Idaho Lawyer Assistance Program

REFERENCE MANUAL

(Updated August 2018)

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SECTION 1:
LAWYER ASSISTANCE PROGRAM - AN OVERVIEW[1]

WHY THE LAWYER ASSISTANCE PROGRAM?

According to a recent Gallup Poll, more than a third (36%) of Americans report drinking has been a source of problems for their families. Of the 64% of Americans who say they drink alcoholic beverages at least occasionally, 26% say they sometimes drink more than they should. A significant portion of these (16%) report they have made a serious attempt to stop drinking.

The American Bar Association estimates that fifteen to twenty percent of attorneys and judges suffer from addiction or mental illness.

Addiction rates among lawyers are nearly twice that of the general population. Substance abuse includes other drugs and ranges from abuse of prescription drugs to dependence on illegal drugs, including heroin and cocaine. Some studies indicate lawyers use cocaine at twice the rate of non-lawyers.

While alcoholism continues to be the major issue among lawyers and judges, mental health problems impact the legal community at alarmingly high rates. A recent John Hopkins study of 103 professions indicates lawyers top the list when it comes to depression. Benjamin Sells, in his book *The Soul of the Law*, writes that lawyers are four times more likely to be depressed than the general population. Lawyers now have one of the highest suicide rates of any profession, surpassing (in the late 1990's) the high rate of suicide among dentists.

Compulsive gambling problems are not frequent, but when they occur they are extremely serious and often involve financial, mental health, and legal consequences. The LAP intervention model has been applied with good success and LAP can refer problem gamblers to individual professionals and specialized treatment programs for assistance.

Other compulsive behaviors are less frequently reported, but many cause serious problems that impact work and family relationships.

Lawyers work more hours than most professionals and experience stress that is immediate, ongoing and not confined to office hours. Competition, long office hours, considerable responsibility, and the need for financial productivity are inherent in the practice of law. While these factors do not cause addiction or mental health problems, they can certainly trigger or intensify addictive use or disruptive behaviors.

In the mid 1970's and early 1980's, the first lawyer assistance programs began popping up throughout the country to help legal professionals impaired by substance abuse. Lawyers, particularly those who had struggled with their own addiction and found recovery, saw the impact of alcoholism in the legal community and wanted to help their colleagues. Thus began a powerful movement that has led to an important resource for those in the profession of law.

[1] Sections 1-4 have been adapted from the "Judges' Volunteer Handbook," with the gracious permission of the Illinois Lawyers Assistance Program, LLC.

HISTORY OF LAWYER ASSISTANCE PROGRAM IN IDAHO

The Idaho State Bar established the Lawyer Assistance Program by resolution approved by the membership in November 2001, and the Idaho Supreme Court formally adopted Idaho Bar Commission Rule Section XII, effective July 1, 2002.

The problem was identified as follows:

> *Impairment of a lawyer's performance may result from physical, mental or emotional illness, including addiction. Impairment may also result from circumstantial problems of the lawyer in family, financial, or other areas. The stress of practice adversely affects some members of the bar, as do pathological gambling, depression, neuroses and other health problems.*
>
> *Lawyers and judges, at least as often as members of any other profession or occupation, fail to seek professional help for these problems. This is as true of those suffering from negative stress syndrome or alcoholism as it is of those with depression and high blood pressure. Denial is a factor in this problem. Frequently the manifestations of illness are submerged in the clutter of other important influences on a lawyer's life while the effects of the illness on his or her practice are still minimal. In many cases the remedy can be as simple as peer support; others, however, require professional medical or other health care.*

PURPOSE OF IDAHO LAP

The Idaho Lawyer Assistance Program recognizes that the impairment of a lawyer's performance may result from physical, mental or emotional illness, including addiction. The purposes of the LAP Program are as follows:

(1) Protect the interests of clients from harm caused by impaired lawyers;

(2) Educate the bench, bar and community to the causes of and remedies for lawyer impairment;

(3) develop and administer resources to assist lawyers and judges in securing treatment for addictive diseases and mental health issues, including but not limited to alcoholism and chemical dependency, by providing a system which encourages early entry of the impaired attorney, while recognizing the necessity for absolute confidentiality and trust;

(4) Provide assistance to impaired lawyers in a manner that is separate and distinct from attorney discipline proceedings and to maintain that distinction.

(See, *Idaho Bar Commission Rule 1201)*

CONFIDENTIALITY

All records of the LAP Program are held in strict confidence. The LAP does not maintain permanent records relating to the names of the participants or the nature of their participation. Each person who is the subject of any form of inquiry under these Rules is assigned a number, which shall thereafter be used in any subsequent action taken by the LAP Committee, the LAP Program or the Program Coordinator.

The Idaho Rule of Professional Conduct 8.3(c) and Idaho Bar Commission Rule 1205(a) provide further guarantees of confidentiality for all communications made to LAP by lawyers, judges and law students who may request treatment referrals or consultation assistance from LAP, for themselves.

Please note, however, certain LAP Committee members may be required to comply with federal and/or Idaho statutes mandating that certain crimes, such as child abuse, be reported to legal authorities.

EXCERPTS FROM IDAHO RULES OF PROFESSIONAL CONDUCT (Amended, effective July 1, 2004) AND IDAHO BAR COMMISSION RULES (Effective July 1, 2002)

Maintaining the Integrity of the Profession – Rule 8.3: Reporting Professional Misconduct

(a) A lawyer who knows that another lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question as to that lawyer's honesty, trustworthiness or fitness as a lawyer in other respects, shall inform the appropriate professional authority.

(b) A lawyer who knows that a judge has committed a violation of applicable rules of judicial conduct that raises a substantial question as to the judge's fitness for office shall inform the appropriate authority.

(c) **This Rule does not require disclosure of information otherwise protected by Rule 1.6 or information gained by a lawyer or judge while participating in an approved lawyer's assistance program.** *(Amended, effective July 1, 2004)*

Lawyer Assistance Program – I.C. § 54-4902: Protected Action and Communication

There shall be no liability on the part of and no action for damages against:

(1) Any Idaho state bar commissioner, member of the lawyer's assistance program committee, member, employee or contractor of a lawyer's assistance program for any action taken or performed by such person within the scope of the functions of such lawyer's assistance program when acting without malice and in the reasonable belief that the action taken by him is warranted; or

(2) Any person providing information to the lawyer's assistance program without malice in the reasonable belief that such information is accurate.

Idaho Bar Commission Rule 1205: Confidentiality and Immunity; Records

(a) Confidentiality/Records. All records of the LAP Program shall be confidential. The LAP shall not maintain permanent records relating to the names of the participants or the nature of their participation. Each person who is the subject of any form of inquiry under these Rules shall be assigned a number, which shall thereafter be used in any subsequent action taken by the LAP Committee, the LAP Program or the Program Coordinator.

(b) Immunity

(1) ***Absolute***. Such appointee or appointees shall be immune from civil liability for acts and omissions in the performance of duties under this Rule, except for demonstrated fraudulent or malicious conduct, so long as he or she or they are acting:

(A) Pursuant to any order made under or pursuant to these Rules; or
(B) Pursuant to any like or similar order directing or providing for legal assistance to clients or of persons adversely affected by the lawyer; or
(C) Pursuant to this particular Rule or any similar request or direction by the Idaho State Bar of an appointed or acting lawyer to so act in the public interest or for the protection of any member of the public.

(2) ***No Immunity***. The provisions of this Rule shall not, however, provide immunity to any lawyer, whether or not appointed and whether or not originally concerned with the matter by reason of any appointment, order or relationship of the kinds enumerated above, if it be legal work which he or she has agreed to do for a fee which has been privately negotiated with, and agreed to by, the client.

(3) ***Qualified Immunity***. Notwithstanding the provisions of subsection (2) of this Rule, to the extent that a lawyer provides services under this Rule, which work or services reasonably and equitably justifies the charging or reserving of a fee for legal services, qualified immunity shall apply even though such fee be fixed and charged if the same is pursuant to the appointing or authorizing authority or the Supreme Court and is not pursuant to a negotiated private fee arrangement with such client.

