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Addressing family entropy in the context of behavioural health challenges – a new paradigm of culturally competent and clinically excellent care

Paul Hokemeyer

Introduction

Over the last four years, global families and family businesses have experienced a host of external and internal disruptions that have diminished their holistic health.[1] External disruptions include COVID-19, climate change, humanitarian violations, border conflicts, currency devaluations and geopolitical events. During this same time period, these same entities have seen an uptick in disruptions from within. These include issues relating to a family member's mental health such as addictive disorders, anxiety and depression, relational disorders such as infidelity and divorce, and emergent identity manifestations that challenge the family's status quo. In this article, I use the umbrella term 'behavioural health' to describe these issues and provide an empirically based strategy to enable families to transcend them in a way that creates unity and a healthy identity through dignity and respect, repair and optimal functioning, order and adaptation.

A holistically healthy family

Through his work with multigenerational families, Dennis Jaffe, PhD found that "a generative family is anchored in two major achievements".[2] The first is the family's success in the quantitative aspects of wealth creation. These families have amassed an amount of wealth that defines them in the top tier of income and wealth holders known in financial circles as ultra-high net worth (UHNW) families.[3] The second comes after the wealth is created and is a function of the family's success in uniting around a shared sense of identity. According to Dr Jaffe, "after the family has generated [its] wealth, it commits resources, time, and energy to building a family that adapts over generations and has a strong sense of [a] shared identity".[4] Other family advisers have developed expertise in assisting UHNW families attain multigenerational cohesion and avoid the entropic drift[5] that occurs in families who fail to channel the energy inherent in their wealth in constructive ways.

As it relates to the first, families who remain generative utilise best-in-class financial advisers who help them navigate market turbulence and capitalise on financial opportunities. With regard to the second, the field of family governance has an esteemed group of professionals who have skills in helping families manage interpersonal conflict and enhance their communications through family bylaws and constitutions, philanthropic vehicles such as foundations, donor advised funds, family retreats and meetings. Central to the efficacies of these relationships is the family office professional (FOP). As the most trusted adviser in the family system, she or he is vested with the power and responsibility to ensure the family is receiving the best-in-class services that protect and repair a family's holistic health.

More recently, and in response to the entropic forces inherent in what has been referred to by the World Economic Forum as a crisis in global mental health,[6] innovative families through their FOPs have begun to seek out best-in-class behavioural health[7] professionals (BHPs) to include in their ecosystem. These BHPs help families navigate the chaos and disorganisation that occurs when a family member or generation of family members manifest behavioural health challenges that are inconsistent with the family's idealised narrative and cause them to orient around a pathologised family identity. This expansion of professionals in a family's ecosystem comes at a time when an emergent group of family members such as Generations X and Y as well as women from all generations are calling for a deeper appreciation of issues related to their personal wellbeing and the behavioural health of their families.

It also comes at a time of great need. Data emerging from the pandemic indicate rates of mental health and relational disorders increased exponentially over the last three years. According to a late 2022 study by the Pew Research Center, at least four out of 10 adults in the United States suffered from high rates of emotional distress during the pandemic.[8]

International data mirror these findings. According

to the World Health Organization, rates of depression and anxiety increased 25% worldwide during the course of the pandemic.[9] Most notable in these findings is that young people and women have suffered the most.[10] While these findings are disturbing, they have also had a positive impact on UHNW families and family businesses by expanding the definition of generativity to include issues related to family emotional and physical health.[11]

Family reactions that threaten its holistic wellbeing

When a family member manifests internal disruptions related to behavioural health, families can overreact and consciously and unconsciously attempt to shut down the manifestation by wielding their power in destructive ways. Three examples from my clinical practice where power was so used include an American family who threated to financially cut off a 47-year-old second generation daughter who suffered from an opioid addiction, a middle-eastern family who emotionally and financially disowned their 22-year-old son for exploring a non-binary gender identity while he was attending university in Paris, and a English brother who managed his twin sister out of a family real estate business when she manifested treatment resistance depression.[12] As I discuss in my book *Fragile Power* (Hazelden, 2019)[13] and other writings,[14] such harsh and unforgiving measures such as cutting a family member off from funds, forcing them against their will into residential treatment programmes and denying fundamental truths of their beings, result in significant damage not just to the individual who is manifesting the symptomology, but also to the family unit itself. Instead of empowering the patient, they shame them; and, instead of motivating them towards health, they punish them into deeper realms of their pathology by diminishing their internal motivation to change.[15]

