Family enterprise guide to major mental illness

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1. Introduction

Most families have members with mental illness and most businesses encounter issues relating to mental illness in their workforce. For family controlled enterprises, these issues present additional complexities and opportunities. It is critical for both the continuity of the enterprise and the health of the family that the family enterprise stakeholders understand how to identify, approach and manage major mental illnesses as it impacts the family enterprise.

Medical psychiatry is still a young discipline: mechanisms of action in major mental illnesses have yet to be defined and there are no definitive diagnostic tests. However, most major mental illnesses can be managed through diagnosis and treatment by a skilled psychiatrist, often combined with the help of a knowledgeable counsellor.

This chapter is a lay person's guide to identifying, diagnosing, treating and managing people with major mental illness. It is not exhaustive, complete or intended to direct the diagnosis, treatment or management of any particular person or case. It begins with advice on how to recognise common mental illnesses encountered in the workforce (and elsewhere) and how they might be handled, and it concludes with observations about the special strengths and unique challenges facing leaders of family controlled enterprises who encounter mental illness in their businesses.

2. Identifying mental illness as a potential issue

Significant changes in behaviour may indicate the onset or recurrence of illness. It is in everyone's interest – employer, co-workers, family members, the enterprise, advisers and the person at issue – that these changes are noticed and that mental illness, as well as somatic illness or other problems, be considered when trying to identify what is causing the changes.

It is significant if someone:

- starts losing his/her temper easily;
- becomes unusually irritable;
- seems distant;
- is talking to the point of incoherence;
- is very negative;
- becomes difficult to manage;

- is complaining that people are out to get him/her;
- is unreasonably frightened or suspicious;
- starts making mistakes or missing deadlines;
- can't finish projects;
- seems to be talking to him/herself;
- says things that don't make sense;
- has a serious drop in personal hygiene;
- has alcohol on his/her breath during time at work;
- has slurred speech;
- disappears periodically without explanation;
- is always short of money; or
- is spending unusual amounts of money.

When these 'red flag' behaviours are identified, the response of the person in question and the people around them is often denial. Reports or complaints are ignored or they are dismissed as inconsequential. When the person in question is a family member, the urge to overlook these behaviours and avoid family complications may be strong. Regardless of the source of information or especially if the person is a family member, those in authority should enquire further when learning of these behaviours.

Another common response is disciplinary action – taken on the assumption that the problem is lack of self-discipline, lack of will, laziness, weakness or other characteristics within the control of the person at issue. If the source of the behaviour is mental illness, however, disciplinary action will probably be ineffective and may well be counterproductive. In addition, in some countries applicable laws governing disabilities in the workplace may limit disciplinary options and/or mandate accommodation for persons with major mental illnesses.

When these behaviours appear in persons with authority (or even control), complexity of response increases. People around the person are often reluctant to identify the behaviour as symptomatic of illness out of respect, fear of a punitive response or concern that identification will be misattributed to interpersonal motives. The role of trusted advisers in these situations becomes critical. Trusted advisers (such as primary-care physicians and long-time family enterprise consultants and other professionals) generally have enough experience and emotional distance to analyse the changed behaviour and consider what steps are appropriate (such as consulting the family primary-care physician or psychiatrist). They are most likely to have the gravitas and credibility to overcome denial, dismissal, criticism and other emotional responses to the changed behaviour, and to convince the enterprise, family and workplace to move forward with appropriate steps.

Family enterprise advisers and colleagues may learn of 'red flag' behaviours from other family members, colleagues or co-workers. They will need to deal not only with the person at issue but also with the response(s) of others within the family enterprise and the family system.

3. Possible diagnoses

After realising that mental illness may be an issue, the first step is to understand that there are many forms of psychiatric disorders and, even today, diagnosis is as much an art as a science. The symptoms of different illnesses may overlap, and so proper medical diagnosis is the key to effective treatment and management.

The following is a brief description of some major forms of mental illness, their symptoms, presentation characteristics, present-day treatment and common obstacles to treatment. It is not exhaustive or technical, being designed to assist lay people in their general knowledge of the issues.

3.1 Depression

(a) Characteristics

Depression is the most common psychiatric disorder. It can and does occur at any age – from childhood to senior citizenship. It can have gradual or acute onset. It can be chronic or occur in acute episodes, or both (known as 'double depression'). Some depression is familial. Some is seasonal, often worsening in late autumn and winter. It may or may not be related to life events. It can have a wide range of severity and at times can carry a risk of suicide.

When the science is better understood, it should become easier to distinguish the illness of depression from related somatic and psychological conditions.

