include in family documents, the reasons underlying these suggestions and explains from a "stages of recovery" perspective why leverage must remain in place for many months.

C. *Systems Transformation to Improve Outcomes*

5. The New Treatment Model and Family Systems Transformations to Improve Outcomes

- Discusses why current treatment is ineffective and describes a new model derived from the pilot/physician programs. Reviews family relationships in affluent family systems. Describes 12 Core Concepts to consider in promoting recovery in affluent families.

D. *Improving Treatment for the Affluent:* ***Substantive Program and Clinical Issues***

6. Our Family/Advisor Recovery Management Program for Affluent Alcoholics and Addicts

- In depth review of the clinical needs of the affluent in treatment and in the context of applying the pilot/physician program model to the affluent. Explains why current treatment is inadequate and describes strategies to improve outcomes.

7. Families, Wealth and Addiction

- A new clinical approach to addiction, treatment and recovery for affluent families. Discusses barriers to finding and receiving effective treatment (four page overview).

E. *Advice for Families*

8. Flawed Family Assumptions about Addiction and Treatment: Information for Families

- Misconceptions by parents about treatment impede recovery for their adolescents and young adults.

9. Fifty Seven (57) Things I Wish I Had Told You When First Becoming Aware Your Loved One Has "A Problem"

- Written after a friend's child died five months after leaving treatment. This tragedy motivated the author to enroll in addiction studies school and become an advocate for improved treatment outcomes, using the pilot/physician model as a prototype for services to other groups*.

10. Advice for Parents of Adolescents and Young Adults

- A parent's perspective on the developmental impact of addiction and recovery issues*.

F. *Individual Blocks to Change: Childhood Experiences and Counseling Inadequacies*

11. How Childhood Experiences in Affluent Families Impede Change as Adults

- Counselors and family members must understand how these experiences negatively influence the addict's ability to benefit from treatment, including lack of trust and inability to connect with peers*.

12. Counselor - Client Relationship and Conditions Promoting Change

- Identifies blocks to recovery for the affluent in the treatment and counseling setting*.

G. *For Family Offices, Family Businesses, Trustees, Lawyers, Accountants and Advisors*

13. Trustees and Beneficiaries*

- *The Demise of Trustee Discretion and Ascertainable Standards as Effective Controls on Dysfunctional and Underperforming Beneficiaries"*[47]. Discusses ways beneficiaries access funds despite restrictions on distributions. Suggests language to include in trusts and other governance documents to address addictive behavior in family members (See Article 4, above).

14. 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*

15. 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*

16. Family Integration Services; the Key to Successful Succession Planning for the Family Business, Foundation and other Enterprises (with Larry Hause)*
- Families need much than sound legal and financial planning; they also need to make sure their relationships and roles are on a sound footing for the business to survive.

17. Functional Alcoholism Distinguishing Between Safe and Potentially Dependent use of Alcohol and Drugs*
- Reducing risk to family wealth and well-being by understanding contemporary medical definitions of safe drinking, at risk drinking and prescription medicine use, and definitions of abuse of and dependence on addictive substances.

18. 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*

H. *Lawyers and Law Firms*

19. 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)*

20. Bench and Bar Article
- *Lawyer Seeks Treatment, Boss Seeks Assurance* by Todd Scott, GPSolo Magazine October/November 2009

* Articles marked with an asterisk are in progress or being revised

---

Author Information

William Messinger, JD, LADC

Bill is the author of a series of articles for families on improving treatment outcomes. He emphasizes the effectiveness of the highly successful pilot and physician (PHP) recovery model when applied to other groups. Bill is also an expert on the intersection of addiction and family wealth, including modifications of trust documents to account for addiction. These articles educated family members on the treatment and recovery process and clinical issues unique to affluent addicts, as well as advice for family offices, advisors and trustees. Bill is a graduate of Yale University, University of Minnesota Law School, and the Hazelden School of Addiction Studies.

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.

For more information, please email us at info@billmessinger.com, or call us directly at 651.209.7670. Bill Messinger can also be reached directly at bill@billmessinger.com.
Find us online at www.billmessinger.com (www.NNAP.com is currently under development).