(A) **Fees Allowed by Court**. This Rule shall not be construed to limit or preclude the Supreme Court or appointing authority from allowing reasonable fees in proper cases for work done pursuant to any directive, order or authorization in keeping with these Rules, which fees may be accepted without waiver of or prejudice to the qualified immunity herein above provided so long as the fees are not privately negotiated.

(c) Referrals. Any attorney member of the Idaho State Bar may contact the LAP seeking assistance or may be referred by any other source.

(d) Location of Facility. The LAP office should be located outside the Idaho State Bar office and maintain an "800" confidential hotline number. Only the LAP staff should have access to receiving calls on the "800" hotline number.

(*Adopted May 28, 2002, effective July 1, 2002*)

LAP SERVICES

The Idaho Lawyer Assistance Program provides:

- 24-hour phone calls, all of which are confidential
- Guidance for the impaired lawyer or referral sources
- Information relating to alcohol/drug education, mental health treatment, interventions, monitoring, and/or family support
- Guidance for re-entering the workplace
- Assistance in ascertaining lawyers who will volunteer time as temporary replacement for those lawyers going to treatment
- Recommendations for appropriate treatment centers

If you are concerned about

- Your own use of alcohol or other drugs
- The use of alcohol or drugs by a partner or associate
- A fellow attorney or judge who you see is affected by the use of alcohol or other drugs
- A family member's use of alcohol or other drugs

...Contact the LAP for assistance

Have you or a lawyer you care about

1. Failed to show up at the office or to appear in court because you had a hangover or were "a little under the weather?"
2. Experienced deteriorating relationships with clients, staff, and friends?
3. Frequently missed appointments with clients?
4. Ever awakened to discover that you couldn't remember what happened the night before?
5. Showed up drunk at court or for a deposition?
6. Been drinking or using drugs during office hours?
7. Used, misused, co-mingled or borrowed clients' trust funds?
8. Had to have another lawyer make your court appearances for you because you were hung over?
9. Regularly had more than one drink at lunch?
10. Noticed that drinking is affecting your reputation?
11. Missed deadlines, filed pleadings late, allowed a statute of limitations to run, failed to pay your bar dues?
12. Worried that these things are happening to you more and more frequently?
13. Needed a drink because something good or bad happened?
14. Gotten drunk at Bar meetings and social gatherings?

...Contact the LAP for assistance.

Who to Call

For assistance or to make a referral, please contact:

Southworth Associates
5530 W. Emerald
Boise, ID 83706

Ben Seymour, CADC, Program Coordinator
(208) 949-0363
(866) 460-9014 toll free
(208) 323-9222 fax
E-mail: Southworth.associates@gmail.com

Web: www.southworthassociates.net

Eden Minnick, Assistant
(208) 323-9555

ABA Judicial Assistance Initiative
National Helpline for Judges Helping Judges
1-800-219-6476, *call during business hours Central time*

DOCUMENTATION

Record Keeping:

- LAP keeps no long-term records on individuals. Anonymous demographic data is collected and may be provided to the American Bar Association or a division thereof, such as the ABA Commission on Lawyers Assistance Programs (CoLAP).
- LAP's data collection includes information on where the call was received, gender, age, type of practice, problem, service provided, and judicial district.

ADDITIONAL QUESTIONS

If you have additional questions, feel free to contact any LAP member.

Jamie C. Shropshire, Chair – Boise
(208) 305-2344

Kevin S. Borger – Boise
(208) 608-7950 / Cell: (208) 440-4754

Ronald D. Christian – Caldwell
(208) 455-5999

Hon. Gregory M. Culet – Nampa
(208) 454-7375

Yvonne A. Dunbar – Boise
(208) 344-5800

Jeremiah M. Hudson – Boise
(208) 345-7000

Thomas B. Humphrey – Boise
(208) 830-4319

Hon. Robert Jackson – Payette
(208) 642-6019

Matthew L. Kinghorn – Pocatello
(208) 478-2046

Dylan B. Lawrence – Boise
(208) 907-1529

Susan D. Powell Mauk – Boise
(208) 344-5457

Paul D. McFarlane – Boise
(208) 342-1948

Hon. Daniel B. Meehl – Twin Falls
(208) 733-8310

Hon. Victoria A. Olds – Nez Perce
(208) 937-2251

Andrea P. Patterson – Boise
(208) 947-7437

Joseph N. Pirtle – Boise
(208) 343-5454

Danielle C. Scarlett – Nampa
(208) 465-5412

Julie Stomper – Idaho Falls
(208) 557-5211

Thomas M. Vasseur – Coeur d'Alene
(208) 664-4457 / Cell: (208) 819-1100

Douglas A. Werth – Boise
(208) 332-3570

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NOTES

SECTION 2:
ADDICTION

DEFINITION OF ADDICTION

Addiction is a primary, progressive, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over use of the substance, preoccupation with the substance, use of the substance despite adverse consequences, and distortions in thinking. Addiction is defined by meeting the criteria for substance dependence.

This information is taken from The Diagnostic and Statistical Manual – IV of the American Psychiatric Association.

CRITERIA FOR SUBSTANCE DEPENDENCE

A maladaptive pattern of substance abuse, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 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) the characteristic withdrawal syndrome for the substance;
   (b) the same (or a closely related) substance 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;
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects;
6. Important social, occupational, or recreational activities are given up or reduced because of substance use;
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 (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption);

This information is taken from The Diagnostic and Statistical Manual – IV of the American Psychiatric Association.

ALCOHOL: A DRUG OF ADDICTION

Definition of Alcoholism

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

(a) **Primary** refers to the nature of alcoholism as a disease entity in addition to separate from other pathophysiologic states which may be associated with it. Primary suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.

(b) **Disease** means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.

(c) **Often progressive and fatal** means that the disease persists over time and that physical, emotional, and social changes are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart, and many other organs, and by contributing to suicide, homicide, motor vehicle crashes, and other traumatic events.

(d) **Impaired control** means the inability to limit alcohol use or to consistently limit on any drinking occasion the duration of the episode, the quantity consumed, and/or the behavioral consequences of drinking.

(e) **Preoccupation** in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned to alcohol by the individual often leads to a diversion of energies away from important life concerns.

(f) **Adverse consequences** are alcohol-related problems or impairments in such areas as: physical health (e.g. alcohol withdrawal syndromes, liver disease, gastritis, anemia, neurological); psychological functioning (e.g. impairments in cognition, changes in mood and behavior); interpersonal functioning (e.g. marital problems and child abuse, impaired social relationships); occupational functioning (e.g. scholastic or job problems); and legal, financial, or spiritual problems.

(g) **Denial** is used here not only in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers designed to reduce awareness of the fact that alcohol use is the cause of an individual's problems rather than a solution to those problems. Denial becomes an integral part of the disease and a major obstacle to recovery.

Approved by NCADD 2/3/90, Approved by ASAM Board of Directors 2/25/90

OTHER DRUGS OF ADDICTION

Although alcohol is the most abused drug and the most prevalent drug in addictive illness, there are many other drugs of dependence, either alone or in combination with alcohol.

