CHEMICAL

DEPENDENCY

AND

INTERVENTION

You may find the below test helpful for yourself or for others.
The Other Bar (statewide confidential and anonymous number): 1-800-222-0676

ARE YOU AN ALCOHOLIC?

Ask yourself the following questions and answer them as honestly as you can:

		Yes	No
1.	Do you lose time from work due to drinking?		
2.	Is drinking making your home life unhappy?		
3.	Do you drink because you are shy with other people?		
4.	Is drinking affecting your reputation?		
5.	Have you ever felt remorse after drinking?		
6.	Have you gotten into financial difficulties as a result of drinking?		
7.	Do you turn to lower companions and an inferior environment when drinking?		
8.	Does your drinking make you careless of your family's welfare?		
9.	Has your ambition decreased since drinking?		
10.	Do you crave a drink at a definite time daily?		
11.	Do you want a drink the next morning?		
12.	Does drinking cause you to have difficulty in sleeping?		
13.	Has your efficiency decreased since drinking?		
14.	Is drinking jeopardizing your job or business?		
15.	Do you drink alone?		
16.	Have you ever had a complete loss of memory as a result of drinking?		
17.	Do you drink to escape from worries or trouble?		
18.	Has your physician ever treated you for drinking?		
19.	Do you drink to build up your self confidence?		
20.	Have you ever been to a hospital or institution on account of drinking?		

If you have answered YES to any one of these questions, there is a definite warning that you may be an alcoholic.

If you have answered YES to any two, the chances are that you are an alcoholic.

If you have answered YES to three or more, you are definitely an alcoholic.

(The above Test Questions are used by Johns Hopkins University Hospital, Baltimore, Maryland, in deciding whether or not a patient is an alcoholic.)

(You may substitute any drug, even as prescribed, in the place of alcohol/drinking, as a possible indicator. The test was devised specifically regarding alcohol.)

THE RESCUE MISSION

San Francisco, California

November 1, 1997

Dear Sir:

Perhaps you have heard of me and my nationwide campaign in the couse of temperance. Each year for the past fourteen, I have made a tour of Washington, Oregon, Nevada, California and Arizona and I have delivered a series of lectures on the evils of drinking. On this tour, I have been accompanied by my young friend and assistant, Clyde Lindstone. Clyde, a young man of good family and excellent background, is a pathetic example of life ruined by *excessive indulgence in whiskey and wild women.*

Clyde would apper with me at the lectures and sit on the platform, wheezing and staring at the audience through bleary, bloodshot eyes, sweating profusely, picking his nose, and passing gas and making obscene guestures, while I would point him out as an example of what *over-indulgence* can do to a person.

This past Summer, unfortunately, Clyde died. A *mutual friend* has given me your name and I wonder if you would be available to take Clyde's place on my 1998 tour?

Please advise by return mail.

Yours in Faith,

Reverend Elton Manko Jones
Rescue Mission-San Francisco

EMJ/gf

DEFINITION OF CHEMICAL DEPENDENCY:

Chemical Dependency is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is progressive and fatal. It is characterized by continuous or periodic impaired control over drinking and other drug use, preoccupation with alcohol and other drugs, use of alcohol and other drugs despite adverse consequences, and distortion in thinking, most notably denial.

Adapted by the American Society on Addiction Medicine (ASAM).

CODEPENDENCY

I. Definitions:

A. Rescuer, Caretaker, Enabler

B. "a person who has let someone else's behavior affect him or her and is obsessed with controlling other people's behavior." M. Beattie

C. "a relationship addiction in which people predictably give their power over to others to such an extent that they neglect their own needs and their lives become increasingly distressed."

D. "person who intervenes in such a way as to prevent another person from facing the consequences of their actions."

E. "addicted to another person"

DOS and DON'T'S:
FOR THE FAMILIES, FRIENDS AND CO-WORKERS OF ALCOHOLICS AND OTHER DRUG DEPENDENT PEOPLE

DO talk to someone who understands the disease of alcoholism and other drug addictions.

DO learn the facts about chemical dependency.

DO develop an attitude to match the facts.

DO go to Al-Anon and/or seek professional help.

DO learn about yourself, your needs, desires, reactions and behavior patterns.

DO maintain a healthy and consistent atmosphere in your home or workplace as much as possible.

DO share your knowledge with others.

DO be committed to your own growth, health and life goals - be constructively selfish.

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DON'T preach and lecture to the person addicted to alcohol or other drugs.

DON'T make excuses for the chemically dependent person.

DON'T rescue – let them clear up his or her own mistakes and assume the responsibility for the consequences of his or her drinking behavior.

DON'T make threats you won't carry out.

DON'T believe that you are the cause of the other person's alcoholism or drug dependency.

DON'T suffer for the chemically dependent person.

DON'T protect the chemically dependent person from alcohol or drinking situations whether he or she is drinking or in a program or recovery.

ADAPTED FROM INFORMATION PROVIDED BY:
The National Council On Alcoholism and Other Drug Dependencies - Bay Areas.

Addiction and the Legal Profession

1. Addiction – General Discussion

Magnitude of the Problem

The American Medical Association defines alcoholism and all other types of addiction as a *disease*. In a "perspectives" article in the journal of the American Medical Association, Brian Vastag wrote, "The brain changes during addiction." Mr. Vastag explained that all drugs of abuse activated a pleasure pathway in the brain, the "dopamine reward circuit." Eventually, he wrote "the dopamine circuit becomes blunted; with tolerance, a drug simply pushes the circuit back to normal, boosting the user out of depression but no longer propelling him or her toward euphoria." With repeated use, a new state of "normal" is created, requiring continued use to feel normal. The changes in the brain, though not permanent, can be long lasting. Whether the addiction is to alcohol, illegal drugs or prescription medication, addiction is addiction, no matter what substance is being abused. An earlier view, remarkably accurate for its time, was that alcoholism is an allergy of the body coupled with an obsession of the mind. Either way, it is a problem over which the abuser has very little control.