(b) Symptoms

Symptoms of depression include:

- a depressed mood;
- pessimism;
- feelings of hopelessness, helplessness or worthlessness;
- sleep disturbance (particularly with early morning awakening);
- irritability;
- difficulty concentrating;
- suicidal ideation;
- decreased appetite/weight loss;
- somatic concerns;
- social withdrawal; and
- a lack of initiative or motivation.

Some of these symptoms are clearer indicators of depression than others and, generally speaking, depressions do not include all these symptoms. However, depression should be considered when a group of symptoms is present, particularly when combined with behavioural impacts.

(c) Impacts

Depression has behavioural impacts, such as missed deadlines, excessive or obsessive worry about small matters, pessimism about results, misreading of the environment, hesitancy about taking opportunities, overestimation of liabilities and threats, or a

fixation on a single idea or concern (rumination). Difficulty concentrating is not always seen as a symptom of depression but can be one of the more distressing symptoms as the individual cannot exert mental control of ruminations.

It is difficult for depressed persons to control these behaviours when they are caused by their illness. Criticism or instructions to change are likely to make the depressed person defensive and/or to cause them to conceal their symptoms.

(d) Treatment

Antidepressants can be quite effective in reducing/eliminating major symptoms. The most common medications prescribed these days are serotonin-specific reuptake inhibitors (SSRIs). Some depressions respond better to tricyclics (an older and less commonly prescribed class of medication). Electric shock therapy is a tool of last resort, but when indicated can be successful. Cognitive therapy can help to challenge false assumptions. Psychotherapy may be helpful in understanding the impact of depression and how it has affected the patient's life course. Hospitalisation or partial hospitalisation may be needed in situations of suicide risk or extreme dysfunction.

(e) Obstacles to treatment

Depressed people may fail to identify their need for help, fail to obtain help or resist help for a variety of reasons. They may have concerns that are realistic, such as social stigma or medication side effects; but these concerns may be out of proportion to the reality of their situation. Their inaction may be a natural consequence of the stress she/he is undergoing – inertia is a common part of the illness's demotivating symptom. Feelings of hopelessness may make the effort seem fruitless.

Acute onset depressions tend to be more noticeable to third parties than chronic depressions, and thus more likely to lead to treatment. Chronic depressions may be seen as the 'normal' state of the person and go untreated, with damaging long-term consequences to the depressed person, his/her family, his/her work performance and the family enterprise.

3.2 Bipolar disorder

(a) Characteristics

Bipolar disorder is characterised by extreme mood states, with prolonged periods (many weeks or months) of mood extremes ranging from elevated mood (mania) to severe depression. It can be hard to diagnose when it presents only its depressive side, and no clear diagnosis can be made until both extremes occur. It can have acute onset, or first present itself as chronic depression. Onset can occur at many ages, most commonly in young adulthood. Mania may appear as euphoria, increased energy, hostility, impulsiveness, unusually high levels of spending, excessive talking, risk taking and paranoia.

Bipolar depressions can be extremely long and extremely withdrawn. Significant mania is often detected and treated as it is clearly outside the realm of usual experience. Less severe swings of mood can go undetected and untreated as they often border on normal states. For example, a mildly manic (termed 'hypomanic')

bipolar person can appear (and be) funny, creative and energetic; a chronically depressed bipolar person can appear to be subdued and asocial.

(b) Symptoms

The symptoms of bipolar illness are both mania and depression.

Bipolar mania exhibits symptoms including some of the following: impulsiveness, impaired judgement, increased energy, less need for sleep, hyperactivity, humorousness, irritability, aggressiveness, combativeness, delusions and excessive talking. Often, bipolar patients, when manic, make rash or imprudent decisions, putting themselves at increased risk of physical harm because of misjudgement. A manic person might spend unusually large amounts of money and take unrealistic financial risks, creating financial risks to him/herself and others. Onset can be gradual or may appear as a switch-like process.

Bipolar depression is similar to unipolar depression, but tends to manifest itself in increased sleep (rather than trouble sleeping). It also tends to have slowed motor activity and thought ('psychomotor retardation'), and extreme social withdrawal (long periods in the home or in bed). It can sometimes last for years.

(c) Impacts

Bipolar mania can cause misuse of funds, excessive or inappropriate speech, rash decisions, erratic behaviour and misjudgements, and so mania can create serious exposure to financial and other types of liability. A bipolar manic person's aggressiveness and irritability can adversely affect workplace and personal relationships, as well as reputation and effectiveness with other entities.

The impacts of bipolar depression are similar to those described in unipolar depression: absence from work, missed deadlines, overestimation of risks and obstacles, and reluctance to act.

(d) Treatment

Mood stabilisers are currently the primary medications used for the treatment and prevention of mood swings. Major tranquillisers may be needed for episodes of acute mania and can also be used as alternative mood stabilisers. Antidepressants, used judiciously and in combination with mood stabilisers, can be helpful in treating bipolar depression (with a watchful eye in case they induce a switch to mania).