My conclusions are based on my professional experience and the work of Alison Fragale and her colleagues at the University of North Carolina. Fragale *et al* (2011) found that to be effective and manifest positive outcomes, power must be used with status.[16] In explaining this calculus, Dr Fragale *et al* defined power as, "… the extent to which an individual can control others' outcomes by granting or withholding valued resources". They explain further that "… status (is) the extent to which an individual is respected, admired, and highly regarded by others". In defining status, Fragale *et al* found the "perceived warmth" of the person yielding the power was crucial to the effectiveness of their intervention and use of power. While Dr Fragale's work has historically been applied narrowly in the realm of business, I've found it to be of great value in the addressing the *mélange* of issues that arise in UHNW families when they are forced to deal with the internal disruptions from issues related to their behavioural health. An example from my clinical practice that illustrates this dynamic is as follows:[17]

Case study

Bushra is a 27-year-old cisgendered woman from a traditional Muslim family.[18] Born in Saudi Arabia, her family moved to India when Bushra was six. She attended an elite boarding school in Switzerland and completed an undergraduate degree in French literature from a selective women's college in America. When Bushra was about to graduate from university, her father, who had attained enormous financial success in the realm of mobile communications, sold his company for €4.6 billion and moved the family to Dubai. While Bushra knew her family had resources prior to the sale, she was catapulted into a new sphere of wealth when the sale occurred. Despite her attempts to get clarity around her and her family's wealth from her father, her two older brothers and the various other male financial advisers in her family's professional ecosystem, Bushra was continuously dismissed and told: "No need to worry. You never have to worry about money." She was also told by her mother: "Women of our stature shouldn't pursue paid work. It's beneath us." Relying on this advice, Bushra spent her days in leisure and her nights developing a poly addiction to OxyContin, Ambien and Veuve Clicquot.

I received an email from the FOP after Bushra fell down the stairs of their family home during Eid al-Fitr in a state of intoxication. The family, horrified by what they described as Bushra's 'antics', subsequently engaged a series of hardline tactics to force her into 'moral and religious' compliance. Unaware of the

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nature of substance use disorders and the mood disorders that frequently underlie them, the family was stunned to find their demands that Bushra comply with religious and cultural proscriptions only resulted in elevating her substance use and driving her further and further out of the family's sphere of influence. The family's most recent intervention, where the father, brothers and male advisers brought Bushra into a conference room and gave her an ultimatum to stop her substance use or be cut off from her trust funds did not go as planned. Rather than motivating her to step into line with the family's traditional cultural and religious identities, they shamed her and forced her deeper into the malignancy of her disease. Bushra left the meeting explicitly promising to comply with her family's requests, while simultaneously planning her exit from her family's control and influence. Three days later she booked a flight to London and holed herself up in her boyfriend's flat where she was threatening to jump out of the window.

In their email to me, the FOP and Bushra's mother requested a Zoom meeting to discuss a professional engagement to sort out the situation. I was relieved and not surprised the mother wanted to be a part of this process. Over the years I've found, regardless of the family's culture, religious identity or location, women or those in same-gender couples, it is the partner who manifests the more feminine traits of nurturance who are the primary decision makers in matters relating to their family's behavioural health. Again, my professional experience is supported by the literature in this realm. According to the US Department of Labor, women make 80% of the decisions regarding their family's healthcare.[19] In my work around globe over the past two decades, I've found this percentage to be closer to 100%.

During our initial call, I was moved by the FOP's and the mother's care, concern and love for Bushra. I was also not surprised by their frustration, anger, confusion and exhaustion about the state of affairs. In contrast to family issues that relate to a family's financial wellbeing, issues relating to behavioural health are messy and nonlinear. The person in the family who most needs the help, referred to in clinical realms as the identified patient (IP),[20] is often the most resistant to change and the least willing to embrace the help that's needed. As a result, the entire family revolves around the IP's pathology. In this state of diminished functioning, emotional reactivity governs and rational thinking becomes compromised. Caught in the cross fire of this dynamic, the family devolves into a state of disorganisation, splinters off into unhealthy alignments and is unable to focus its resources towards short-term and long-term clinical solutions.