Under any characterization, substance abuse is a serious and widespread public health problem:

- 18 million Americans are estimated to have problems with alcohol,
- 5 – 6 million people in the U.S. have problems related to drug use,
- Alcohol and drug abuse cost the American economy an estimated $276 Billion each year in lost production, health care expenditures, crime, accidents and other factors,
- Untreated alcoholism and addiction are more costly public health problems than heart disease, diabetes, cancer and AIDS - - - combined![1]

[1] Substance Abuse: The Nation's Number One Health Problem; Institute for Public Health Policy, Brandeis University (Initially published in 1994 and updated 2001

The problem is no longer confined to alcohol and illegal drugs. Increasingly, people are innocently becoming addicted to widely prescribed stimulants, tranquilizers and painkillers. An April 9,2001 issue of Newsweek has an excellent cover article on painkillers. Vicodin is one of the most widely prescribed and highly addictive painkillers. Codeine, darvon, percodan, and the latest potent painkiller, oxycontin, are also highly addictive and being abused.

The harsh reality is that substance abuse is still present in alarming proportions, and it generates an enormous range of medical, social and criminal problems.

Statistically, the impact of substance abuse on health should, by itself, be enough to force most alcoholics and drug users to seek assistance. Drugs and alcohol are involved in 35% of psychiatric admissions, 20% of hospital admissions, account for 75% of trauma victims and 80% of the prison population, according to studies cited by the Betty Ford Professional Recovery Program.

Physically, alcoholics lose their health or their lives to a large range of devastating diseases, including:

- liver disease
- gastrointestinal bleeding
- anemia,
- pancreatitus,
- throat cancer,
- neurological disorders,
- injuries incurred from auto accidents or fights
- alcohol poisoning
- suicide.

Alcoholics have a reduced life expectancy: for men it is 48; for women it is 52, although longer life expectancy is probably a result of later onset of abuse. In fact, because of their smaller size and genetic differences, women succumb faster than men.

Addiction – Specifics within the Legal Profession

Substance abuse has always been identified with the legal profession. The stereotype of the "old drunken trial lawyer" has existed since the 18th century. Unfortunately, recent studies have confirmed a larger problem in the legal community than elsewhere.

While it is estimated that approximately 8- 10% of the general population suffers from the disease of chemical dependency, according to the American Bar Association, the corresponding estimate for lawyers is nearly double, between 15-18%. Most lawyers experiences extraordinary amounts of ***STRESS*** each day, resulting from long hours, deadlines, dealing with difficult clients, judges, and colleagues. Over time, these elements of stress take their toll, often resulting in a diminished or neglected family or social life. Substances are often used to relieve stress and can eventually become habitual. In a study done in 1990 by John Hopkins Medical School, lawyers were found to have the highest rate of clinical depression of all professions surveyed. Substance abuse often develops as an attempt to self-medicate the underlying mental health issue.

Roadblocks to recovery in the legal community include the outdated, but deeply ingrained, notion that addiction is a sign of weakness or moral failing. Lawyers and judges are held in high regard and usually maintain outside appearances. They are held to a higher standard of conduct. They are accustomed to being in control, and giving advice rather than receiving it. They are often more likely to intellectualize the problem

and are fearful of disclosure, loss of respect of colleagues, loss of clients, loss of job, loss of license. But these very roadblocks are also great motivators for addressing the problem, particularly loss of family, job and/or license. In approximately 50-70% of cases in which lawyers face disciplinary charges, alcoholism and/or addiction is involved.

1.3 Substance Abuse, Addiction and the Workplace

As extensively outlined in Alcohol and the Workplace, an article by Karen Clopton in theJuly 2001 issue of the California Bar Journal, alcoholism is a covered disability under the *Americans with Disabilities Act (ADA)*, the *California Fair Employment and Housing Act (FEHA)*, and federally, under those governed by Sections 501,503 and 504 of the *Rehabilitation Act* 29USCA s2612 (a)(1)(D). Under the *Family Medical Leave Act (FMLA)*, it is also deemed a serious health condition.

Not all substance abuse indicates an addiction. The difference between the substance abuser and one addicted to a substance is best described as follows. Once a person who is a substance abuser (a chronic heavy user or a periodic heavy user, one who on occasion after periods of abstinence, gets out of control for a period of time, rather than a habitual user) starts running into problems, legal, personal, professional, or medical, he/she can and will stop. If one has crossed the line into addiction, however, that person will no longer be able to predict or control their use on a consistent basis, and will continue to ingest the substance in the face of problems. It might here be noted that cocaine is the only substance that rats will take until they die. Once addiction has set in, a person loses the power of choice. Usually, a person will try to do controlled drinking or using, drinking only on weekends or switching drinks Sometimes, the method of control will work, but at other times, it won't. Those who have become addicted never know what the outcome will be once they start. They will find themselves getting into trouble even

when they started out with the best of intentions. They frequently will then suffer feelings of remorse and demoralization, anger at themselves which can then be projected onto others, often as blame.*

This is because **the brain has undergone changes** that set up what is called the phenomenon of **craving**, which sets in after the first drink or hit or pill. It is an allergy of the body, an inability to metabolize the substance in the same way that a person without such an addiction can, similar to the diabetic's metabolism of sugar. The allergy of the body is accompanied by an obsession with getting and using the desired substance.

Increasingly, studies point out a **genetic predisposition** to the disease. This is particularly true from male parent to sons, and especially so if both parents themselves suffer from alcoholism/addiction. In studies of adopted children, children of alcoholics have a 2-4x greater chance of developing the disease themselves, even if raised in a non-alcoholic home. *Similarly, in studies of the brain, the brain waves of sons of alcoholics differ markedly from the brain waves of non-alcoholics, studied long before they had ingested alcohol.* Alcoholism is a **chronic disease** and a **progressive** one. It will always get worse if untreated. There might be brief recovery, but without ongoing support, there is usually a **relapse**. It is a disease that tells you that there is no disease. This aspect, called **denial**, is a major hallmark of someone with a problem. Only 3 to 5% of those afflicted lose everything. Most have family, friends, jobs and function fairly well. However, *some* area of the addict or alcoholic's life will eventually suffer: family, social, financial, or professional.