Hospitalisation may be indicated for severe mania, which carries a risk of significant harm – involuntary hospitalisation may be needed in cases of extreme risk. Hospitalisation for depression may be indicated for starting treatment, although admissions in such circumstances are currently quite short in duration. Psychotherapy can be helpful to understand the condition and its impact on a person's life and relationships, as well as to understand underlying psychological issues that may impair function.

(e) Obstacles to treatment

When manic, a person feels subjectively quite well and does not see the need for treatment, even when symptoms are extreme. Hence third parties (such as family

members, law enforcement officers or the courts) may become involved in treatment decisions.

The obstacles to treatment for bipolar depression are the same as those listed under unipolar depression. Since bipolar depressions can involve extremely low energy and motivation, an inability to mobilise oneself to accept treatment is common.

3.3 Alcohol abuse disorder

Alcohol abuse is widespread in many societies without regard to money, class, race or ethnicity. Its impacts on families, businesses and the economy are heavy and well documented around the world.

However difficult it may be to identify, treat, manage and discuss, family members, their advisers and their businesses should undertake that effort. Laws vary from country to country, but most jurisdictions recognise the impact of liquor on behaviour and regulate its use in situations such as driving a car or operating machinery.

(a) Characteristics

Alcohol abuse disorder is characterised by use of alcohol that is not objectively under control and within appropriate parameters. Overuse and/or frequent intoxication can be quite recognisable, but the disorder may also not be clearly apparent. Abuse may take the form of binges or be continual.

There may be a familial susceptibility toward abuse, possibly related to the way alcohol is metabolised in the body. Those that can 'hold their liquor' may be at greater risk to addiction. Denial is extremely common and self-reported use often underestimates or conceals use entirely.

(b) Symptoms

The most obvious symptoms are hidden bottles of alcohol, alcohol consumption early in the day, and a smell of alcohol in inappropriate environments such as work or professional settings. Unexplained absences and inconsistent functioning may indicate that there is a problem of intoxication – whether continual or intermittent. Acute intoxication causes disinhibition, with behaviour that can be harmful to the intoxicated person, other people and business.

Depression is quite common among those suffering from alcohol abuse, either co-occurring with or as a consequence of overuse. People with this symptom often use more alcohol to mask their depression.

(c) Impacts

Misuse and chronic use of alcohol can cause impaired judgement on business decisions and relationships within and external to the family enterprise. Alcohol abuse may cause inconsistent work performance and/or attendance, as well as disrupted family, social and work relationships. Alcohol overuse can cause multiple physical medical consequences, including liver disease, cognitive impairment, gastro-intestinal problems, insomnia and sexual dysfunction. Alcoholism bears an increased risk of suicide.

(d) ***Treatment***

Treatment is difficult and relapse is common. For acute alcohol poisoning, emergency treatment may be needed. Brief hospitalisation for detoxification can help with the physical addiction, but is not sufficient for long-term treatment. Some medication treatments can help with cravings. Other medical treatments are aversive. However, medication is rarely definitive.

Treatment of co-occurring depression can be important. Twelve-step programmes are very useful by establishing a culture of sobriety. Residential treatment programmes may also be helpful for those who have frequent relapses, can afford the cost of such programmes and agree to participate. Al-Anon or Alcoholics Anonymous can be an important resource for families if groups are available locally.

(e) ***Obstacles to treatment***

In most countries, alcohol is a legal substance, used openly in many settings and socially accepted, so it may be difficult to discern when use becomes overuse. Denial is extremely common and makes acceptance of treatment difficult.

3.4 Substance abuse disorder

Substance abuse disorder is similar to alcohol abuse disorder, discussed in section 3.3 above – but with some significant differences. Mostly obviously, there are many chemical substances involved and the substances used are generally not used openly or with widespread societal approval. Substance abuse often involves violations of the local laws.

(a) ***Characteristics***

Substance abuse is the use of substances when such use is out of control. Some substances, such as the opiates (heroin, morphine, oxycodone etc), are highly addictive and rapidly addicting. Others (such as cocaine and other stimulants) become addictive less quickly and casual use is more common. The substances may be entirely illegal and only obtainable through illegal gateways; or they may be obtainable legally by prescription and misused by the prescription holder or sold illegally. Illegality makes substance use much more expensive and riskier than alcohol use.

(b) ***Symptoms***

The symptoms vary by substance. Stimulant intoxication may cause symptoms similar to mania: hyperactivity, talkativeness, irritability, lack of sleep. Intoxication with hallucinogenic substances or designer drugs may cause psychosis-like symptoms. Depressants such as opiates may cause disinhibition, social isolation, and antisocial behaviour occurring in order to pay the high cost of the habit, including theft from family, friends and/or the family business. Erratic behaviour is a further symptom of substance misuse.

