

***SUBSTANCE ABUSE, CHEMICAL DEPENDENCY
AND
MENTAL HEALTH CONCERNS
IN THE
LEGAL PROFESSION***

OHIO LAWYERS ASSISTANCE PROGRAM, INC.

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TABLE OF CONTENTS

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY

Definitions of Addiction	3
Primary Classification of Substances.....	3
Disease Concept of Addiction	6
Etiology of the Disease	9
How Disease is Manifested.....	12
Personal Costs.....	14
Professional Costs.....	15
Why We Avoid Treatment.....	16
Other Defenses to Getting Help.....	16
Promoting Recovery	18
Treatment Objectives	19
OLAP	19
Role of 12 Step Programs	22
What Can I do?	24
Lawyers Assistance Committee/OLAP.....	24
Contacting OLAP & Other Resources	25
Conclusion – Addiction	26
Self-Exams – Alcohol & Addiction.....	28

MENTAL HEALTH CONCERNS

What is Mental Illness?.....	38
Anxiety Disorders	
Generalized Anxiety Disorder (GAD)	40
Self-Exam GAD	45
Obsessive-Compulsive Disorder (OCD).....	46
Self-Exam OCD	50
Contacting OLAP & Other Resources	54
Depression	
Etiology of Depression.....	55
Facts on Depression	57
Depression & Suicide	59
Warning Signs.....	60
Major Depressive Episode	61
Mixed Episode	62

Dysthymic Disorder	63
Bipolar Disorder.....	65
Attention-Deficit/Hyperactivity Disorder (ADD/ADHD)	68
Behaviors/Warning Signs	71
Co-Existing Conditions.....	76
Dual Diagnosis	
Definition	82
Behaviors/Warning Signs	84

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IN THE LEGAL PROFESSION***

Ohio's integrated program:

The legal profession's response to substance abuse, chemical dependency and mental health concerns in Ohio

I. The Organization

The Ohio Lawyers Assistance Program, Inc. (OLAP)

II. The Three Components

Education
Advice and Intervention Assistance
Treatment and After-Care Support

III. Key Rules and Statutes

Gov. Rule I, Section 3(E)(2)--One hour of instruction to sit for bar examination

Gov. Rule X, Section 3(A)--CLE Requirements

Professional Cond. Rule 8.3(c)--Confidentiality

R.C. Section 2305.28--Qualified Immunity for Intervention Participant

Gov. Rule V, Section 9(B)--Monitoring

IV. Funding and Other Support

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INTRODUCTION

Since 1990 OLAP has assisted Ohio's judges, lawyers and law students obtain appropriate treatment for substance abuse, chemical dependency, and mental health issues. Over 2,000 men and women have been helped. Recognizing that an impaired lawyer negatively affects nine other people each day, over 18,000 men, women and children have somehow been touched by OLAP.

The American Bar Association surveyed attorneys in 1990. Among the startling statistics at that time were that:

1. One-third of practicing lawyers suffer from depression at some time, making lawyers 5 to 10 times more likely than other professionals to suffer from a major depressive disorder;
2. 18% - 20% of lawyers suffer from alcoholism, compared with 10% of the rest of Americans. After 20 years of practice, the rate rises to 25%. Alcohol and drug problems cause half the disciplinary cases involving lawyers (*Wall Street Journal*, 11/30/90); and
3. Lawyers are twice as likely as other professionals to commit suicide.

Florida Coastal School of Law Professor Susan Daicoff, who is also a psychologist, has studied this issue. In an article she wrote, which was published in *The Georgetown Journal of Legal Ethics* in Spring, 1998, she states the following:

. . . "D. INCIDENCE OF SUBSTANCE ABUSE AND DEPRESSION AMONG LAWYERS.

A serious influence complicating and compounding the . . . crisis is the incidence in substance abuse and depression among lawyers. Estimates of the frequency of substance abuse problems, including alcoholism, among lawyers range from three to thirty times that of the general population. About nine to ten percent of the general population in the United States is alcoholic, while empirical studies consistently show that about eighteen percent of lawyers and law students are alcoholic. Similarly, while three to nine percent in the general population in the United States is clinically depressed, as much as nineteen to twenty percent of practicing attorneys is depressed. A 1986 study found that only about ten percent of entering law students exhibited significant symptoms of psychological problems including depression, anxiety, hostility,

paranoia, and obsessive-compulsive symptoms, but this percentage jumped dramatically to thirty-two percent by the end of the first year of law school. By the end of the third year of law school it was forty percent, and two years after graduation it was 17.9%. A 1995 study replicated these findings and found that problems did not significantly abate after the individuals entered the practice of law. Depression, anxiety, social isolation and alienation, hostility, paranoid ideation, and obsessive-compulsive symptoms were more frequent in attorneys than in the general population. Thus, a greater than average percentage of attorneys (as a group) is psychologically impaired in some way. Further, it appears that while the problems often do not appear until the first year of law school, lawyers do not return to their pre-law school level of psychological health after graduation.” (pages 555-557)