The Implications of the Disease

Personally: marriages, family life and other social relationships suffer

Professionally: over time, there is a great, adverse, effect on productivity:

- poor work performance
- absenteeism
- excessive sick days
- unexplained absences especially on Mondays and Fridays
- lateness
- long lunches
- frequent breaks
- not returning from lunch
- neglect of appearance: smell of alcohol, bloodshot eyes or dilated pupils
- irritability
- argumentativeness
- insubordination
- missed deadlines, court appearances or late filings
- misuse of client funds
- complaints by colleagues, client etc.,

Symptoms of Dependency:

1) Tolerance, needing more of the substance to produce the desired effect;

2) A variety of withdrawal symptoms, which are treated with repeated use of the substance;

3) Increased use, drinking or using more than planned;

4) Craving, an overwhelming desire to use the substance;

5) Continued use in spite of problems;

6) Much time spent procuring, hiding and obsessing about getting or using the substance;

7) Repeated failed attempts to control use;

8) Isolation, loss of interest and abandonment of many social activities.

Three of these symptoms over a 12 month period indicate a problem.

Symptoms of abuse:

1) Failure to fulfill home or workplace responsibilities.

2) Physically dangerous use, e.g., driving under the influence.

3) Legal problems;

4) Continued use in the face of legal and/or personal consequences.

One or more of these symptoms over a 12-month period indicates substance abuse.

Treatment and Assistance

The best prognosis involves a person's honesty is admitting there is a problem, their willingness to seek or accept help, a supportive family and work environment, and continued contact with a support network. A person may be able to address the problem on his/her own with participation in a twelve-step program. These include, AA, NA, CA, MA etc. **The Other Bar** is a non-profit, free assessment and referral service available without cost to lawyers, judges, law students, active or retired who need assistance with substance abuse. It is meant to be a bridge to a recovery meeting, but also has its own support meetings throughout the state. **(800-222-0767; www.otherbar.org)** The Other Bar also offers educational and prevention programs and is an MCLE provider. Consultants throughout the state can bring a panel to a law firm, law school, corporation, the judiciary etc. It operates a 24hr/7day support hotline **(800-222-0767).**

Sometimes, a combination of counseling, out-patient treatment and attendance at a support network will be sufficient. At other times, residential treatment is the best approach to treatment, coupled always with follow-up in an ongoing support meeting. If there is family involved, it is important that the family be treated as well. It is a disease that affects the whole family. They need to learn how to be supportive in a detached rather than an enabling way. The addict/alcoholic needs to face consequences. **Interventions,** done with the guidance of a trained interventionist, can often be used to successfully persuade the substance abuser that he or she needs treatment.

Professionals have been found to have a higher success rate in recovery when they recover with other professionals. They are likely to be less guarded in sharing their problem with others in their profession, who share common experiences and work environment. The shame and denial that often

accompany addiction are more easily penetrated.

The Lawyer Assistance Program

For attorneys facing mental health disabilities, which may or may not be accompanied by substance abuse and for attorneys with discipline issues, there is the Lawyer Assistance Program (SB479) which became effective January 1, 2001. (866-436-6644)

This is a more structured program than the assistance provided by the Other Bar. It may require up to a 5 year commitment, an expenditure of funds for which financial aid may be available, random testing and meetings facilitated by a therapist. For the attorney facing discipline or experiencing mental health issues, this program is especially beneficial.

Conclusion

Substance abuse affects the legal profession more so than the general population. It is a threat to the public, can be fatal to the one impaired, and has disastrous consequences to those in close personal or professional relationships with the one impaired. If you or anyone you know, personally or professionally, needs help, there is help and hope . Get help for yourself. Attend Alanon meetings and learn how to take care of yourself and not enable the substance abuser. Enlist the assistance of the Lawyer Assistance Program and the Other Bar. Consider an intervention. But do not ignore the problem. Urge the addict/alcoholic to seek help. You may save a life or a license.

SOME SIGNS and SYMPTOMS of CHEMICAL DEPENDENCY

(with thanks to Florida Lawyers Assistance, Inc.)

Family	Physical	Community	Office	Professional
Withdrawal from family and pleasurable activities	Multiple Complaints	Decreased participation in community affairs	Disorganized appointment schedule	Inappropriate behavior or mood
Frequent absences	Increased use of prescription medication	Change of friends, acquaintances	Hostile behavior to staff and clients	Decreasing quality of performance
Frequent arguments; child/spouse abuse	Increased hospitalization	Drunk and disorderly incidents, public intoxication, DWI arrests	Locked door syndrome (drinking or using at work)	Inappropriate pleadings, decisions
Family members display codependent behaviors	Frequent visits to doctors, dentists, medical professionals	Leaders in community lose confidence	Borrowing money from partners, associates or staff	Partners, associates, staff notice and discuss changes in behavior
Children may engage in abnormal, antisocial, or illegal activities	Personal hygiene, dress, and appearance deteriorate	Marked change in participation in weekly routines – including religious and volunteer participation	Frequently absent, sick, or missing from work	Client complaints, disciplinary issues and malpractice suits
Sexual problems (dysfunction, affairs)	Accidents, trauma, ER visits	Sexual promiscuity	Clients openly complain to partners, associates and staff	Missed appointments, hearings, depositions
Separation or divorce (often initiated by spouse)	Serious emotional crisis	Isolation from support systems, friends and family	Increasing unexplained absences	Loss of clients, practice, unemployment

THE SOLUTION

Depression: The Parable of the Boiling Frog

By Doreen A. Diego

As a case manager for the California Lawyer Assistance Program, I have found that the lawyers I counsel inevitably fall into one of two categories: those who seek help early and those who do not. Lawyers in that second category always remind me of the unfortunate subjects in the scientific experiment that gave rise to the Parable of the Boiling Frog. Although I've heard the story a million times, I'm continually intrigued by how applicable its findings are to basic human behavior.

If you recall, the experiment compares the responses of frogs to two different scenarios. In the first scenario, researchers place a frog into a pot of boiling water. Without hesitation—and regardless of the water level—the frog immediately acts on instinct and jumps to safety.

In the second scenario, the same frog is put into a pot of water, but this time the water temperature begins as comfortable, pleasing, and non-threatening. Researchers then gradually raise the temperature and wait for the frog to realize it is in danger and take appropriate action. As you may suspect, this never happens. Although the frog displays sporadic moments of pain and discomfort, it does nothing. It continues to endure, adapt, and withstand the intolerable environment. The frog becomes increasingly lethargic and less responsive. Then it dies.

Like the frog unable to react to gradually heating water, lawyers who ignore the gradual onset of depression do so at their own peril. Lawyers who experience sudden, debilitating depression won't think twice about seeking help. But in its milder form, depression can creep steadily forward, overtaking your life when you least expect it.