Addressing entopic forces within the family

As this relates to empirically based literature, the situation referred to above, wherein Bushra's family devolved into uncertainty, disorder and disconnection, is known as entropy.[21] While the construct of entropy was first articled by the German physicist Rudolf Clausius in 1850 to measure the amount of disorder in a thermodynamic system, over the years it's been applied in the context of family therapy to capture the amount of disorder and disorganisation that occurs in a family environment in response to behavioural health concerns.[22]

By the time the family reached out to me, entropic forces had taken hold and were compounding the problems not just with Bushra and her family, but with the family business as well. Rather than spending its time on matters related to the family's financial affairs and market volatility, the FOP and trustees had become consumed with managing Bushra's affairs and the family's emotional instability. Fortunately, they soon realised that while they had expertise in matters relating to the family's quantitative wealth, they needed to bring a professional into their ecosystem to address and resolve the issues relating to their mental and relational wellbeing.

A four-point, empirically based solution for FOPs to address behavioural health issues in the families they serve

At the micro level, issues relating to a family's behavioural health tend towards a nonlinear progression. When addressed from a macro point of view, however, they can be effectively addressed through a highly structured strategic plan. Over the past decade, I've distilled this prescription into a four-step process grounded in the work of Dr Fragale and her colleagues that FOPs can use in their work with UHNW families. In the section that follows, I set forth this plan and apply key features of it to my work with the case involving Bushra.

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Information gathering

Issues related to the behavioural health of UHNW individuals and families are complex and nuanced. Like other minority populations, UHNW individuals and families manifest distinct cultural markers that are relevant to the formulation and implementation of effective treatment interventions.[23] In *Fragile Power* (2019), I identified these distinct cultural markers as:

- isolation;
- suspicion of outsiders; and
- hyper-agency.[24]

In the same way that behavioral health professionals (BHP) understand the need to have cultural competency when formulating an effective therapeutic alliance and tailor clinical interventions to meet the unique identities of other minority populations such as LGBTQ, women and religious communities, clinicial professionals who work with UHNW patients in the realm of behavioural health need to understand the unique identity constructs of the niche population they are called to serve. Accordingly, when confronted with behavioural health challenges, FOPs who work with UHNW families will benefit from bringing a BHP experienced in working with this highly niched clinical population into their ecosystem.

Given the highly sensitive nature of this work, FOPs need to be hyper-aware of issues relating to their clients' confidentiality. This is especially true when dealing with global families. While in America licensed BHPs are bound by rules of confidentially when providing direct clinical services to an IP in the state in which the BHP is licensed, beyond America and across state lines when a BHP is providing behavioural health consulting and case management, these rules will not apply. As such, it is incumbent upon the FOP to obtain a confidentiality agreement drafted according to the family's terms prior to engaging and disclosing any identifying information about the family and the IP with the BHP under consideration.

Once a contractually valid confidentiality agreement is in place, and a competent and qualified BHP chosen, the next step of the engagement will be for the BHP to enter the family to make a preliminary clinical assessment by learning how the family operates, what it values, who is the IP in the family and what are the various other pathologies that exist among the individual members and the family as a whole. While the BHP needs to have solid clinical skills, they must also be practised in the art of establishing a reparative therapeutic alliance[25] with the family as a unit and with as many of the family members as are willing and able to participate in the process.

Case application

One of the strengths of my engagement with Bushra's family was that I came on the recommendation of one of their London-based wealth advisers who was also of Saudi descent. In this regard, my power had been pre-established and my main task at this initial stage was to garner status with the mother and CEO by earning their trust. In response to the email I received, I requested the FOP to send me a confidentiality agreement that I could review and execute. Once we had an enforceable agreement in place, we secured a time for our meeting.

During my initial call with the mother and the family CEO, I found them to be warm and humble. They were well educated and open to learning about the nature of behavioural health conditions. I also learned that while the father was concerned with the wellbeing of his daughter, he was culturally schooled that parenting issues are the responsibility of the wife. He was happy to provide financial support for the engagement, but he would not be participating in any sort of therapeutic process to address the situation.

Risk analysis

Following the information-gathering stage, the BHP needs to quickly assess which issues are acute and which are chronic. At this point, they have hopefully earned enough status within the family to make appropriate recommendations for specialised medical and mental health care. Here, it's critical for the BHP to engage with the family members in psychoeducation to bring issues of behavioural health

out of the shadows of shame and place them squarely in the light of empirically based science. It's also important for the BHP to meet the family where they are in their cultural experience and not be dictatorial with the power inherent in their credentials. Through this process, the professional continues to earn the family's trust by developing their status with the power inherent in their professional knowledge.