1. Marijuana is the most commonly used illegal drug in the U.S. The main active chemical is THC.
2. Cocaine is a powerfully addictive drug which makes the user feel euphoric and energetic.
3. Heroin is an opiate that can be snorted or injected into the bloodstream.
4. Methamphetamine is a highly addictive stimulant that can be snorted, smoked, mixed with water and injected, and inserted into body orifices.
5. Prescription Drugs
   (a) Opioids such as Oxycodone and Hydrocodone
   (b) Sedatives and hypnotics such as Xanax and Valium
   (c) Stimulants such as Dexedrine and Ritalin
6. Club Drugs
   (a) Ecstasy (MDMA)
   (b) LSD

COMPULSIVE BEHAVIOR

The primary characteristic seen in the above definitions is compulsivity. Compulsive use of a substance is seen in the failure to abstain despite clear evidence of the difficulties caused by the use. Compulsive behavior is not easy to understand and accept as it threatens our perceptions of ourselves as rational people who can avoid harmful behavior. When the consequences of compulsive drinking or using become severe, colleagues and family members will often react in typical ways:

1. Look for Causes: They think there must be some underlying problem that can be identified and fixed
2. Moralism: Accuse the person of being weak or of bad moral character
3. Avoidance: Through denial or escape either physically or emotionally
4. Shame, blame, hide

PROGRESSION IN USE

Most addicts show progression in use and its consequences:

- Increased use (both frequency and amounts) of drug(s)
- Mental preoccupation
- Increased tolerance
- Rapid intake or ingestion
- Solitary drinking and using
- Hiding and protecting the supplies
- Blackouts, i.e., periods of amnesia
- Negative effect on marriage and family
- Negative effect on social life
- Negative effect on work performance
- Deterioration of physical health

CAGE QUESTIONS: DO YOU HAVE A DRINKING PROBLEM?

The CAGE Questions:

- **C**ut Down: Have you ever felt the need to **cut down** on your drinking (or drug use)?
- **A**nnoyed: Have you ever been **annoyed** by criticism of your drinking (or drug use)?
- **G**uilty: Have you ever felt **guilty** about your drinking (or drug use)?
- **E**ye-Opener: Have you ever had a morning **eye-opener** (used drugs/alcohol first thing in the morning to get started or to relieve withdrawal)?

Interpretation:

The total number of "yes" answers:

- ONE: Indicates possible alcohol or drug problem – discuss further with patient;
- TWO: Indicates probable alcohol or drug problem – diagnostic assessment necessary to confirm or rule out alcohol/drug abuse or dependence; and
- THREE-FOUR: Nearly diagnostic by itself.

CAGE References:

Ewing, J. A., *Recognizing, Confronting and Helping the Alcoholic*, Am Fam Physician, 18:107-114, 1978.

Beresford, R. P., Low, D., et al., *The Cage Questionnaire in Assessing Alcoholism Prevalence in a General Hospital*, Proceedings of the Sixth World Congress of the International College of Psychosomatic Medicine, Montreal, 1981.

Bush, B., Shaw, S., et al., *Screening for Alcohol Abuse Using the CAGE Questionnaire*, Am J Med, 82:231-235, 1987.

Mayfield, D., McLeod, G., et. al., *The CAGE Questionnaire: Validation of a New Alcoholism Screening Instrument*, Am J Psychiatry, 1121-1123, 1974.

Ewing, J. A., *Detecting Alcoholism: The CAGE Questionnaire*, JAMA, 252 (14): 1905-1907, 1984.

Beresford, T. P., Blow, F. C., et al., *Comparison of CAGE Questionnaire and Computer-Assisted Laboratory Profiles in Screening for Covert Alcoholism*, Lancet, August 25; 336 (8713): 482-485, 1990.

DENIAL

Definition of Denial: The inability or refusal to see and accept an unpleasant reality.

Common Defense Mechanism: Denial is used by everyone, usually in response to something emotionally threatening or painful. Its healthy use is when it gives us time to gradually accept pain by blocking it temporarily. This helps us cope under crisis, such as:

- Death, loss, grief: "It can't be true."
- Unattractive characteristics of self or loved ones: Renaming negative features; and
- Chronic disease: Coping with cancer, heart disease or diabetes.

Distortion of Reality: If temporary, it may be helpful and not a problem. Usually, denial helps us adjust gradually to an unpleasant fact, and then fades away as reality takes over. If it becomes a long term response, it presents necessary change.

Addiction + Denial = Denial System:

- Gradual Progressive Onset: The denial mechanism allows the user, family, and coworkers to transform abnormal problem behavior into normal behavior;
- There is a chemical effect on the brain's ability to perceive accurately; and
- The sporadic or intermittent appearance of problem behavior tricks and deceives the user and others into thinking;
- It's not a disease;
- It's not permanent — it will go away by itself; and
- It's under willful control.

Professionals and Denial:

- High intelligence and verbal skills intensify a denial system:
- Usually control and manage others; and
- Work patterns and productivity are not as easily measured and monitored with more opportunity to hide problem behavior.

Gradual Nature: The denial system in addiction to alcohol or another drug is built up gradually and becomes incorporated into the life patterns of both the user and the significant others. It is powerful, sophisticated, insidious, and resistant to challenge.

Interventions: Organized interventions prepare significant others to respond effectively by assembling a concentrated array of reality-based facts to dismantle the wall of denial.

NOTES

SECTION 3:
MENTAL HEALTH

LAWYERS AND STRESS

Lawyers Have High Rates of Mental Health Problems:

- One out of four lawyers suffers from elevated feelings of psychological distress. Highest on the list of complaints are interpersonal feelings of inadequacy and inferiority, followed closely by depression, anxiety, social alienation, and isolation.
- Fifty two percent of lawyers say that they are dissatisfied with their careers.
- Forty four percent of lawyers feel they don't have enough time to spend with their families, and 54% say they don't have enough time for themselves.
- Over 50% of all lawyers say they do not have mentors interested in their careers.
- Lawyers' Assistance Program is receiving more calls for help with mental health problems than with addiction issues, those both often coexist.
- Depression is the single highest problem identified by lawyers who seek LAP's help.
- Lawyers now have one of the highest suicide rates of any profession.

Stressors Reported by Lawyers:

- Deadlines and inadequate time to complete jobs satisfactorily;
- The high stakes involved, *e.g.,* loss of property, freedom, even life;
- Clients' high, though sometimes unreasonable, expectations of expertise;
- Constant scrutiny and critical judgment from opponents and the court;
- The inherent conflict-driven nature of the entire legal process;
- Job insecurity and law firms' demands for high billable hours;
- An ever-present threat of liability for legal malpractice;
- A tendency to assume the clients' burdens;
- Self-criticism, focusing on weaknesses, rather than on strengths;
- Absence of recognition or reward for good job performance;
- Powerlessness, the failure to see available choices;
- Hurrying, constant pressure to perform better and faster;
- Comparison of achievements, or lack of them, to those of peers;
- Inability to use personal talents effectively;
- A diminishment of professional cordiality and camaraderie;
- Prejudice and bigotry expressed by colleagues; and
- Fear, uncertainty, and doubt.

STRESS INDICATORS

Signs and Symptoms of Stress: Note that stress may result from both positive and negative experiences: marriage and divorce, a new job and loss of a job, the birth of a child and the death of a parent, etc. Signs and symptoms of stress may include:

Physical Symptoms:

- ☐ Pounding heart;
- ☐ Tightened stomach;
- ☐ Neck and back pain;
- ☐ Headaches;
- ☐ Mouth and throat dryness;
- ☐ Insomnia;
- ☐ Disruption of digestion.

Behavioral Symptoms:

- ☐ Inability to sit still and concentrate;
- ☐ Self-medicating: increased smoking, drinking, use of drugs;
- ☐ Loss or increase in appetite;
- ☐ Prone to accidents;
- ☐ Isolation.

Personality Changes:

- ☐ Emotional tension and alertness;
- ☐ General irritability;
- ☐ Listlessness;
- ☐ Depression;
- ☐ Hyper-excitation;
- ☐ Diminished self-esteem.

Impact on Professional Performance:

- ☐ Procrastination;
- ☐ File stagnation: cases and projects are not moving forward;
- ☐ Failure to respond to phone messages;
- ☐ Making excuses;
- ☐ Lowered productivity.

DEALING WITH STRESS

You can minimize or eliminate the negative effects of stress if you practice the following ten techniques (from *The Stress Management Handbook*):

1. **Don't let small aggravations get to you.**
   - Don't ignore your frustration or aggravation. Acknowledge them, then look beyond.
   - Keep your perspective. Many things that are crises today are forgotten tomorrow.

2. **Don't give in to guilt.**
   - Don't let others impose it on you. Don't impose guilt on yourself.
   - If you regret actions, fix them or learn from them; don't make the same mistake again.