Major Depressive Disorder

In the United States, major depressive disorder is reported to affect nearly 14.8 million adults every year. Although this illness can develop at any age and affect both men and women, the median age at onset is 32 years old, and the disease is more prevalent in women than in men. According to the National Institute of Mental Health, a person must exhibit five (or more) of the following symptoms during the same two-week period to qualify as having major depressive disorder (and the combination of symptoms must include one of the first two categories below):

- Persistent sad, anxious, or "empty" mood
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, oversleeping
- Loss of appetite or weight loss, or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

The core of one's depression may be biological—such as a neurochemical imbalance—or it may be triggered by a psychosocial event, such as losing a loved one, losing a job, foreclosure on a home, or being diagnosed with a life-threatening disease. Regardless, individuals suffering from major depressive disorder are in incredible pain, and as ironic as it may sound, this may be to their advantage. Ultimately, their heightened sense of awareness in knowing that the water is hot, that their pain is real, and that they can no longer cope on their own is enough to prompt them to seek help immediately, thus saving their lives.

Dysthymic Disorder

In the United States, dysthymic disorder is reported to affect 3.3 million adults every year. Although it can develop at any age, the median age at onset is 31 years old. The symptoms of dysthymic disorder can be similar to those previously described for major depressive disorder. However, the criteria and intensity of the symptoms with this disorder are typically milder and less rigid. According to the National Institute of Mental Health, an individual must have a depressed mood for most of the day for more days than not for at least two years to qualify for a diagnosis of dysthymic disorder.

Individuals suffering from dysthymic disorder typically describe their circumstances as less intense and more tolerable. Like the frog in the second scenario, they have been sitting in the water for some time and don't believe that they are in danger. Over time, they internalize, adapt to, and negotiate the signs and symptoms of their depression, while unconsciously accommodating the negative changes and behaviors that are taking place in and around

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them. Like the frog, they are unable to see that they are at risk until it is too late.

Froggy Went A Courtin'

Unlike their amphibious counterparts, however, lawyers suffering from the slow progression of dysthymic disorder do get one final wake-up call for action, one dreaded event that has the power to unleash their ability to act and confront their problems head-on: a state bar discipline complaint.

Time and time again, their story is the same. It begins, "I am now contacting the Lawyer Assistance Program and seeking help owing to a State Bar discipline complaint . . . a matter that could have been avoided had I just taken action." Tearfully they describe a common innate feeling of dissatisfaction—dissatisfaction with themselves, with their lives, and especially with their jobs.

They contemplate whether or not they want to continue practicing law, whether it would be easier simply to walk away from their profession (and thus avoid getting help altogether) rather than take the steep punishment that appears inevitable.

They describe their days as little more than going through the motions. They are unable to open their mail, can stare at paperwork for hours, and do nothing on their computers. They shuffle papers from pile to pile and don't return calls. They forget important dates and make excuses to cover their inadequacies. They are late for appointments, forget to file documents, and miss court dates.

They are financially burdened. They possess the fallacious belief that having more money will solve their problems. They acknowledge that clients owe them money, but they are unable to gather the strength to confront the matter and follow through with a plan.

Similarly, their personal lives are a shambles. Their relationships are either severed or dormant, and their family and intimate partnerships are typically no longer satisfying. If they have been fortunate enough to remain married or in a stable relationship, rarely do they find the kind of fulfillment they wish for in their homes, marriages, and especially in their sex lives. They may argue with those near and dear, or they may have taken a virtual oath of silence, avoidance, or non-confrontation.

They are lonely. Incredibly lonely. They are isolated and disconnected. They will tell you that they have many acquaintances but few true friends. They are angry, embarrassed, and shameful for their failure, with their best intentions never being enough.

Physically, they disclose numerous health concerns and psychosomatic complaints. They describe memory loss, forgetfulness, and a fearful sense of awareness that their thinking is not what it used to be. They report visiting doctors frequently and taking an array of medications to ease their pain.

So Get Jumping!

By this time, I hope I have conveyed my purpose for writing this article. If you recognize in your own life any of the symptoms described above, seek help early—before that dreaded notice from the state bar. Realize that matters only escalate. Rather than trying to ignore or adapt to your increasingly intolerable circumstances, try doing something different. First, acknowledge that the water is getting steamy. Stop denying it! Then, try jumping to safety—seek the help that is available to you, whether through your local lawyer assistance program or through private counseling.

Although this article was written around the theme of depression, it goes without saying that my message will apply to numerous other illnesses, behaviors, and mental health disorders—including addiction, anxiety, eating disorders, post-traumatic stress, infidelity, alcoholism, and anger. Any number of physical or psychological factors may be the cause, but the effects can be quite similar. And if you find that you completely identify with the professional or personal predicaments described above but you still can't put your finger on exactly what is wrong—seek help anyway! The water will only get hotter.

IN THE SOLUTION

Defense Strategies: Good in Court, Bad in Recovery

By Doreen A. Diego

Why is obtaining treatment and adhering to the fundamental framework and principles that govern mental health and substance abuse programs difficult for most lawyers? What is it that most lawyers struggle with, and why? And how can lawyers better succeed in recovery? The answers to all of these questions involve defense mechanisms.

Before I begin, I would like to make one thing clear. What I am about to discuss is not exclusive to lawyers. Almost any substance abuse or mental health clinician will tell you that every client exhibits forms of defense mechanisms during the treatment process. However, it is my clinical observation that lawyers as a specific population appear more highly skilled and comfortable utilizing these behaviors, thus making the recovery process even more difficult.

Redefining Recovery

Typically, when people hear the word "recovery," they immediately think "addiction"—and then conclude, of course, that it doesn't apply to *them*. I would propose that there is a broader definition of "recovery" that can apply to any one of us. William A. Anthony, executive director of the Boston Center for Psychiatric Rehabilitation, describes recovery as a deeply personal and unique process involving the changing of one's values, attitudes, goals, skills, roles, and feelings. Furthermore, he believes that recovery involves the process of developing new meaning and purpose as the individual strives toward living a much more satisfying, hopeful, and contributing life.

Lawyers may enter the recovery process for any number of reasons. For some it is addiction, for others it may be depression, anxiety, grief and loss, or a recurrent pattern of poor relational functioning with spouses, children, family, friends, or co-workers. Regardless, lawyers must become more aware of the various defense mechanisms that can operate in and through them, understand why they are formed, and see how they can negatively impact and sabotage the recovery process.