(c) ***Impacts***

The costs of substance usage create an increased need for money, financial duress and

a risk of mismanagement (or theft) of funds. Use of the substances can result in erratic work performance, loss of focus, unexplained absences, interpersonal issues and generally a lack of transparency regarding behaviour. Illegal activities can jeopardise a business and business relationships.

(d) Treatment

Treatment is difficult and relapse is common. Opioid addiction has a particularly high rate of multiple relapse. As with treatment for alcoholism, hospitalisation may be needed for detoxification from addiction or the management of temporary psychosis, but it is not sufficient for long-term treatment.

For some substances, medication may assist in addressing symptoms and there are a range of therapeutic options. For opiate use disorder, other opiates can be useful to prevent cravings and block the 'high' of opiate use. Here, too, residential treatment programmes may be helpful for those who have frequent relapses, can afford such programmes and agree to participate.

Narcotics Anonymous can help to maintain long-term abstinence. Again, family support groups can be extremely helpful to both individual family members and the enterprise.

(e) Obstacles to treatment

Denial and secretiveness/deception are common and prevent addicts from seeking or accepting help. Opiate addiction particularly can be very hard to treat and has limited success rates.

3.5 Psychotic disorders: schizophrenia and later-life psychoses

(a) Characteristics

Psychosis is a disorder of thinking. In all likelihood it is a symptom produced by a number of distinct biophysical disorders.

Schizophrenia is the most common disorder, with psychosis as a symptom. It is not a 'split personality' (a real but entirely different and rarer disorder), but a disorder of thinking. Approximately 1% of the population is afflicted with schizophrenia. Thoughts are bizarre and can be paranoid and persecutory. Onset of schizophrenia most often occurs in adolescence and is quite often disabling.

There are also later-life psychoses, which usually occur from a person's forties onward. Such psychoses can be quite severe and often have a depressive component. Although many people with psychotic disorders have clear symptoms and presentation, some have more mild and encapsulated symptoms and can appear outwardly unremarkable, if perhaps somewhat odd or limited.

(b) Symptoms

Psychotic people can have delusions (often of persecution), hallucinations (usually auditory in the form of voices in the head), ideas that random events refer to self (eg, the TV talking directly to the person rather than a wider audience). Other symptoms are a dishevelled appearance, inattention to hygiene and an inability to concentrate

and complete tasks. Better-functioning individuals may work, but appear unusually restricted and limited or have odd ideas/thinking and difficulty in relationships.

(c) Impacts

Psychoses are often disabling conditions. Early onset may cause lifelong disability. Such individuals will manage to work only infrequently, and then in simple jobs. The family, its advisers and its business need both to address issues of long-term management and provision for the family member (as with other disabled family members) and strategies to manage such family members within the family enterprise. Late-onset psychoses can be particularly problematic for the family enterprise if involving a principal, or person with significant responsibilities.

(d) Treatment

Antipsychotic medication can be quite helpful in controlling symptoms but is not curative. Hospitalisation may be needed at times, as well as participation in other psychiatric rehabilitation services. Social services can help with daily life issues. Government assistance or private disability insurance may be available, but long-term planning for suitable support will be needed.

(e) Obstacles to treatment

Psychotic individuals often have limited insight into their condition and often refuse treatment. Legal proceedings to arrange hospitalisation and treatment with anti-psychotic medication involve legal requirements that vary from jurisdiction to jurisdiction. Individuals with major business responsibilities, afflicted with later-life psychosis, may deny that a problem exists and use their position of power to thwart efforts to manage and treat the illness.

3.6 Anxiety disorders

(a) Characteristics

The term 'anxiety disorders' covers a group of disorders in which the predominant symptoms are a degree of anxiety that is outside the realm of everyday anxiety and that has marked effects in a person's functioning. Others close to such individuals are often asked to accommodate themselves to symptoms that seem objectively irrational. There is a good deal of overlap/co-occurrence between anxiety and depressive disorders.

(b) Symptoms

Below are symptoms of a few forms of anxiety disorders.

Obsessive compulsive disorder (OCD): is marked by unusually repetitive behaviour and thought patterns that are over and above neatness or orderliness and not within the control of the individual. Obsessions and compulsions intrude on a person's behaviour and time in a way that may seem irrational to others. Examples include repetitive behaviours (such as checking the gas or locks multiple times), hand-

washing rituals (such as counting, or performing a series of behaviours before an action) and intrusive or unwanted thoughts. The individual often knows that the obsessions and compulsions are irrational. Infrequently, there is an overlap between OCD and psychotic symptoms.