3. **Develop strategies.**
   - Maintain control during stressful situations by developing either an *action strategy* if you can identify a solution, or a *coping strategy* if you can't.

4. **Learn to accept and adapt to change.**
   - Look for the opportunities, hidden or obvious, that result from change.
   - Take a leadership approach to your life. Use your strategies to keep moving.

5. **Change the way you look at stress.**
   - Stress isn't an external force being imposed on you. It is your personal reaction to situations.
   - Try to look at stressful situations from a new angle. Look for choices and alternatives.
   - Avoid letting your fears take over.
   - Try to see the problem-solving process as a challenge, not a burden.

6. **Develop a support system.**
   - Have friends, co-workers, family members or counselors act as a sounding board.

7. **Learn to accept the things you can't change.**
   - Learn to accept a difficult situation without seeing it or yourself as hopeless.
   - Accept that life has its ups and downs. Look to the future when things will improve.
   - Don't try to suppress your feelings. Acknowledge them and get support if necessary.
   - Keep busy. Having too much free time allows you to dwell on negative feelings.
   - Pamper yourself. Find time to recharge your emotional battery.

8. **Develop your personal anti-stress regimen.**
   - A program of diet, relaxation and exercise helps reduce or eliminate stress.
   - Use techniques that conveniently fit your personal preferences and lifestyle.

9. **Don't take it personally.**
   - Much of others' negative behavior is caused by the stress they experience and isn't directed toward you personally. If you "catch" their stress, you participate in a stress cycle.

10. **Believe in yourself.**
    - Trust your inner strength to see you through adversity. Cultivate your sense of self-confidence.

MOOD DISORDERS

Mood refers to sustained emotion that colors the way we view life. 20% of women and 10% of men may have a mood disorder. Prevalence is increasing in both sexes, and they account for as much as 50% of a typical mental health practice. Occurrence is across races, social classes, is more common among those without significant other (especially men); has genetic component.

The most prevalent mood disorders are:

- Major Depression
- Dysthymia
- Bipolar Disorder
- Cyclothymia

Depression is the leading cause of disability in the US and worldwide. According to the National Institute of Mental Health (NIMH), depressive disorders affect 9.5% of adult Americans in a given year or about 19 million people in 1999. Nearly twice as many women (12%) as men (7%) are affected each year. Treatment leads to full recovery in more than 80% of cases. Untreated depression is costly. A RAND Corp. study found that people with depressive symptoms spend more days in bed than those with diabetes, arthritis, back problems, lung problems or gastrointestinal disorders.

Major Depression

Major depression is a combination of symptoms that interfere with the ability to work, sleep, eat, and enjoy once pleasurable activities. Episodes can occur once or multiple times.

Symptoms of Major Depression:

- Depressed mood
- Decreased interest in activities formerly enjoyed
- Sleep disturbance--either excessive or not nearly enough
- Eating and weight changes
- Fatigue, loss of energy
- Low self-worth, inappropriate guilt
- Concentration problems, indecision
- Thinking about death or about suicide; suicide attempt

Symptoms of depression in the workplace:

- Decreased productivity
- Morale problems
- Lack of cooperation
- Safety risks, accidents
- Absenteeism
- Frequent statements about being tired
- Complaints of unexplained aches, pains
- Increased alcohol and drug use

Dysthymia

Dysthymia is a less severe type of depression that involves long-term (two years or more), chronic symptoms. It is not disabling but keeps one from functioning at an optimal level or from feeling good. It may be associated with episodes of major depression.

Symptoms are the same as for depression except that there are no thoughts of death or suicide and no manic episodes. Dysthymia affects about 6% of adults during their lifetimes. These people typically regard their chronic low mood as normal. Because they suffer quietly and are not severely disabled, such individuals often don't come to light until a major depressive episode supervenes.

Bipolar Disorder

Bipolar disorder (manic-depressive illness) is characterized by cycles of depression and mania, sometimes in a rapid-cycling pattern, but more often in gradual changes. Mania often affects thinking, judgment, and social behavior in ways that cause serious problems and embarrassment; e.g., spending sprees, sexual adventures, foolish investments. Bipolar disorder is usually a chronic, recurring condition. It has a stronger genetic component than depression.

Manic episodes are much less common than depressive episodes. Mania affects about 1% of all adults, men and women equally. About 25% of people with mood disorders experience manic episodes. Alcoholism is present in about 30% of bipolar clients.

Symptoms of Mania include:

- Grandiosity or exaggerated self-esteem
- Reduced need for sleep
- Flight of ideas or racing thoughts
- Easy distractibility
- Speeded-up psychomotor activity or increased goal-directed activity (social, sexual, work or school)
- Poor judgment

Cyclothymia

The person with cyclothymia is chronically (minimum of two years) either elated or depressed, but the symptoms never fulfill the criteria for a manic or major depressive episode. The symptoms cause clinically important distress or impair the individual's work, social or personal functioning.

CAUSES OF MOOD DISORDERS

There are many causes of depression. These include:

1. ***Inherited vulnerability***. 80-90% of those with Bipolar Disorder have a relative with some form of depression. Researchers have identified several genes involved in bipolar depression, and they are looking for genes linked to other types of depression.

2. ***Biological factors***. Bipolar Disorder is often triggered by a disturbance in neurotransmitters that regulate mood and activity. An imbalance in the amount or activity of these neurotransmitters can cause major disturbances in thought, emotion, and behavior.

3. ***Environmental triggers***. Stressful life events, particularly a loss or threatened loss, can trigger depression; e.g., death of a loved one, divorce, breakup of an important relationship, loss of job, financial problems, loss of health or independence.

4. ***Medications***. Long-term use of certain medications may cause symptoms of depression. These include the beta blocker Inderal, some blood pressure drugs and some drugs used to treat arthritis and Parkinson's disease.

5. ***Illnesses***. People with chronic illnesses such as heart disease, stroke, diabetes, cancer, and Alzheimer's disease are at high risk for developing depression. About a fourth of stroke survivors, more than a third of Parkinson's sufferers, and a quarter of those with Alzheimer's experience major depressive disorder.

6. ***Personality***. Certain traits such as having low self-esteem and being overly dependent, self-critical, pessimistic, easily overwhelmed by stress can make one vulnerable to depression.

7. ***Alcohol, nicotine and drug abuse***. Previously experts thought that people with depression used alcohol, nicotine, and mood-altering drugs as a way to ease depression; but new studies indicate that these may actually contribute to depression and anxiety disorders. About 30% of people with major depressive disorder and 60% of those with bipolar disorder abuse alcohol and drugs. A family history of alcoholism also increases the risk of bipolar disorder. Also, people with a depressive disorder are twice as likely as those without depression to be addicted to nicotine.

8. ***Diet***. Deficiencies in foliate and vitamin B-2 may cause symptoms of depression and a poorer response to antidepressant medications.

9. ***Post-partum depression***. Hormonal changes can trigger an episode of bipolar disorder in women who are genetically vulnerable.

10. ***Other mental disorders***. Depression can accompany many mental disorders.

LEVELS OF DEPRESSION

Healthy ("Normal") Depression

- Based on real life experience
- Able to function (feel bad, less effective)
- Appropriate feelings from current experience
- Feeling of temporary helplessness; not suicidal
- Withdrawal for hours or 1-2 days
- Feeling hurt, but hopeful of healing
- Feeling bad about self, but self-blame comes and goes
- Productive: wisdom, creativity, maturity intact

Unhealthy ("Disabling") Depression

- Based on distortion: denial of real experience or overwhelming, negative experience
- Unable to function at work, in relationships, physically, etc.
- Distorted reaction to current or past trauma (experiencing past or present loss as permanent or greater than reality
- Feeling of hopelessness, despair; suicidal thoughts
- Emotionally unresponsive for days, weeks, months
- Feeling of being defective and damaged beyond repair
- Chronic low self-esteem, perhaps self-hatred
- Unproductive: physical and mental deterioration

SUICIDAL THINKING

Suicidal thinking and incidents of suicide attempts are on the rise. A report by Surgeon General David Stacher dated May, 2001, identified problems of suicide and suicide prevention as critical public health priorities.