Understanding Defense Mechanisms

Defense mechanisms begin developing in early childhood and typically form to help us emotionally survive in reaction to a specific need or stressor. As children, we have limited cognitive abilities and simplistic views of the world. It is difficult for us to make sense of and file away emotionally disturbing experiences. Consequently, defense mechanisms shield us from distressing life experiences and aid in cognitively processing and compartmentalizing our chaotic life experiences.

For example, a child who grows up in a dysfunctional home may unconsciously engage in *denial* as a means of coping. When she is able to convince herself that nothing is wrong in her family, she can normalize the experience and calm down the intrusive and distressing feelings, thus removing them from the conscious part of her mind.

And what about the child who discovers that *acting out* will relieve his anxiety and allow him to feel emotionally calm once again? At a young age he learns that defiance can divert the dysfunction away from the external problem and onto him, thus allowing him a greater sense of control. He is now able to make sense of the experience internally—by blaming himself as the problem.

Humor is a defense mechanism often seen in the younger siblings of a dysfunctional home. The child unconsciously learns that humor can be an effective coping strategy to divert the emotional chaos away from the problem and onto himself—by being humorous and making others laugh.

As children mature, however, it is expected that they will develop a more sophisticated set of healthy coping strategies that typically replace childhood defenses. For example, you would expect that the child who once employed the primitive defense of *acting out* would eventually mature and become better equipped to cognitively process and efficiently compartmentalize his distressing life experiences, thus no longer needing the defense.

Unfortunately, this is not always the case.

Identifying Defense Mechanisms

According to Timothy J. Sweeney, director of the Recovering Attorneys' Program at HealthCare Connection in Tampa, Florida, lawyers display an array of defenses as a means of contesting, counteracting, and sabotaging the treatment process. He agrees that lawyers are not the only ones to use defense mechanisms, but he finds they are typically more skilled in their application than non-lawyer patients.

Over the last 15 years he has observed a number of common themes displayed by lawyers who struggle with

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embracing recovery. For example, lawyers will *externalize the focus* away from themselves and onto other patients in the program. They do this to minimize the severity of their illness by rationalizing that others are sicker than themselves. They will also blame their family for their problems or attack the protocol and procedures of the treatment facility. To manipulate the process and avoid dealing with their recovery, lawyers may employ a strategy of *ultra-compliance* with the treatment team staff, using kindness, phony cooperation, and sycophancy disguised as affability; alternatively, they may *create personality conflicts* with staff and patients, requiring (in their minds) termination of treatment.

As a case manager for the California Lawyer Assistance Program, I, too, have observed a common set of behaviors that lawyers employ to resist change. For example, some lawyers are comfortable *intimidating* others, presenting themselves as non-friendly and stoic, with limited verbal disclosure and closed-off nonverbal behavior. These lawyers have learned that intimidation is an effective tool to keep others at a distance—thus allowing themselves to remain in denial.

Intellectualizing is another defense that comes easy for lawyers. It can be quite useful and effective with regard to their professional careers. Unlike lawyers who use intimidation, lawyers who engage in intellectualizing may present as more controlled, polite, and mild-mannered. For example, when a clinician is doing the work of recovery, some lawyers may sidetrack the process by getting intellectually caught up in the logistics of the program, thus diverting the emphasis away from them.

Rationalization can be used for the same purpose. Lawyers may employ an advanced set of cognitive and psychological skills to effectively feed their denial and normalize the uncomfortable experiences surfacing as a result of their illness. They may measure themselves against others in order to prove that they are not that bad off. Or they may convince themselves that if they truly had a problem, they would not be as successful as they are.

Minimizing is a defense mechanism by which lawyers are consciously aware of a painful reality but are unwilling to give it much weight. People who minimize make such statements, as "it's no big deal," or "it was just one DUI."

Victimization is another favorite strategy of lawyers in recovery programs. Being the victim can have a very powerful effect on how people approach you. Unlike the intimidator who uses behaviors to push people away, the victim uses behaviors to pull people closer. They elicit the sympathy and compassion of others, but not in a healthy direction that addresses their recovery.

Conquering Defense Mechanisms

As a lawyer entering the recovery process, how can you begin to overcome these strategies?

Determine your defense. Explore the various forms of defenses and see if any resonate. Although I've named just a few, there are hundreds of defense mechanisms operating in each and every one of us. Jerome S. Blackman's book, *101 Defenses: How the Mind Shields Itself*, is an excellent resource.

Evaluate its effectiveness. Identify at least one dominant defense mechanism that you recognize in yourself and honestly reflect on its consequences. Has the behavior created more good than bad? Or has it caused you to feel internally guilty and troubled? Have others expressed concern about it? Do a critical evaluation of the behavior and see if it's worth further exploration.

Find the fear. It's time to critically explore what underlying fear you are preventing by not letting go of the defense. Maybe it's a fear of conflict. Maybe failure. Maybe a fear of vulnerability—that others will take advantage of you—or a fear of disapproval. Maybe it's fear of needing to be assertive. Sorting this out won't be easy. As a start, try looking back into your childhood. Reflect on what was most difficult for you while growing up. You might be surprised at how that still operates in you today.

Convert to a healthy coping mechanism. It's time to look at replacing defenses with healthy coping strategies. This may be challenging. I recommend considering your local lawyer assistance program as a valuable resource to begin the recovery process. For example, the California Lawyer Assistance Program offers lawyers a dynamic program that is both clinically sound and comprehensive in nature, thus providing a therapeutically safe haven to begin the process. Furthermore, the safety and support offered in our lawyer-only groups assist lawyers in better understanding the challenges specific to their problems. Don't miss out on what's available to you. Remember, it's time to trust, to step out of the box and do something different, to begin anew.

Criteria for Substance Dependence Disorder
Diagnostic Statistical Manuel -IV-TR

FEATURES

The essential feature of Substance Dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine. The symptoms of Dependence are similar across the various categories of substances, but for certain classes some symptoms are less salient, and in a few instances, not all symptoms apply (e.g., withdrawal symptoms are not specified for Hallucinogen Dependence). Although not specifically listed as a criterion item, **craving** (a strong **subjective drive** to use the substance) is likely to be experienced by most (if not all) individuals with Substance Dependence. Dependence is defined as a cluster of three or more of the symptoms listed below occurring at any time in the same twelve (12) month period.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (3) or more of the following, occurring at any time in the same twelve (12) month period.