Panic and agoraphobia: Panic attacks are marked by intense feelings of panic occurring spontaneously and unpredictably. They are marked by extreme anxiety, shortness of breath, rapid pulse, sweating or light-headedness. The individual may be fearful that he or she is having a heart attack and seek help in emergency rooms.

Agoraphobia is usually a consequence of untreated panic. Such individuals will retreat to the safety of their home environment. While they are able to function within the home, they may be unable to leave the home independently. This condition can be quite severe, with people sometimes staying at home for months or even years at a time.

Performance anxiety: This is a relatively benign condition in which a person experiences symptoms of anxiety only in the context of activities such as public speaking or acting.

(c) Impacts

OCD reduces efficiency in the workplace because of the sufferer's inflexibility; it also impacts personal relationships and may have an impact on the morale of supervisees and co-workers. Individuals with severe agoraphobia and panic may be disabled and unable to perform in the workplace – they may reasonably considered disabled and may apply for disability benefits. Less severe cases may impact attendance when symptoms are more severe and may cause interruption at the workplace in the event of acute panic. Performance anxiety can inhibit workers/leaders from freely giving speeches to large gatherings of employees and clients.

(d) Treatment

OCD can be difficult to treat. High-dose antidepressant medications are approved for the treatment of OCD and may be effective, particularly if administered over a long period of time and if combined with behavioural treatments such as cognitive behavioural therapy and exposure therapy.

Panic disorder can usually be readily treated with anti-anxiety or antidepressant medication. Psychotherapy and cognitive therapy can be helpful in readjusting to life without panic if successfully treated. Agoraphobia can improve with the treatment of panic, but often requires a more concerted effort with home-based treatment, staged exposure to the outside world, cognitive therapy and support.

Performance anxiety can often be readily treated with beta blockers, which take away physical symptoms such as rapid heartbeat and sweating, or anti-anxiety medications, which can promote a feeling of calm. For chronic anxiety, a gradual re-exposure to presentations may make sense.

(e) ***Obstacles to treatment***

OCD and agoraphobia can be difficult to treat and the nature of the disorder tends to make the sufferer avoid treatment. For other anxiety disorders, social stigma is always an issue; but the sufferer's discomfort and availability of treatment may make them more accepting of treatment, especially for acute episodes of panic or performance anxiety.

3.7 Trauma and post-traumatic stress disorder

Although these two conditions are technically anxiety disorders, post-traumatic stress disorder (PTSD) and other trauma disorders are very distinct from others in that category and hence are treated separately here. They are perhaps the best example of how life's circumstances can produce biological change.

(a) ***Characteristics***

Although there are traumas in life, major trauma is outside the range of usual experience and includes such events as assault (sexual or otherwise), sexual trauma, military trauma, witnessing violence, natural disasters and life-threatening experiences. These traumas produce similar symptoms, which may occur in a delayed fashion – sometimes years after the traumatic event(s). PTSD and trauma are severely disruptive of a person's relationships, ability to trust and quality of life. Severely traumatised individuals can be quite disabled.

(b) ***Symptoms***

Full-blown PTSD can have symptoms such as flashbacks and the reliving of traumatic events, easy startling and increased arousal, emotional numbing, feeling disconnected (known as 'dissociation'), traumatic nightmares and sleep disturbance, avoidance of issues and difficulty concentrating. Persons who have experienced significant trauma may not meet the full criteria for PTSD but may have many of the symptoms and be adversely impacted by traumatic memories.

Many victims of past trauma exhibit symptoms that are similar to 'borderline personality disorder', such as neediness, emotional volatility and lack of trust. Without identification of the traumatic origin of symptoms, such persons may not receive appropriate treatment – being subjected to rigid limit-setting and demands for self-control (which are ineffective and often counterproductive) rather than thoughtfulness, patience, encouragement and medication.

(c) ***Impacts***

Traumatised victims generally have disturbed and inconsistent relationships, overly emotional and erratic responses to stress (as perceived by others), over-predicting threat in the present, and difficulty accepting supervision or guidance. Undiagnosed, they can be difficult to manage.

(d) ***Treatment***

PTSD can be helped with medication to help with associated depression, anxiety, impulse control difficulties, sleep disturbance and traumatic nightmares. Cognitive

therapy can help to address the need for a reordering of one's cognitions concerning the nature of threat and stress. Psychotherapy and group treatment, often over the long term, can help to integrate traumatic experience and improve interpersonal relationships.

(e) ***Obstacles to treatment***

Severe PTSD can be disabling and preclude consistent work performance. Persons with traumatic disorders have often had experiences that impede trust and collaboration and may be perceived (and be) erratic, overly emotional and defensive, making them very difficult to work with. Limit-setting responses may exacerbate the disorder and the resultant difficulties.