A study by the National Mental Health Association (NMHA) published in May, 2001 found:

- 8.4 million Americans (4%) have contemplated suicide
- 6.3 million (3%) have had continuing "thoughts of suicide throughout the same 2-week period."

Michael Faenza, NMHA President and CEO noted that:

The Surgeon General's report and the NMHA survey on suicidal thought are evidence of a public health epidemic of major proportions. In the majority of cases, suicide is the most tragic result from common and treatable mental illness. Because of the lingering stigma of mental illness and discriminatory insurance practices, too many Americans are not seeking and receiving the treatment they deserve. Why are we still living in the Dark Ages when it comes to mental illness?

Who is the "typical" suicidal person? According to the Suicide Information Center in San Diego, most suicidal people (perhaps 95%) do not want to die. They are seeking relief or escape from an intolerable situation. The person usually wants help but has difficulty asking, doesn't know where to get help, doesn't know what s/he specifically wants others to do to help. Descriptors of the typical suicidal person are Hopeless, Helpless, and Hapless.

Suicide Risk Factors (from the Centers for Disease Control and Prevention, CDC).

Males are at least four times more likely to die from suicide than are females, but females are far more likely to attempt suicide. The risk that the suicide actually will be completed is greater in males, in people who have lost a spouse (by death or divorce), in people with substance abuse problems, in those with a history of previous suicide attempts, or in those with a family history of suicide.

Suicide Rates

In the United States, the annual average is 12 suicides per 100,000 people.

- Among adolescents, suicide is now the 3rd leading cause of death in the US. From 1980 to 1997, the rates for ages 15-19 increased 11%; the rates for ages 10-14 increased 109%.
- In mid-life, people may experience loss of spouse or parents; children leaving; serious illness.
- Elderly people commonly experience life-altering changes such as the loss of loved ones, decline in health, loss of independence. The largest relative increase in suicide rate from 1980-1997 occurred among those ages 80-84.

"Hardcore" Suicidal People

About 5% of the suicidal population is virtually impossible to stop since they are unlikely to present early warning signals, don't seek help, generally act quickly and with determination, usually use a weapon that kills quickly.

No suicide talk should be dismissed or treated lightly. Should someone state the intention to take their life and express a plan for how they will do it, be prepared to call 911 for immediate assistance!

Warning Signs

- Veiled threats such as "You'd be better off without me" or "Maybe I won't be here..."
- Overt statements such as "I want to die." "I want to sleep and never wake up."
- Expressions of hopelessness and/or helplessness
- Previous suicide attempts
- Daring or risk-taking behavior
- Personality change (withdrawal, aggression, moodiness)
- Depression
- Giving away prized possessions
- Lack of interest in the future
- Organizing case files
- Cleaning house and office

Assessing the Degree of Suicidality

Ascertain whether the person has suicidal thoughts, a plan, and access to the plan requirements. Sample Questions are "Have your problems been getting you down so much lately that you've been thinking about harming yourself?" If yes, ask, "How would you do it [harm yourself]?" Listen for how **specific** the details of the plan are; the **lethality** level of the proposed method; the **availability** of the method; and the **proximity** of helping resources.

DO:

- Trust your instincts and believe that the person may attempt suicide.
- Talk with the person about your concerns, and show that you care and want to help.
- Remember that the most important thing is to listen.
- Get professional help, even if the person resists.

DO NOT:

- Leave the person alone; offer to go with the person to get help.
- Swear to secrecy.
- Act shocked or judge the person.
- Counsel the person.

Mood Disorder Treatment Strategies

- Evaluation. The first step is always a complete diagnostic evaluation by a licensed professional. With an accurate diagnosis, proper treatment can be recommended.
- **Medication**
- **Psychotherapy**
- **Combination**. For mild to moderate depression, either medication or therapy alone may be successful. In severe cases, a combination of medication and psychotherapy is more effective.
- **Electroconvulsive Therapy or Shock Treatment**. Used when medication and therapy prove ineffective. It is highly effective for severe depressive episodes. Risks of memory problems and physical harm have been reduced with modern techniques.

Mood Lifters

- Act rather than react to bad feelings and problems.
- Substitute positive thinking for negative thoughts.
- Contact someone close.

"INTERVENTIONS" IN MENTAL HEALTH

"Intervention" is defined as: "to come between as an influencing force, as in order to modify, settle, or hinder some action." In the human services field, it is best known as the method used to help someone get help with a drinking or drug abuse problem. It involves the use of significant others in a confrontation process designed to alter the natural or expected outcome of a pattern of behavior.

The conceptualization and articulation of this practice is credited to Vernon Johnson, (author of the book, *I'll Quit Tomorrow),* an Episcopal priest in MN who helped many alcoholics into recovery through a process he called "intervention." He practiced this by teaching family members and friends that there was something they could do to prod a troubled individual into getting help.

The conventional wisdom at the time (during the 50's & 60's) was that AA and treatment could be very effective in many cases, but you had to wait for the alcoholic to "hit bottom" and ask for help. The thinking of the time was that until the alcoholic hit bottom, external attempts to create positive change were mostly a waste of time, and often actually seemed to exacerbate the problem. It was also noted that family members typically responded with guilt and anger in their attempts to control or fix the alcoholic, so they actually got worse as they tried many different attempts to intervene on the problem. The standard advice to the family was to "Take care of yourself; there's nothing you can do to stop alcoholics until they want help."

Classical (Johnson Institute style) interventions are practiced by many professional therapists. These follow the traditional approach of careful preparation of significant others to prepare what they know from their own experience, role play practice in expressing their observations to the subject in a context of love and caring concern, and the leadership of a professional therapist or trained intervention leader. Other interventionists practice modifications of this approach, including "surprise" or "ambush" interventions in which the subject is surprised at home or work by an organized team of concerned people. Other professionals espouse quick one time interventions while others focus primarily on professional diagnosis by a physician or other health professional.

The Illinois LAP Experience:

For many years, the traditional intervention approach has been limited to situations involving substance abuse. As programs such as LAP encounter more of their profession who have symptoms of mental illness, or who have concurrent substance abuse and mental illness, the question is raised whether this practice can be applied to those situations also.

The answer is that intervention principles do apply very directly, but that the procedures will differ depending on the situation. Substance abuse intervention teams invariably assessed the situation based on the facts that came out of the discussions with participants to determine whether this truly was a case of alcohol or drug abuse. Most interveners had personal experience with alcohol or drug problems, treatment, and recovery so they felt comfortable "walking with" and guiding a subject into treatment and recovery. Although the training emphasized that diagnosis and treatment were the responsibility of healthcare professionals, in actual practice the team made a working diagnosis and they knew what to do with the problem. The intervention process focused on the problems known to the participants, and the need for remedial action. Intervention teams always avoided discussion about the definitions and diagnosis of alcoholism, but they "knew one when they saw one" and acted with confidence.

Impairment from mental disorders is a quite different issue as accurate diagnosis and treatment is not well known to lay people. There is understandably considerable fear over doing the wrong thing and maybe making the problem worse. There is always the fear that saying the wrong thing may trigger a suicidal person to action. Many types of mental illness are quite baffling to colleagues and family members. *The Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* (DSM-IV) of the American Psychiatric Association includes sixteen major categories and runs to almost 900 pages.

So what can you do to intervene with dysfunction from mental illness?

1. **Act.** Just as with substance abuse, most people suffering from mental illness get help when someone cares enough to do something about their concern.
   a. If the person seems down and depressed, ask them about it.
   b. If the person seems suicidal, ask them directly.
   c. If you observe a change in the person's behavior not associated with alcohol/drug abuse, share your observation and ask if you can help.

2. **Encourage/assist the person to seek professional help.**
   a. Mental illnesses do not have the same kind of denial system inherent in addictive illnesses. Denial is usually not as entrenched or systematic.
   b. The intervention process with mental illness is more individualized depending on how aware the person is about having a problem.
   c. The focus of the intervention is getting professional help for an assessment and treatment plan.
   d. People with mental illness often struggle with fear both about what's happening to them and also what getting help may involve.