(1) ***tolerance, as defined by either of the following***

- (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
- (b) markedly diminished effect with continued use of the same amount of the substance

(2) ***withdrawal, as manifested by either of the following***

- (a) a characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
- (b) the same (or a closely related) is taken to relieve or avoid withdrawal symptoms

(3) The substance is often taken in larger amounts or over a longer period than was intended (*loss of control/centrality/maintain and denial)*

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use *(loss of control)*

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances) *(centrality)*

(6) important social, occupational, or recreational activities are given up or reduced because of substance abuse *(narrowing /centrality/ isolation)*

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance *(deny/maintain)* (e.g., current cocaine use despite recognition of cocaine-related depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) *(loss of control of substance use)*

Criteria for Substance Dependence Disorder, continued

Course Specifiers

Early Full Remission - for at least one (1) month, but less than twelve (12) months, but no criteria for Dependence or Abuse have been met

Early Partial Remission - for at least one (1) month, but less than twelve (12) months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

Sustained Full Remission - used if none of the criteria for Dependence or Abuse have been met at any time during a period of twelve (12) months.

Sustained Partial Remission - used if full criteria for Dependence have not been met for a period of twelve (12) months or longer, however, one or more criteria for Dependence or Abuse have been met.

Criteria for Substance Abuse Disorder

FEATURES

The essential feature of Substance Abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. *(deny and maintain)* In order for an Abuse criterion to be met, the substance-related problem must have occurred repeatedly during the same twelve (12) month period or been persistent. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurring social and interpersonal problems (Criterion A).

Unlike the criteria for Substance Dependence, the criteria for Substance Abuse Disorder **does not** include tolerance, withdrawal, or a pattern of compulsive use and instead include **only the harmful consequences of repeated use.** A diagnosis of Substance Abuse is preempted by the diagnosis of Substance Dependence if the individual's pattern of substance use has **ever** met the criteria for that class of substances (Criterion B).

Although a diagnosis of Substance Abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of Substance Dependence

The category of Substance Abuse does not apply to caffeine and nicotine.

The term *abuse* should be applied only to a pattern of substance use that meets the criteria for this disorder, the term should not be used as a synonym for "use," "misuse," or "hazardous use."

Criteria for Substance Abuse Disorder, continued

A A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g.,repeated or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school: neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or inter-personal problems caused or exacerbated by the effects if the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B The symptoms have never met the criteria for substance dependence for this class of substance

Substance-Induced Disorders
Substance Intoxication

A The development of a ***reversible*** substance-specific syndrome due to recent ingestion of (or exposure to) a substance. ***Note***: different substances may produce similar or identical syndrome.

B Clinically significant maladaptive behavioral or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgement, impaired social or occupational functioning) and develop during or shortly after use of the substance.

C The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Diagnostic Features

The essential diagnostic feature of Substance Intoxication is the development of a reversible substance-specific syndrome due to the recent ingestion of (or exposure to) a substance (Criterion A). The clinically maladaptive behavior or psychological changes associated with intoxication (e.g., belligerence, mood lability, cognitive impairment, impaired judgement, impaired social or occupational functioning) are due to the direct physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance (Criterion B)

The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C).

THE DIAGNOSTIC AND STATISTICAL MANUEL OF MENTAL DISORDERS - DSM-IV -TR

Please note: The italicized text refers to the concept of
Deny-Maintain
Centrality of Problem
Loss of control
(Brown: 1985)
It is not noted in the DSM-IV-TR

FAMILY - TRYING TO REMEMBER WHO WE WERE

I'm trying to remember who we were before this addiction thing pushed in our doors, flooded our house, then left us homeless.

There came this pall. This cloud; we could feel it, couldn't discuss it, because we had no language, no history with it ... seeing it wasn't easy either. In your face and ever so invisible, we tried making sense of the uninvited, prominently elusive home invader. It was as if our son had brought it home with him, in him ... he was not as we had known him.

Who were we before it showed up? I can't forget, but I can't quite remember either. Stealth waves of confusion washed over us, daunting, making us blink, shaking our heads in disbelief and intent to wake up, defining us, and silencing us before we knew what to call it.

The intruder had taken our beloved son, making him only a ghost of what he was before. We could see *his* changes, but not *our* own. My anger sometimes turned to hatred, the shame of it kept me silent. He became a familiar stranger, we became invisible, mute was our language, our silence, our own safe oblivion.

We did seek help. I knew we needed help. We were accused of playing victims and in desperate need of tough love. All that we did was wrong? What in the hell was that? Forced to take action on something so pervasive, so invisible silenced us even more. Strained manikin-like smiles plaster our faces. Stop this, do that - our grins grew really grim. Sad masks for confusion and feigned, counterfeit contact reigned - and became our norm.

I don't know when we became aware of living in dread, a silent morbid anticipation became our way of being; I stopped breathing, dad stopped laughing, we all slipped into it. We began to forget, just forget. I don't know how we got there. We changed too. Does this explain anything, Does any of this make sense? Does any of this help???

The difference between passion and addiction is that between a divine spark and that a flame that incinerates. The sacred fire through which Moses experienced the presence of God on Mount Horeb did not annihilate the bush from which it arose: "and YHWH's messenger was seen by him in the flame of a fire out of the midst of a bush. He saw: here the bush is burning with fire, and the bush is not consumed!" Passion is divine fire: it enlivens and makes holy; it gives light and yields inspiration. Passion is generous because it is not ego-driven; addiction is self-centered. Passion gives and enriches; addiction is a thief. Passion is a source of truth and enlightenment; addictive behaviors lead you into darkness. You're more alive when you are passionate, and you triumph whether or not you attain your goal. But addiction requires a specific outcome that feeds the ego; without that outcome, the ego feels empty and deprived. A consuming passion that you are helpless to resist, no matter what the consequences, is an addiction.

You may devote your entire life to passion, but if it is truly a passion and not an addiction, you'll do so with freedom, joy, and a full assertion of your truest self and values. In addiction, there's no joy, freedom or assertion. The addict lurks shamed-faced in the shadowy corners of her own existence. I glimpse shame in the eyes of my addicted patients in the downtown Eastside, and in their shame, I see mirrored my own.