3.8 Alzheimer's disease and other dementias

(a) ***Characteristics***

The most common characteristic of dementia is a decline in cognitive capacity, most often seen in older individuals. Onset can be insidious and early signs may be hard to detect, or attributed to depression or 'normal ageing'. (Note that, conversely, depression is often undiagnosed in the elderly and treated as 'normal ageing' or dementia.) Early dementia can occur in individuals in their fifties and can be particularly hard to detect in the early stages.

(b) ***Symptoms***

Symptoms of dementia include significant memory loss, disorientation to time or place, difficulty with problem solving, apathy, social withdrawal, changes in mood and personality, difficulty performing previously familiar tasks, and perceptual changes. The condition progresses with time but the pace of progression is variable.

There are different forms of dementia, which can be identified by neurological and neuropsychological testing; but the symptoms and impact of the various forms are usually the same. Identification of dementia in its early stages is helpful to patients, their family and associates, as well as for necessary planning.

(c) ***Impacts***

Dementia, even in its early stages, impacts judgement, planning, attendance and performance within both the workplace and other organised settings. However, the cause of such deficits are sometimes not initially appreciated by the person involved and/or those around him/her – out of embarrassment or other reasons the person and those around him/her may deny the existence of the deficits. Whatever the reasons, the longer that action is delayed, the greater the likelihood of risk to the person, his/her family and the family enterprise, particularly where the demented person has authority or control within the enterprise.

As dementia reaches its later stages, diagnosis becomes clearer and action is imperative. Persons with more advanced dementia are unable to function in the enterprise, and if they do they may cause irreparable harm to the enterprise and/or the family.

(d) ***Treatment***

Medications are available that may slow progression of dementia, but there is no definitive treatment. Significant (and expensive) support may be needed in the later stages of the disease, including institutional placement.

(e) ***Obstacles to treatment***

There are no known treatments for dementia. The early stages can be hard to detect and the individual does not perceive or accept the existence of problems. In the absence of advanced directives, interventions can be complex.

3.9 Personality disorders

(a) ***Characteristics***

The term 'personality disorders' describes a broad category of maladaptive personality traits that diagnostically have been grouped in clusters: odd or eccentric; having overly emotional, demanding or unpredictable behaviour; or having anxious or fearful thinking or behaviour. These traits often describe behaviours that cross a spectrum from 'disorder' to 'normal' without clear dividing lines (eg, from avoidant personality to shyness). At other times the traits describe behaviours that range across a spectrum of full-blown disorder (eg, from schizoid personality to psychosis).

In subsections (b)–(e) below, only an antisocial personality disorder is discussed because this disorder can have a highly destructive impact on a family enterprise or the family itself.

(b) ***Symptoms***

People with antisocial personality disorders exhibit all or some of the following symptoms: exploitative behaviour, recklessness, irresponsibility, impulsivity, deceitfulness, a tendency towards violence, lack of empathy, lack of intimacy, callousness, and skill at manipulation. In relation to the last in the list, because they are often skilled manipulators and superficially charming and personable, they may be highly successful at masking their symptoms to further their interests.

(c) ***Impacts***

These are individuals who put their own interests above the interests of others or of any organisation, including the family enterprise (or others supported by the family enterprise). Criminal behaviour is possible. Risky behaviour and lack of empathy can at the very least damage relationships, impair the reputation of a business and inflict serious financial and human harm.

(d) ***Treatment***

There is currently no known medical treatment for the antisocial personality. Management should focus on identification of the disorder, containment of behaviours (perhaps through positive and negative reinforcement) and protective measures to prevent harm to others and the enterprise.

(e) Obstacles to treatment

Such individuals do not readily accept treatment, since they cannot see their actions as problematic or themselves as needing change. Given an ability to present superficially as engaging or sincere, it may take time for others to identify symptoms and appreciate the nature of their deceptiveness.

3.10 Attention deficit hyperactivity disorder

(a) Characteristics

Attention deficit hyperactivity disorder (ADHD) impairs function and impacts interpersonal relationships. It should not be confused or conflated with a desire for improved performance at work (or school) by individuals without significant deficits in concentration. It may occur as extreme distractibility or inability to focus, with or without hyperactivity. Symptoms usually are recognised first in childhood; in adults, it may be co-morbid with alcohol or substance abuse disorder.

(b) Symptoms

The most common symptoms of ADHD are a difficulty with maintaining attention to tasks, difficulty with organisation, and unusual sensitivity to extraneous stimulation. The patient may be characterised as easily distracted, avoiding tasks requiring prolonged concentration, with forgetfulness, lateness, losing things, inattention to detail, impulsivity, fidgeting, restlessness, irritability and trouble coping with stress.

(c) Impacts

Impacts comprise erratic behaviour and decision-making, poor follow-through, lack of attention to detail, procrastination, and difficult interaction with co-workers.