Case application

In the early stages of a family engagement, it is unrealistic to have the participation of all family members. As this relates to the case at hand, having Bushra's mother and the FOP onboard was enough to get started with the case. While it would have been better to have more of a therapeutic commitment from the father, it wasn't necessary. As these things go, hardline pronouncements from family members are often part of the systemic pathology and are culturally based. They also work themselves out over time as the BHP earns more status with the family. In conducting my initial risk assessment, I rated Bushra's mental health and her threats of self-harm to be the most pressing issue needing to be addressed. As such, I needed a trusted colleague, ideally a female, on the ground in London to meet with Bushra, earn her trust and be the point person on the case in London. Here it's important that families find a BHP who has a trusted network of colleagues who can provide culturally competent and clinically effective care in hyperlocal communities. These networks should include psychiatrists, medical doctors, interventionists, trauma therapists, family therapists, relationship therapists, acupuncturists, and nutritionists. Again, given the highly sensitive nature of the work and the importance of earning family trust, every point of contact with the case needs to be bound by a separate confidentially agreement.

Formulating a treatment plan

Once the professional has made a clinical assessment of the situation and has continued to earn status with the family and the IP, the next step will be for the BHP to articulate a clearly defined strategic plan to address the pathology that is running through the family.

Here, the calculus between status and power begins to migrate into the realm of the BHP's power. As the licensed professional, it's expected and incumbent upon them to diagnosis the IP and articulate the clinical issues that are impacting the family. Over the years, I've found this step this critically important in both helping the family manage the chaos inherent in issues relating to behavioural health as well as enabling BHPs to embrace their power in a very powerful system. While some of my colleagues are resistant to give a clinical diagnosis, I have found they give the treatment team and family not only a place to ground themselves and their work, but also a huge sense of relief that there are empirically proven and scientifically based courses of treatment.

Case application:

Within three hours of my initial call with Bushra's mother and the FOP, I had a London-based female therapist and female psychiatrist teed up for the engagement and had enforceable confidentiality agreements in place for their work with the family. The plan was for the therapist to reach out to Bushra's boyfriend to see if Bushra would meet with a therapist to minimise the chaos in which they were living. Here, the goal was to have the therapist earn status with Bushra so we could get a solid clinical diagnosis from the psychiatrist and start Bushra on a recovery plan. Fortunately, the boyfriend was very eager to have some help stabilising Bushra and he easily convinced her that meeting with my colleague was in everyone's best interest. In this regard, the gender of the selected therapist is important. In some cases, gender differences can be beneficial, but given the cultural background of this family and the fact that Bushra had a negative history of male authority figures both power and status would best be garnered by an all-female team.

Risk mitigation and family repair

The best strategic plans are of little value if not carefully implemented. In this regard, 'carefully' refers to the BHP's ability to get a majority of the family's support, to have the family believe in the competency of the professionals engaged and to have a basic

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understanding of the science underlying the interventions contained within the plan. At this stage, the BHP should also be using the power and status they've garnered with the family to provide direct services where appropriate, refer out where needed and oversee the entire process as a conductor of a symphonic orchestra. Families also need to be tutored in the nonlinear process of family recovery and have their expectations realistically managed. Unlike issues related to a family's physical health, issues related to their behavioural health resolve slowly, over time.

Case application

Over the course of the next 48 hours, the therapist and boyfriend convinced Bushra to participate in an in-person meeting at the boyfriend's flat. As this relates to the power and status titration, the main goal of the meeting was not for the therapist to yield her power in a way that viewed Bushra as broken and sick, but rather to earn status with her by manifesting compassion, warmth and empathy for her situation. During their three-hour meeting, the therapist successfully motivated Bushra to see the psychiatrist for an assessment and secured the necessary releases for her to communicate with me as the BHP in the case and be the liaison with the family. The next day, Bushra, the therapist and the boyfriend went to the psychiatrist where an initial determination was made that Bushra did not suffer from moral degradation, but rather from an undiagnosed and untreated bi-polar disorder that she was self-medicating with a host of intoxicants. In yet another fortunate turn of events, Bushra, suspicious of her mental health for years, found great relief in her diagnosis; and while she, like most of my patients, initially resisted the need for medication, her immediate clinical team had enough status with Bushra that she was willing to accept the psychiatrist's recommendations.

At the macro level, my role as the BHP in the family was to facilitate communication between Bushra's clinical team in London and her family team back in Dubai. Central to this task was educating them on the science of bipolar disorders as well as the benefits and drawbacks of the course of treatment. Through this process, the family team in Dubai began communicating with Bushra through a lens of respect rather than shame. Over the course of the next six weeks, Bushra remained in London and worked with her clinical team to stabilise physically and emotionally. During this time, I helped the family team interact with Bushra through the love and concern they had never lost, but that had gotten overshadowed by the entropic forces that were tearing the family apart by defining it through a pathologised identity.