Addiction is passion's dark simulacrum and, to the naïve observer, its perfect mimic. It resembles passion in its urgency and in the promise of fulfillment, but its gifts are illusory. It is a black hole. The more you offer it, the more it demands. Unlike passion, its alchemy does not create new elements from old. It only degrades what it touches and turns it into something less, something cheaper.

Am I happier after one of my self-indulgent sprees? Like a miser, in my mind I recount and catalogue my recent purchases - a furtive Scrooge, hunched over and rubbing his hands together with acquisitive glee, his heart growing even colder. I wake from a buying binge, I am not a satisfied man.

Addiction is centrifugal. It sucks the energy from you, creating a vacuum of inertia. A passion energizes you and enriches your relationships. It empowers you and gives strength to others. Passion creates; addiction consumes - first the self and then the others within its orbit.

Gabor Maté, MD
In the Realm of Hungry Ghosts
Close Encounters with Addiction
ISBN 978-1-55643-880-6 (2010)

RESOURCES

The Other Bar (California)
1 (800) 222-0767 - otherbar.org : confidential@otherbar.org
The Other Bar is a network of recovering lawyers and judges throughout the state, dedicated to assisting others within the profession who are suffering from alcohol, chemical dependancy and substance abuse problems. They are a private, non-profit corporation founded on the principle of anonymity and provide services in strict confidentiality. The program is voluntary, does not report to anybody or entity (not sponsored by or part of the State Bar) and is open to all California lawyers, judges and law students.

California Lawyer Assistance Program
1 (877) 527-4435 - calbar.ca.gov
State bar sponsored program including assessment, testing and counseling as a lawyer assistance resource for alcohol and substance misuse and mental health. The program is completely confidential unless part of the disciplinary process.

Lawyers Assistance Programs (CoLAP: Commission on Lawyer Assistance Programs)
1 (800) 285-2221 - americanbar.org
Lawyer Assistance Programs are available nationwide. Some are independent, some are under the auspices of the court and some are part of the bar association. They are listed at:
americanbar.org/groups/lawyer_assistance.html

12 Step Support Meetings

Alcohol:	1 (212) 870-3400 - aa.org
Overeating:	1 (612) 377-1600 - overeaters.org and eatingdisordersanonymous.org
Cocaine:	1 (310) 559-5833 - ca.org
Sex:	1 (800) 477-8191 - saa-recovery.org
Gambling:	1 (626) 960-3500 - gamblersanonymous.org
Co-Dependency:	1 (888) 425-2666 - al-anon-alateen-msp.org

SAMHSA: U.S. Department of Health and Human Services and Substance Abuse and Mental Health Services Administration: clearinghouse for alcohol and drug information
1 (877) 726-4727 - samhsa.gov
This organization has a great deal of information for individuals seeking help, professionals in the helping professions and researchers.

Recovery Month
1 (877) 726-4727 - recoverymonth.gov
This annual event is held every September. It features events and resources for those with substance abuse use issues and those who are about them.

American Bar Association
1 (800) 285-2221 - americanbar.org
americanbar.org/groups/lawyer_assistance.html for lawyer assistance resources and information across the country. National resources are listed at apps.americanbar.org/legalservices/colap/laplinks.html
Numerous articles are linked at apps.americanbar.org/legalservices/colap/resourcelib.html

Past issues of GP Solo, a publication of the ABA General Practice, Small Firm and Solo Division,

include four theme issues "Bumps in the Road." Many topics related to addiction, mental illness, stress and others are available. Back issues may be viewed at:
americanbar.org/publications/gp_solo/past_issues.html

National Alliance on Mental Illness
1 (800) 950- 6264 - nami.org
NAMI has information on a wide variety of mental illness including ADHD, Bipolar Disorder, Personality Disorders, Depression, Eating Disorders, OCD, PTSD and others. There are also national and local support resources.

Depression and Bipolar Support Alliance
1 (800) 826-3632 - ndmda.org
A patient-directed organization whose purpose is to educate patients, families and the public concerning the nature of depressive illness.

American Psychological Association
1 (800) 374-2721 - apa.org
Numerous resources on many mental health and wellness topics

American Psychiatric Association
1 (888) 357-7924 - healthyminds.org
The site provides information on psychiatric disorders such as depression and provides help locating a psychiatrist in your local area.

American Psychiatric Foundation
1 (703) 907-8503 - psychfoundation.org
Committed to operating programs and funding initiates that promote awareness of mental illness, the effectiveness of treatment, and the importance of early intervention.

Mental Health America
1 (800) 969-6642 - nmha.org
An association that works with over 340 affiliates to promote mental health through advocacy, education, research, and services.

National Institute of Mental Health
1 (301) 443-4513 & 1 (866) 615-6464 - nimh.nih.gov
Information regarding various mental health issues, including anxiety disorders and depression.

National Institute on Drug Abuse
1 (301) 443-1124 - drugabuse.gov
This division of the National Institutes of Health provides information on the science of drug and alcohol addiction. There are links to a wide variety of substances. An excellent, *The Science of Addiction*, is available by mail as a PDF, in English or Spanish.

Behavior Health Treatment Services Locator
This is an on-line source of information for persons seeking treatment facilities in the United States or U.S. Territories for substance abuse/addiction and/or mental health problems.
https://findtreatment.samhsa.gov

LAWYER SUICIDE

by James O. Heiting

This is an article about suicide of lawyers. I write it at the request of your editor and with ever increasing resources and emphasis for suicide prevention and mental health in our profession. But why should we address this? Is it really a problem? Let's take a look.

In a nine year period, the Mecklenburg County Bar Association in Charlotte, North Carolina, lost eight members to suicide. Seven men and one woman (sole practitioners, small firm and large firm lawyers), took their lives through a variety of methods and locations. The average age was the early 40's. Depression and alcohol and drug abuse were identified as some, not all, of the contributing and underlying causes.

Recently, Kentucky reported, over a two year period, one lawyer suicide every eight weeks (in a state bar of approximately 18,000). Maine reports a little less than one suicide attempt per 1000 attorneys in their state bar annually. Illinois reported that, when they held a suicide prevention program in 2013, they had expected 25 to 30 registrants, but instead had 155 register and attend the two and a half hour program. California's acting executive director of the Lawyer Assistance Program advises that the experience in Kentucky "is pretty consistent with the data about suicide"; but he also reports that "a high percentage of folks who are stopped from successfully committing suicide the first time and receive help never make a repeat attempt."