(d) Treatment

Stimulant medication can be very helpful in decreasing the core symptoms. However, where there is alcohol or substance abuse, it may be contraindicated.

(e) Obstacles to treatment

ADHD is difficult to diagnose definitively and often overlaps with other psychiatric issues. For example, depression causes poor concentration and alcohol/substance abuse can impair function globally in similar ways. Premature or unnecessary use of stimulants may mask these other psychiatric issues.

3.11 Autism spectrum disorders

These disorders are not discussed here. They are characterised by dysfunction in social communication/interaction and by repetitive behaviour or interests. These disorders, when severe. are diagnosed in early childhood and consequently do not generally impact a family enterprise except as regards management of the condition.

4. Managing people with major mental illness

The management of people with major mental illness is an enormous field, which cannot be addressed in this chapter. However, we set out below some general advice to help with understanding the management process in different contexts. It should not, however, be taken as advice in any particular case.

4.1 Dealing with the acutely ill

A person with significant disturbance in mood, thought or cognition, which significantly interferes with function and a sense of well-being, is acutely ill. Diagnoses include somatic illnesses that might present with psychiatric symptoms as well as mental illnesses. Examples of such somatic illnesses include: neurological conditions such as seizures and brain tumours; endocrine disorders such as thyroid or adrenal disease; diabetes; and acute infections such as pneumonia. The ill, their family and their advisers should get prompt, good-quality diagnosis and treatment, including an initial assessment that includes consideration of potential somatic causes for the observed behaviours.

There is a range of options for handling the acutely mentally ill. So long as the person is not too agitated or out of touch with reality, the first approach is to try to talk to the person with the goal of having him/her voluntarily seek or accept treatment. Such a conversation should be calm, low-key and direct, containing no hint of value judgement, threat or accusation and using simple, declarative statements. Beating around the bush is confusing and often counterproductive. Express concern in general terms such as "I am worried about you." Expect the person to be defensive and push back on concern. It may be helpful to objectify the symptoms observed – for example, "You seem unable to concentrate on work," or "You are talking a lot about suicide." Reassure the person that you are bringing this up because you want to try to help and not in order to be critical. If the person is a family member, it may be helpful to tie the observations to events: "Remember that, last week, you could not find your way home," or "Since your wife died, you don't leave the house much." For non-family members, reference to personal issues may be too intrusive.

The second option is to bring in family, advisers and/or third parties to help talk to the acutely ill person. The same approach to conversation should apply. Avoid threats, accusations or judgements; express concern and a desire to help. Appeal to their healthy self ("You are such an independent person – your inability to go to work shows you are not doing well."). See whether the person will agree to accept help.

If the person who is ill will not accept that he or she needs help, or if there are significant concerns about that person's potential response to a personal approach (such as reactive use of authority), family or advisers may want to seek trained advice on handling the situation. The person's primary-care physician or treating physician is the most obvious choice for such a consultation. In many jurisdictions, physicians are under legal or professional constraints that make them unable or reluctant to provide information without their patient's consent. However, those constraints should not prevent them from receiving information and using it in treating the patient. The goal is the alleviation of suffering.

If the person in question is extremely agitated, out of touch or presents a threat of danger to him/herself or others, that person needs to be treated on an emergency basis. First, see whether he or she will go voluntarily by whatever means seems to work. Involuntary means of obtaining treatment are a last resort, but sometimes the only option available. In emergency situations, professionals may be less constrained by confidentiality concerns in order to ensure a person's safety.

4.2 Managing the chronically ill

The keys to managing the chronically mentally ill are:

- identifying and obtaining good treatment providers;
- managing the environment for the chronically ill, including their family systems; and
- accepting the illness as a reality that is likely to require long-term, perhaps lifelong, treatment and management.

That said, each illness is different and each person is different, so this discussion is necessarily confined to some general outlines.

Good treatment and treatment teams are critical to the management of the chronically mentally ill. The treatment team generally includes a primary-care physician, a psychiatrist for medical/psychiatric treatment and a psychotherapist for help with insight, dealing with life's stresses, and reality checks. Social workers can provide both psychotherapy and case management to mobilise resources as needed. Counsellors can be brought in to help family members accept, understand and manage both the treatment and the person with illness. Good treatment is hard to identify, particularly for lay people dealing with a problematic illness. It is helpful to listen, analyse information and, if the information does not make sense, obtain another opinion.

Very often, the family members and family systems of the chronically ill have primary responsibility for care and management of the patient. The overarching task for the family providers is to guard against denial and wishful thinking, which may provide emotional solace but which may ultimately prove to be counterproductive and even destructive. Maintaining a balanced, structured approach to the provision of care is very helpful to all involved.