3. **Focus on the problem behavior.** You do not need to be an expert on mental illness and attempt to diagnose the problem. You do not need to decide how the disorder is to be treated. But you can share your care and concern. The focus is always on: "Something has changed, and I want to help you get some help."

ANXIETY DISORDERS

Anxiety disorders, according to the National Mental Health Association, affect more than 19 million people each year and are the most common mental illness in the US. Left untreated, they can dramatically reduce productivity and significantly diminish the person's quality of life. The major anxiety disorders are Panic Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Social Phobia and Generalized Anxiety Disorder.

Panic Disorder

Panic Disorder is characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of breath, a choking sensation, sweating, dizziness and/or abdominal distress. Because the symptoms mimic a heart attack, diagnosis is often made only after extensive and costly medical procedures fail to provide relief. Fear of an attack produces intense anxiety between episodes. It affects about 1.7% of the adult population in a given year, especially women and tends to strike in young adulthood.

Obsessive-Compulsive Disorder (OCD)

OCD involves recurrent, unwanted thoughts (obsessions) or rituals (compulsions). Rituals (e.g., hand washing, counting, checking, or cleaning) are performed in hope of preventing obsessive thoughts or making them go away. It afflicts about 2.3% of people, men and women equally and occurs in a spectrum from mild to severe. Current search for causes focuses on the interaction of neurological factors and environmental influences.

Post-Traumatic Stress Disorder (PTSD)

PTSD is an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Trigger events can include violent personal assaults (rape, mugging), natural or human-caused disasters, accidents, and military combat.

Symptoms include repeated re-experiencing of the ordeal in the form of flashbacks, memories, nightmares, and frightening thoughts, especially when exposed to reminders; emotional numbness and sleep disturbance; depression, anxiety, irritability or outbursts of anger; feelings of intense guilt; avoidance of any thoughts or reminders of the ordeal. It affects at least 3.6% of US adults during a given year. PTSD develops at any age, including childhood.

About 30% of people who have spent time in war zones experience PTSD. Sexual assault is more likely to lead to PTSD than other traumatic events. This is explained in part because survivors are more likely to have been injured, to perceive the event as life threatening, to blame the event on someone else, and to have experienced multiple traumatic events.

Recent research has found that debriefing people very soon after a catastrophic event may reduce some of the symptoms; also that people with PTSD tend to have abnormal levels of key hormones involved in response to stress.

Social Phobia

Social phobia involves persistent, intense, and chronic fear of being scrutinized by others and of being embarrassed or humiliated by their own actions. Sufferers may avoid social situations and often worry for days or weeks in advance of a dreaded situation. Symptoms include blushing, profuse sweating, trembling, difficulty talking, and stomach discomfort. These visible symptoms heighten the fear of disapproval, so that the symptoms themselves become an additional focus of fear. This creates a vicious cycle as worry about symptoms creates a greater chance of developing the symptoms.

Social phobia affects at least 3.7% of individuals in a given year, twice as often in women, although a higher portion of men seek help for this disorder. It typically begins in childhood or early adolescence.

Generalized Anxiety Disorder

Generalized Anxiety Disorder involves chronic and exaggerated worry and tension that is unfounded or much more severe than normal. People with Generalized Anxiety Disorder usually expect the worst. Symptoms include excessive worry about health, money, family, or work, even when there are no signs of trouble; and inability to relax; frequent insomnia; and physical symptoms such as fatigue, trembling, muscle tension, headaches, irritability, or hot flashes.

Generalized Anxiety Disorder affects about 2.8% in a given year, women more than men. Onset is usually in childhood or adolescence, but can begin in adulthood.

Treatment of Anxiety Disorders

In general, the optimal treatment for any given Anxiety Disorder is usually a combination of medication and psychotherapy: therapy to work on the underlying issues and/or learn new behaviors; and medication to calm the anxiety symptoms.

In a Word

When working with someone in distress, always:

- Listen attentively without judging.
- Try to understand what the person is experiencing.
- Trust your intuition.
- Get appropriate help.

DEMENTIA

Dementia is a loss of cognitive function due to brain disease or trauma. The changes may occur gradually or quickly, and how they come about is paramount to determining whether the condition is reversible or irreversible.

The U.S. Congress Office of Technology Assessment estimates that 1.8 million Americans suffer from severe dementia and another 1 to 5 million experience mild to moderate form of the disease. Five to eight percent of people over age 65 have some form of dementia, and the number doubles every 5 years over age 65.

Symptoms of Dementia

- Erosion of recent and remote memory (amnesia)
- Impairment of one or more of the following functions:
- Language: misuse of words or inability to remember and use words correctly (aphasia)
- Motor activity: inability to perform motor activities even though physical ability remains intact (apraxia)
- Recognition: inability to recognize objects even though sensory function is intact (agnosia)
- Executive function: inability to plan, organize, think abstractly

Causes of Dementia

More than 50 conditions are associated with dementia, including

- Degenerative neurological disorders (e.g., Alzheimer's disease)
- Vascular disorders (e.g., multi-infarct disease)
- Inherited disorders (e.g., Huntington's disease)
- Infectious diseases (e.g., HIV/AIDS)

Some are irreversible. Alzheimer's disease causes 50-70% of all cases of dementia. Those that may be reversible include:

- Alcoholism, chronic drug use
- Viral, bacterial, fungal infection including Meningitis, Encephalitis, Neurosyphilis dementia
- Structural abnormalities (operable benign brain tumors, chronic subdural hematoma)
- Damaged caused by stroke
- Metabolic disorders such as hypothyroidism, hypoglycemia, hypercalcemia, liver disease

Differential Diagnosis

Delirium is a temporary but acute mental confusion due to heart or lung disease, infection, poor nutrition, hormone disorder, *reaction to medication*. Emergency treatment is vital. Pseudo dementia is a type of severe depression with cognitive changes that resemble dementia. It occurs mostly in elderly people and may exist with dementia. The depression is treatable.

Diagnosis of dementia involves a complete medical and neuropsychological evaluation, a complete history, and brain scan (e.g., CT, MRI, PET, SPECT) to rule out treatable causes. A definitive diagnosis requires an autopsy.

CO-OCCURRING DISORDERS

Adults with a substance use disorder were almost three times as likely to have a serious mental illness (20.4%) as those who did not have a substance use disorder (7.0%), according to a report from the Substance Abuse and Mental Health Services Administration (SAMHSA). The report, "Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders," presents information on the prevalence and the treatment of serious mental illness and the association between mental illness and substance use among adults aged 18 or older in 2002.

According to the report 33.2 million adults age 18 or older had a serious mental illness or a substance abuse disorder in 2002. Of those adults, 40.4% (13.4 million) had a serious mental illness; 47.4% (15.7 million) had a substance use disorder; and 12.2% (4.0 million) had both serious mental illness and a substance use disorder. The data also indicate that while 47.9% of adults with both a serious mental illness and a substance use disorder received some type of treatment, only 11.8 % received both mental health and addiction treatment disorders.

Of the three age groups examined, adults age 18 to 25 had the highest rate of serious mental illness (13.2%), followed by adults age 26 to 49 (9.5%), and those age 50 or older (4.9%). Overall, the rate of serious mental illness was almost twice as high among women than among men.

Commenting on the report, SAMHSA Administrator Charles Curie said, "The time has come to ensure that all Americans who experience co-occurring mental and substance use disorders have an opportunity for treatment and recovery. Clearly, our systems of services must continue to evolve to reflect the growing evidence base that promotes integrated treatment and supportive services. Both disorders must be addressed as primary illnesses and treated as such."

The report can be accessed at www.oas.samhsa.gov. *Source: SAMHSA, "Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders," July 2004.*

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NOTES

SECTION 4:
ISSUES AFFECTING OTHERS

FAMILY ISSUES

Interventions: May provide a break-through into recovery for the entire family circle.