Footnotes

[1] In the Interest of Alcoholics Anonymous at Union Club. February 8, 1940. Digest of proceedings at a dinner given by Mr. John D. Rockefeller, Jr. Rockefeller Archives. New York City.
[2] Stephen Davis. What I Learned About Recovery. COUNSELOR, The Magazine for Addiction Professionals. Vol. 6, No. 2. April, 2005.
[3] William L. White, MA, and Mark Godley, Ph.D. Addiction Treatment Outcomes: Who and What Con You Believe? COUNSELOR, The Magazine for Addiction Professionals. Vol. 3, No. 3. June, 2006: p. 52.
[4] Ibid. 62. An abstract of the White and Godley article is at our website: wwwARPrecovery.com
[5] William White, MA and Russell Hagen, Treatment, Recovery, Community: A Call For Reconnection, COUNSELOR, The Magazine for Addiction Professionals. Vol. 6, No. 6. December, 2005
[6] Post-treatment Supervision, PO Box 2243, Scottsdale AZ 85252, 80%-90% recovery 5 years after treatment (12 year time frame); Occupational Medical Consultants, Minneapolis, MN, 90% plus recovery rates for physicians enrolled in their program. 92% to 95% recovery rates for pilots who go through an extensive rehabilitation process. Airline pilots soar to success in recovery. Hazelden Voice Vol. 3, Issue 1.
[7] Goodman and Levy. Biosychosocial Model Revisited. p. 3.
[8] Susan Merle Gordon. Relapse and Recovery: Behavioral Strategies for Change. Caron Foundation Report. 2003: p. 18.
[9] Ibid, p.6
[10] William F. Messinger. Questions for Parents to Consider, The Value of Using Licensed Addiction Professionals. www.arprecovery.com/keyinformation.htm.
[11] Steve Olson, The grand times and grim risks of student drinking, half full & half empty, Yale Alumni Magazine, Nov/Dec, 2005: p. 47.
[12] Post Acute Withdrawal (PAW), Excerpted from Terence T. Gorski with additions by Lee Jameson, as posted on TLC The Living Center website at www.tlctx.com (The Pacific Northwest Relapse Prevention Specialists)
[13] Chuck Rice. Impaired Lawyers Overcome Denial, Stigma to Achieve Road to Recovery. Hazelden Voice. Vol. 9, No. 2. Summer, 2004.
[14] Lesher, p. 5
[15] Olson, p. 47
[16] Alan I. Leshner, Former Director, National Institute on Drug Abuse. National Institute for Mental Health. Science and Technology. Spring, 2001: p. 2.
[17] Goodman, p. 17.
[18] Dayton, Dark Side of Wealth. p. 3.
[19] Rice, Impaired Lawyers.
[20] For clinical needs, see: Joanie Bronfman, Ph.D. Dissertation. The Experience of Inherited Wealth: A Social - Psychological Perspective; The Dark Side of Wealth. Tian Dayton, Ph.D; Sue Erickson Boland. Fame: The Power and Cost of a Fantasy. The Atlantic Magazine. November, 1999: 51-62.
[21] Goodman and Levy. Biosychosocial Model Revisited. p. 6.
[22] Biosocial Model of Addiction, COUNSELOR, The Magazine for Addiction Professionals. Vol. 4, No. 5. September, 2003.
[23] Goodman and Levy. Biosychosocial Model Revisited. p. 5.
[24] Ibid. p. 12.
[25] Boland. Fame. p. 61.
[26] William F. Messinger. Addiction as Transformation. www.arprecovery.com.
[27] Boland. Fame. p. 60.
[28] Boland. Fame. p. 61.
[29] Boland. Fame. p. 60-61.
[30] See Bronfman chapters on childhood and relationships.
[31] Goodman and Levy. Biosychosocial Model Revisited.
[32] Ibid. p. 12-13.
[33] Ibid. p. 14.
[34] Ibid p. 15.
[35] Ibid.
[36] Susan Cheever. My Name Is Bill. Simon and Schuster. 2004: p. 236.
[37] Davis. What I Learned About Recovery.
[38] Goodman, p. 15.
[39] See ARP's Twelve Core Program Concepts for Addicts/Alcoholics with Money and Prominence and their Families.
[40] See Footnote 21
[41] See Addiction As Transformation and Twelve Core Concepts (ARP Website)
[42] Bronfman. The Experience of Inherited Wealth. p. 353.
[43] Goodman, p. 20.
[44] Gordon. Relapse and Recovery. p. 19.
[45] Alcoholics Anonymous. Alcoholics Anonymous. Alcoholics Anonymous World Services, Inc. Forth Edition. New York City. 2001. p. 281.
[46] Cheever. My Name Is Bill. p. 119.
[47] Available on our website, at www.AureusInc.com)