Be practical. For example:

- Pay bills directly to vendors (landlord, utility providers, treatment providers, tax authorities), to avoid the family member who is needing care having to do so. This ensures that the family member's money is used appropriately – if not, it adds unnecessary disruption to the family relationships. Don't pay credit card bills except in small, controlled amounts.
- Triage all information received. Respond to objective evidence. Self-reported information may be the result of impaired insight, misperceived realities or poor judgement, rather than misreporting. With addicts and antisocial personalities, self-reports may be deliberately deceptive.
- Use third-party managers for the management of treatment/support and of financial matters (assets, income) if financially feasible. This approach

simplifies family relationships and objectifies key decisions. Oversee such third-party managers and, as noted above, seek second opinions and alternative advice when 'red flags' pop up.

When/if remissions occur, family members and advisers should use the opportunity to work with the chronically ill person on the systems that are needed to manage the illness. For example, that is the time to obtain consents needed for access to health, treatment, financial and similar information. It is the time to discuss the management and treatment of a recurrence, should one arise, and to agree on the warning signs of recurrence that should trigger permission to bring up the possibility of recurrence. It may take more than one cycle of remission and recurrence for the ill family member to recognise the need for these procedures. Persevere.

Perhaps the hardest task for family caregivers is avoiding guilt or personalisation of the behaviour of the mentally ill. Try not to take unfounded accusations or personal attacks to heart – accept them as symptoms and make decisions without factoring them into the equation. Defensive or apologetic responses are unlikely to be useful. In addition, despite best efforts, stressed caregivers may act in ways that are punitive, judgemental or emotional. Accept the frailties of the well as well as the problems of the ill.

5. The family enterprise and members with disabilities

Family enterprises have unique opportunities and abilities to provide care and support for disabled stakeholders in their systems, whether members of the family, in-laws, outside owners, valued employees or others. Options range from special trusts for the disabled to employment accommodation by a family controlled business. The key is an understanding of the nature of the stakeholder's disability (characteristics, symptoms, impact), some integration in treatment of the disabling condition and use of trusted advisers in managing the systems put in place.

Work can be helpful for those with major mental illnesses. It can provide structure, social contact, financial support and self-esteem. Employers in the US (and elsewhere) are required to make "reasonable" accommodation of persons with disabilities, including mental disabilities, so long as the accommodation needed does not interfere with the business. However, family enterprises often have the financial means and governance abilities to make accommodations and implement structures that reach far beyond those available in other enterprises. One family created a computer business that was able to employ a severely autistic child. Another retained a family member as an officer of a major business after mid-life onset of bipolar disorder, implementing some internal checks and balances for protection of the enterprise. A third created an advisory board position for a founder with early-stage dementia.

Family members and advisers, when considering possible roles for the disabled in the family enterprise, should first consider the best interests of the enterprise, its constituent businesses and its various stakeholders. These interests may be strikingly different from those of a chronically ill family member (and his/her nuclear family).

In analysing the nature of the disabled person's illness, it is key to get objective opinions and advice from experts most likely to be trusted within the family system. It is also helpful to get appropriate advice on whether, what, how and how much to disclose to, and discuss with, other stakeholders in the system.

Family enterprises and their owners also can provide financial support for disabled family members outside the employment realm. For example, families can create for, or apportion to, the care of a disabled member a special class of ownership interest in one or more companies, providing income without control. In many jurisdictions, families can create private trusts for the care of the disabled, preferably managed by trusted advisers. In such ways, the family can ensure continuity of care without regard to employability.

For obvious reasons, family controlled enterprises may well be more committed to accommodating the needs of individual family members suffering mental illness than national or local laws require, or even than best practice in modern business indicates. Such accommodations are most likely to arise in companies where the culture of the controlling family constitutes the basis of the corporate culture of the enterprise. Such enhanced accommodations may not only assist in the management of, or recovery from, mental illness by a family member engaged in the family controlled enterprise, but also may encourage widespread expansion of such accommodations into company-wide state-of-the-art programmes. Such leadership across a family controlled firm in the treatment of mental illness may well provide new models of treatment for a much broader universe of companies and other institutions.

6. Conclusion

It is in the interests of all, from the individual level to the societal level, for mental illness to be promptly identified, properly diagnosed, appropriately treated and well managed. Unfortunately, it may be difficult to identify optimal treatment, because the science of mental illness is still too undeveloped and inexact – good treatment is hard to find, hard for lay people to identify and can be costly. Furthermore, stigma (overt and covert) is pervasive and serves as an obstacle to obtaining care.

There are many obstacles to care among individuals, families, communities and society generally. Thoughtful, well-informed analysis and consideration of objective evidence are the best tools available to overcome such obstacles and to provide suitable care for those with mental health problems in family controlled businesses.