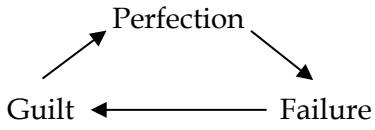
Co-Dependence: Families, co-workers and significant others in the addicted person's life develop many of the same symptoms from living with and reacting to chemical dependence. This syndrome is frequently labeled "co-dependence."

Anxiety: Family members experience anxiety. They worry and try to fix everything because the alcoholic seems to do neither. Family members feel:

- **Anger:** They feel the alcoholic doesn't love them, that he/she is irresponsible, tells lies and manipulates them;
- **Resentment:** Families feel chronically abused and trapped;
- **Fear:** They are afraid of the future, afraid of the alcoholic's moods, afraid of both realistic and unrealistic threats; and
- **Guilt:** Families are told repeatedly the problems are their fault. They believe that "somehow" they are guilty.

Denial: Families also try to find excuses, alibis and reasons for the drinking behavior. Shame and embarrassment contribute to denial. Characteristics of family denial:

- **Cycle of Guilt, Perfection, Failure:** Family members experience a cycle of breaking their own idealistic values, feeling guilt as a consequence, and then vowing to be perfect to handle the guilt;



- **Out of Touch with Reality:** Family members believe their own rationalizations, and may have distorted perceptions of the addict's reality; and
- **Delusional Memory:** Family members become sincerely deceived as to reality.

Preoccupation/Obsession with the Alcoholic: What is going on in the drinker's/user's life dominates the lives of the rest of the family.

Family Rules: Don't talk, don't feel, don't trust are unspoken rules. Each person is isolated and unavailable to the others for emotional and spiritual support.

CO-WORKER ISSUES

Co-workers and colleagues may feel the disruptive effects of this illness in much the same way as families.

Co-Workers and Families

Similarities of Feelings:

- **Frustration and Anxiety:** Can't count on the alcoholic who is often moody and difficult, late with assignments and avoids responsibilities;
- **Anger and Resentment:** Feel overburdened, confused and tired of covering up;
- **Fear:** Feel edgy about the loss of business and worry about the organization's reputation; and
- **Guilt:** Experience the cycle of guilt, perfection, failure because of their own reactions, their anger; desire to get even; to get rid of this problem.

Similarities in Enabling Behavior:

- **Make excuses**, cover for, minimize problems;
- **Look for answers** other than the drinking;
- **Drink** with the alcoholic after work;
- **Shift responsibilities** to someone else; and
- **Avoid** the alcoholic as much as possible.

Special Considerations for the Legal Profession:

- **Shared Responsibility:** Members of a firm share the responsibility and liability for mistakes or misdeeds; may face malpractice suits.
- **Professional Discipline:** Firm members may be held responsible for failure to ensure that all members conform to rules of ethics.
- **Loss of Public Trust:** Incompetent representation of a client's legal matters damages the reputation of the legal profession.

ENABLING

Common Usage: Enabling connotes a beneficial and useful activity. It refers to a healthy and respectable process because it means, "to make able, to provide means or opportunity, to authorize, to empower." In this context, enabling assists a person to accomplish a goal.

Context of Addictive Illness: Enabling, in the context of addictive illnesses, means:

- **Any action or inaction** on the part of others close to the drinker/user;
- Which tends to **support**, **contribute** to, or **allow** the drinking/using (or unacceptable behavior) to continue unabated.

Locus of Control: Enabling may be thought of as:

- **Active:** Well-intended helping gone bad; and
- **Passive:** Doing nothing to remedy a bad situation.

Enablers eventually lose control over their own behavior as the illness increasingly dominates their thoughts and actions. Their enabling will not stop without outside intervention, usually at a time of crisis.

Enabling Roles: Enabling takes many forms in family, social and work settings:

1. **Rescuers:** "Let me do it. I'll take care of you." Rescuers are people who are competent and action oriented. They:
   - "Cushion" the user's life by softening the consequences of inappropriate actions;
   - Make it easier to continue an unhealthy pattern; and
   - Protect the user by manipulating others, or intervening in situations which may result in embarrassment or have painful repercussions.

   Rescuers prevent users from learning from their behavior and correcting their own mistakes. People who rescue often do it because of their own fear, anxiety or guilt. They are meeting their own needs, under the guise of helping the other person.

2. **Victims:** "Poor little me." Victims are people who tend to be passive as they:
   - Assume the user's responsibilities, thus enabling the drinking or drug use to continue without serious effects;
   - Accept the blame, accusations and often violence. They may believe they cause the drug/using. Anger and self-pity are common emotions;
   - Complain to others, seeking sympathy; and
   - Cooperate in silence about the drinking/using.

3. **Provokers:** "If you loved me, you'd change." Provokers' anger causes them to:
   - Try to force change, often by punishment and ridicule, that keep the user angry and on the defensive;
   - Try to control the drinking/using, people or situations in the user's life;
   - Feed back into the relationship fear, resentment, hurt feelings and bitterness.

4. **Adjusters:** "No problem, I can handle it." This is a common management response. Adjusters are fixers who:
   - Try to handle problems that occur for the users, assume responsibilities;
   - Try to make things work by reassignment of work, or relocation; and
   - Never confront the drinking/using itself as the problem.

Examples of Enabling:

- Accepting constant excuses and alibis, no matter how bizarre, for problems, mistakes, irresponsibility and continuing drinking and using;
- Avoiding honest discussion about obvious impaired behavior;
- Drinking and using with the person and encouraging him or her to do the same;
- Covering for the drinking and using and covering for the consequent problems;
- Allowing the person to sidestep attempts to confront drinking related activity;
- Provoking or cooperating in angry arguments and accusations; and
- Making threats but failing to follow through.

ESTABLISHING LIMITS

The Enabling Process:

- Occurs naturally within the interactive circle of an alcoholic's family, co-workers and friends.
- Represents an attempt to normalize the situation by picking up some of the addict's responsibilities or by protecting the addict from the consequences of problem behavior.
- Despite the good intentions, the person with the problem does not see the "problem" in the same way the significant others do. The well intentioned "enabling" behavior is either accepted as normal cooperation or resented as meddling.
- The remedial efforts and the protective responses actually contribute to the continuation of the problem by supporting the denial mechanism.
- The enabler typically experiences anger, frustration, self-pity or despair as the attempts to help resolve the situation fail.

Detachment:

- The process of stepping back ("creating some space") from the problem in order to gain understanding and perspective.
- The distance allows the enabler the freedom to "let go" of the addict and the failing attempts to control or "fix" the person, so realistic choices can be made for more helpful and realistic responses.
- Stepping back also removes the reactive cycle of protection, covering up and other home remedies, so the addict can experience the painful consequences of the problem behavior.
- It is not a manipulative device to change the alcoholic's behavior. It is a necessary step toward freedom for both the enabler and the alcoholic, so that change can occur.

Steps in Detachment:

"Limits" or boundaries need to be established by the enabler. These are standards one establishes both for oneself and relationships.

1. **Self-Responsibility (Self-Respect)**
    a. The beginning of detachment is developing an awareness of my own reactions, emotions and behavior. The problem behavior of the alcoholic cannot be used as an excuse for things I do that I don't respect in myself.
    b. Acceptance of personal responsibility to decide or choose my reactions rather than shifting responsibility for my own behavior to someone else.
    c. Example: *"I had become so attached (addicted) to my husband's drinking problem that my own life had become a reaction to his. I was not making decisions and choices. I explained my behavior as being caused by him and his problems. Detachment helped me to take responsibility for my own life. I realized I could no longer rely upon his problem as an excuse for my own unhealthy behavior."*
    d. People need external support and guidance for this process to develop. Al-Anon meetings and literature are invaluable. The resistance to and fear of change will be intense and deep-seated. Catastrophes will be imagined. This process takes time and patience.