North Carolina once reported that they did a survey on quality of life and found that almost 12% of the bar's members reported that they contemplated suicide at least once every month. Johns Hopkins University studied depression in professionals and determined that lawyers were three times more likely to suffer depression than any other profession. And alcohol and/or chemical abuse appears to raise the statistical chance of an attempt at suicide by ten times over the rest of the population!

Many times we see developing depression that leads to these extremes in people that are good lawyers, good people. They are usually hard on themselves, perfectionists who give great attention to detail and want to do a good job. Many can seem very likeable and light-hearted, but they conceal sadness, anxiety, emptiness. They seem to have lost interest in things that used to give them pleasure. They find it difficult to find pleasure or joy in anything. They may start to feel guilty, worthless, and helpless. They have difficulty concentrating, making decisions, sleeping soundly. They start to develop feelings of hopelessness and pessimism, restlessness and irritability. They may have persistent physical symptoms that do not seem to respond to treatment.

There can be a feeling that, "I am so tired, and I don't see any way out of the box I am in." Such people can find themselves in a place where they have lost all hope. They obsess on a permanent solution (suicide) to what, ultimately, is a temporary problem. "This too shall pass," while true, is extremely difficult to realize.

And, like in chemical dependency or alcoholism, denial is common. We try to convince ourselves that we are not at risk. We try to distinguish ourselves from those who have attempted or died by suicide; yet we continue to withdraw and isolate, thinking and hoping that we can address this issue ourselves, without outside help. That can be a very dangerous road.

Depression may have its onset with the loss of a relationship or a loved one, financial pressure, being diagnosed with a life threatening disease or other major event; or it may be biological through neural chemical imbalances. Depression is treatable.

Actually, the first reported investigation and study of lawyer suicides was in Canada. Incredibly, over a two-year period, the study uncovered that "suicide was . . . the third-leading cause of death among these lawyers . . . after cancer and cardiac arrest. Suicide accounted for 10.8% of all lawyer deaths." They calculated a projected rate of 69.3 suicide deaths per 100,000 lawyers, nearly six times that of the general population. Most at risk were lawyers and judges aged 48 to 65 (with no studies being conducted for those over 65). Thankfully, Canada has put in place education and response programs through their lawyer assistance efforts and suicide prevention professionals that have resulted in a much lower incidence of lawyer suicides ever since.

WHAT CAN I DO TO HELP?

LISTEN! Be non-judgmental and empathetic. Understand that a threat of suicide is very serious. Every threat of suicide is a call for help. Be sure to take it seriously.

One suggestion of professionals is to ask if the person is feeling suicidal. Contrary to the feeling that you may be putting the suggestion in their heads, the question

and your concern will give them permission to talk about it. If they have a plan to carry out the suicide, try to get them to commit not to take any action at least until they see you again. Encourage them to seek professional help, and even offer to make the call for them and take them to their first visit. If they threaten immediate action on their plan, do not leave them alone. Get them into a professional's care as soon as possible, taking whatever steps necessary to do so. You might even take them to the emergency room of the nearest hospital.

Hopefully, with help, the person going through this will realize that this time in their life is not a period; it is a comma, and there is more to the sentence. It is okay to feel depressed. It is okay to ask for and get help. There are times when all of us need help.

Here are some suggested resources. Even though they include other jurisdictions, they can be very helpful: California Lawyer Assistance Program (lap@calbar.ca.gov, 1-877-LAP4HELP); National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org, 1-800-273-TALK); Canadian Bar Association (www.lpac.ca, 24-hour help line 1-800-667-5722); Lawyer Assistance Program of the American Bar Association (www.americanbar.org/groups/lawyer_assistance, 1-866-219-6474); Georgia (for information and education videos, www.gabar.org, 1-800-327-9631); Illinois (www.illinoislap.org, 1-800-LAP-1233); Kentucky (www.kylap.org, 1-502-564-3795); North Carolina (www.nclap.org, 1-704-892-5699); lawyerswithdepression.com; www.kevinhinesstoryinc.com; and there are a variety of other resources.

I wish you the best of good health. Give me a call if I can help.

James Heiting is the former president of the California State Bar and current chair of the Substance Use Disorders Advisory Board to the Health Law Section of the American Bar Association.

The Press-Enterprise

Dec. 2014

NEWS BREAK

FILE PHOTO: THE ASSOCIATED PRESS

Dr. George Koob, director of the National Institute on Alcohol Abuse and Alcoholism, left, and scientist Dr. Lorenzo Leggio.

POUR ANOTHER, FOR SCIENCE

The tequila sure looks real, so do the beer taps. Inside the hospital at the National Institutes of Health, researchers are testing a possible new treatment to help heavy drinkers cut back – using a replica of a fully stocked bar.

The idea: Sitting in the dimly lit bar-laboratory should cue the volunteers' brains to crave a drink, and help determine if the experimental pill counters that urge.

But these bottles are filled with colored water. The real alcohol is locked in the hospital pharmacy, ready to send over for the extra temptation of smell – and to test how safe the drug is if people drink anyway.

"The goal is to create almost a real-world environment, but to control it very strictly," said lead researcher Dr. Lorenzo Leggio, who is testing how a hormone named ghrelin that sparks people's appetite for food also affects their desire for alcohol, and if blocking it helps.

Three drugs are approved by the Food and Drug Administration to treat alcohol abuse.

One, naltrexone, blocks alcohol's feel-good sensation by targeting receptors in the brain's reward system – if people harbor a particular gene. The anti-craving pill acamprosate appears to calm stress-related brain chemicals in certain people. The older Antabuse works differently, triggering nausea and other aversive symptoms if people drink while taking it.

– The Associated Press

P.E. 1-7-15

CDC: ALCOHOL POISONING KILLS 6 A DAY

To the surprise of even health officials, it turns out that most deaths from drinking too much involve middle-aged adults – not teens or college kids.

A report Tuesday from the Centers for Disease Control and Prevention found six Americans die each day from alcohol poisoning. CDC officials said three-quarters of those deaths are adults ages 35 to 64, and most are men. CDC officials said they thought more would be younger.

The report found an average of 2,221 alcohol poisoning deaths a year.