Conclusion

The destruction inherent in external forces must be properly hedged and mitigated by global UHNW families and their FOPs. Simultaneously, in order for these families to maintain their generativity and competitive edge, they must develop the capacity to identify and mitigate internal disruptions that perniciously impact its holistic health. Over the past two decades, I've found internal disruptions caused by behavioural health issues to be some of the most pernicious on a family's quantitative and qualitative wealth. Not only do they erode family fortunes, but they also diminish family connectively, lead to chaos with in the family system and cause the family to identify around a pathologised identity. Fortunately, there is a new generation of family members who understand the importance of investing in their holistic wellbeing and are keen to have open and honest discussions about their mental health and the mental health of their loved ones. They also understand that in these matters not all family members will be eager to engage or may be so compromised that they will initially resist attempts to get the care they need. To address this resistance, family members and their FOPs must utilise their power in ways that recognise it is most effective when delivered through the status of warmth and inclusion rather than shame, stigma and exclusion. The future is bright for families who are embracing intergenerational shifts and the importance of a family's holistic wellbeing. Not only is the science regarding these issues robust, but we now have access to culturally relevant and clinically effective interventions to deliver the science that will enable them to thrive in the challenges of our new world order.

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1 In this article and in my work with global families, I define 'holistic health' as a family's quantitative and qualitative well-being. Quantitative assets consist of a family's financial assets. Qualitative assets consist of a family's intrapersonal and interpersonal wellness.
2 https://dennisjaffe.com/download/preparing-your-rising-generation-to-sustain-family-wealth/.
3 www.investopedia.com/terms/u/ultra-high-net-worth-individuals-uhnwi.asp.
4 Dennis Jaffe, "Preparing the Rising Generation to Sustain Family Wealth" (IMCA, 2016).
5 Entropy refers to the disorder and chaos in a family (R Beavers and RB Hampson, "The beavers systems model of family functioning" (2000) *Journal of Family Therapy*, 22, 128–143).
6 www.godblog.net/resources/C19_global-mental-health-crisis.pdf.
7 According to the American Medical Association (AMA), behavioural health refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioural health care refers to the prevention, diagnosis and treatment of those conditions (www.AMA-assn.org).
8 www.pewresearch.org/fact-tank/2022/12/12/at-least-four-in-ten-u-s-adults-have-faced-high-levels-of-psychological-distress-during-covid-19-pandemic/#:~:text=In%20the%20September%202022%20survey, have%20fallen%20into%20this%20category.
9 www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide.
10 According to a study by Professor Daniel Freeman at the University of Oxford, women are approximately 75% more likely than men to report having recently suffered from depression and around 60% more likely to report an anxiety disorder. Overall mental health conditions were more common in women than in men, by a factor of 20% to 40%. D Freeman, *The Stressed Sex: Uncovering the truth about men, women and mental health* (Oxford University Press, 2013).
11 I refer to this expanded definition of generativity as 'holistic health'.
12 The identifying details of these clients have been changed to protect their true identities.
13 www.hazelden.org/store/item/511163?Fragile-Power.
14 www.campdenfb.com/article/how-approach-gender-non-conformity-business-families.
15 https://psycnet.apa.org/doiLanding?doi=10.1037%2F0003-066X.55.1.68
16 www.sciencedirect.com/science/article/abs/pii/S0022103111000539
17 The identifying details of this vignette have been changed to protect the confidentially of the patient and family.
18 The persons portrayed in this case study are fictitious and are not based on real people.
19 www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/women-and-job-based-health.pdf.
20 https://dictionary.apa.org/identified-patient.
21 https://pubmed.ncbi.nlm.nih.gov/22250757/#:~:text=Entropy%2C%20a%20concept%20derived%20from,entropy%20at%20a%20manageable%20level.
22 CR Bates, J Buscemi, LM Nicholson, M Cory, A Jagpal and AM Bohnert, Links between the organization of the family home environment and child obesity: a systematic review, https://pubmed.ncbi.nlm.nih.gov/29520946/.
23 P Hokemeyer, *Fragile Power: Why Having Everything Is Never Enough* (Hazelden, 2019).
24 Hyper-agency refers to the capacity of UHNW individuals to control their world to inimize 'friction' and avoid discomfort.
25 www.ncbi.nlm.nih.gov/pmc/articles/PMC3198542/.