2. **External or Relationship Boundaries/Limits**:
    a. Once individual boundaries have been established, and the person has established a new sense of self-respect and healthy autonomy, limits or boundaries regarding the addict can also be established.
    b. Behavior that will not be tolerated from the addict.
    c. Responses that will happen to continued unacceptable behaviors. These decisions, and the ability to implement them, can be a critical part of the intervention process.
    d. The subject will test these new behaviors. Never encourage enablers to promise action that they are not able to carry out. Discourage idealistic or dramatic changes that you sense the family member or colleague will not be able to do.

Understanding and Using Limits:

- Many people who call for help are looking for techniques to change the problem person. Typically, they exhibit strong initial resistance to the idea that there is anything problematic about their own behavior. Family members, who probably feel very guilty about somehow "causing" the problem, will often resist the idea that there is something they can change about their own behavior that will improve the situation. They, as well as work colleagues, will often want to stay focused on the addict. They may find it threatening to look at their own reactions and choices as contributing to the problem.
- These people need to learn that there is a better, more effective way of responding to the addict's behavior. Changing their own responses will help them to feel better and thereby begin their own recovery. These changes also will have a positive impact on the problem person, but they are not focused on "fixing" the addict.

- Limit setting involves one in the process of recognizing that all people, including addicts, must be accountable for their own behavior, and that there is a limit to what anyone can or should do for another person.
- Effective limits are always natural and genuine; never artificial or manipulative. They must be developed individually by the persons involved.
- It is important to avoid bluffing or threatening any action they are not fully prepared to take. When the limits are tested the person must follow through or the cycle of alcoholic and co-dependent behavior will continue.
- **"Tough love"** is a phrase widely used to describe limit setting. Unfortunately it can also be an excuse for cold and uncaring behavior towards the alcoholic. It can also become a disguise for anger, punishment, and retaliation. The phrase really means making **tough** decisions about allowing the alcoholic to face the painful consequences of continued problem behavior, rather than continuing to enable by reacting in the old ways. The toughness, or firmness needs to be accompanied by love for the person. Often we best express our love and care for an individual when we are willing and able to make tough decisions.
- Articulating these decisions in a kind but firm way is the essential ingredient of a new freedom from being controlled by the situation. It is also a necessary foundation for participating in an intervention.

Summary:

"Setting limits" begins with a personal decision to change **my response** to the problem, not as a method to control or manipulate the alcoholic. Limits that are developed out of an attempt to control or punish the addict will not be effective.

SAMPLE LIMITS FROM PARTICIPANTS

- "Steve, I need to tell you I cannot continue in the marriage if the drinking continues. I have seen an attorney for advice as to how to separate if this happens again.
- "Jim, I have decided that the children and I can no longer risk our lives by riding in the car with you when you are drinking. If this happens again, we will not ride with you. If you insist on driving, I will take away the keys or call the police."
- "Mary, the senior partners have decided that we will terminate you if there is another drinking episode in which you embarrass the firm when meeting with a client.
- "Jane, I will not lie to your senior partner for you anymore. If you ask me again to explain a missed appointment due to your drinking, I will tell the truth rather than cover up."
- "Bill, we've been good friends as well as partners (colleagues), but I've now decided that if I need to cover an assignment for you again because of your drinking, I will tell the senior partners. I now realize I am not helping you when I do that and I lose my own self-respect."

RECOVERY PROCESS

Recovery: A dual process – both the user and the family/co-workers change. It can be helpful to look at recovery as a parallel track for the addicted person and the family and significant others. It is ideal when both recovery processes occur simultaneously. In practice, this is unlikely: each compliments the other. However, lack of support from family and co-workers cannot be used as an excuse by the addict, nor can the addict's lack of recovery be used by the family or co-workers as a reason to avoid change.

Alcoholic/Substance Abuser

- Intervention: Changes perception of illness.
- Accepts professional help.
- Detox: Abstinence.
- Education: Symptoms and recovery.
- Acceptance: Increased self-esteem through self-responsible actions.
- New life: Planned growth through professional and self-help groups (AA, NA, CA).

Family, Friends and Co-Workers

- Intervention: Changes perception of illness and options.
- Detach: Stop enabling.
- Participates in treatment.
- Education: Symptoms and recovery.
- Acceptance: Increased self-esteem through self-responsible actions.
- New life: Planned growth through professional and self-help groups (Al-Anon, FA).

NOTES

SECTION 5:
LOCAL RESOURCES & ADDITIONAL PUBLICATIONS

LOCAL RESOURCES PROVIDING A.A. MEETING INFORMATION

Boise

Oficina Intergrupal de AA del de Boise
Main: (208)703-1574

Treasure Valley Central Office
Main: (208) 344-6611
www.tvico.org

Bonners Ferry

District 14
- *IDAHO: Bonners Point, Priest River, Sandpoint*
- *WASHINGTON: Newport*
- *MONTANA: Libby, Troy*

24 Hr. Hotline: (800) 326-2164
district14-aa.org

Coeur d'Alene

Central Office of North Idaho
Main: (208) 667-4633

Moscow

North Central Idaho
Main: (208) 882-1597

Pocatello

District 1 Answering Service
Main: (208) 235-1444

Websites Providing A.A. Meeting Information

Area 18: Idaho
www.idahoarea18aa.org

Alcoholics Anonymous
www.aa.org

International Lawyers in Alcoholics Anonymous
www.ilaa.org

Other Resources

Idaho Suicide Prevention Hotline
Call 1-800-273-8255 for 24/7 Support
www.idahosuicideprevention.org

ABA Judicial Assistance Initiative
National Helpline for Judges Helping Judges
Call 1-800-219-6476, during business hours Central time

SOUTHWORTH
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any time, any place

Recommended Reading Material

The following books come highly recommended by Southworth Associates as a good educational base for those seeking to assist their friends and families with their addiction. Most all of these books can be found in the larger national bookselling chains, but if needed, Southworth Associates can ship these books world-wide for just the cost of the books plus shipping. Many, including Love First & No More Letting Go, are also available through electronic formats from Amazon.com or Barnesandnoble.com.

Recommended Reading on Interventions & General Addictions

"Love First: A New Approach to Intervention for Alcoholism and Drug Addiction"
Jeff and Debra Jay $14.95
www.lovefirst.net

"No More Letting Go: The Spirituality of Taking Action Against Alcoholism *and* Drug Addiction"
Debra Jay $15.00

"Being Sober: A Step-by-Step Guide to Getting To, Getting Through, and Living in Recovery"
Harry Haroutunian, MD. $13.00

"Addictions & Recovery: Self-Help for Addicts, Families, Friends" $9.99
Deirdre Boyd

"At Wit's End: What You Need to Know When a Loved One is Diagnosed With Addiction and Mental Illness"
Jeff Jay and Jerry AQ. Boriskin, Ph.D $13.95

"Bradshaw on: The Family: A New Way of Creating Solid Self-Esteem"
John Bradshaw $13.95

"Aging & Addiction: Helping Older Adults Overcome Alcohol or Medication Dependence"
Carol Colleran and Debra Jay $15.95

"The Language of Letting Go"
Melody Beattie $16.95

"The Family Recovery Guide: A Map for Healthy Growth"
Stephanie Brown $24.95

"Quiet Mind"
White Eagle $4.00

"I'll Quit Tomorrow"
Vernon Johnson $15.95

"The Recovery Book"
Al J. Mooney, M.D., Arlene Eisenberg and Howard Eisenberg $15.95

Recommended Reading on Adolescents

"Choices and Consequences: What to do When a Teenager Uses Alcohol/Drugs"
Dick Schaefer $14.95

Southworth Associates also recommends Al-Anon attendance and the following book:

"Courage to Change"
(Acquire at an Al-Anon meeting) $8.00

For meeting information for your area call (800) 4AL-ANON or visit their website at www.al-anon.org

Recommended Reading on Chronic Pain Management

"A Day Without Pain" Dr. Mel Pohl $14.95

5530 W. Emerald St. Boise, Idaho 83706
www.southworthassociates.net
800-386-1695 **Toll Free**
866-460-9014 **24 Hr. Hotline**
208-323-9555 **Office**
208-323-9222 **Fax**

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