In one of Professor Daicoff’s footnotes, she cites a study by Connie A. Beck which was published in 1995-1996. Ms. Beck’s findings are as follows:

	Base Rate		Among Lawyers	
	Male	Female	Male	Female
Depression	8.5%	14.1 %	21%	16%
Anxiety	4%	4%	30%	20%
Obsessive-Compulsive	1.4%-2%	1.4%-2%	21%	15%

The purpose of this publication is to provide you with information, education and resources if you or someone else in the profession is in need of assistance.

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This publication was funded by The Supreme Court of Ohio. However, the opinions expressed in this publication do not necessarily reflect the position of the Court, and no endorsement of the Court should be inferred.

These materials are published as part of the Ohio Lawyers Assistance Program, Inc.'s (OLAP) educational services. The purpose of this publication is to provide Ohio's legal profession with information, education and resources. This publication is not to be used to self-diagnose or to diagnose others. Contact OLAP for further assistance.

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SUBSTANCE ABUSE IN THE LEGAL PROFESSION

Causes, Prevention, Detection and Treatment Alternatives

I. WHAT ARE SOME FUNCTIONAL DEFINITIONS OF ADDICTION?

- A. The inability to stop the use of the substance or behavior in question; the perceived inability to stay stopped.
- B. Behavior characterized by:
 - 1. Compulsion: an internal demand beyond intellectual resource or understanding.
 - 2. Loss of control over amount consumed.
 - 3. Continued use or activity despite adverse consequences.
- C. Another way of saying it:

- 1. Psychoactive Substance Dependence (Addiction).

The essential feature of this disorder is a cluster of cognitive, behavioral, and physiological symptoms that indicate that the person has impaired control of psychoactive substances and continues to use the substance(s) despite adverse consequences.

- D. A related term:

- 1. Psychoactive Substance Abuse.

Psychoactive Substance Abuse is a residual category for noting maladaptive patterns of substance use that have never met the criteria for dependence.

II. WHAT ARE THE PRIMARY CLASSIFICATIONS OF SUBSTANCE

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), American Psychiatric Association, 2000) has divided substances into 11 categories:

- A. Alcohol - a drug in liquid form.

B. Sedatives, hypnotics and *antianxiety* drugs - sleeping pills and “nerve medication”:

Barbiturates	Benzodiazepines	Date Rape Drugs
Seconal	Zolpidem (Ambien)	GHB (Georgia Homeboy, Grievous Bodily Harm)
Pentobarbital (Nembutal)	Flurazepam (Dalmane)	Flunitrazepam (Rohypnol) (“Roofies”, “Roffirs”, “Rophirs”, “Roche”, “Forget Me Pill”)
Tuinal	Lorazepam (Ativan)	(See: Ecstasy under amphetamines and hallucinogens since it has both properties. It is not classified as a sedative hypnotic.)
Phenobarbital (Luminal)	Clorazepate (Tranzene)	
Secobarbital (Amytal)	Chlordiazepoxide (Librium)	
Anembutal	Oxazepam (Serax)	
Butalbital (Fiorinal, Fioricet)	Alprazolam (Xanax)	
	Meprobamate (Equanil, Miltown)	
Butabarbital (Butisol)	Diazepam (Valium)	
Talbutal (Lotusate)	Triazolam (Halcion)	
Mephobarbital (Mebaral)	Estazolam (ProSam)	
Methohexital (Brevital)	Quazepam (Doral)	
Thiamylal (Surital)	Temazepam (Restoril)	
Thiopental (Pentothal)	Halazepam (Paxipam)	
	Prazepam (Centrax)	
	Midazolam (Versed)	
	Clonazepam (Klonopin)	

Older Sedative Hypnotics (not readily available)

Golutethimide (Doriden)
Noludar
Methaqualone (Quaalude, Soper)
Placidyl

C. Cannabis/marijuana/hashish/hash oil.

D. Cocaine/Crack

E. Amphetamines (Stimulants and Sympathomimetics):

Methamphetamine/"Crank"/"Ice" (smokable)/"Crystal"/"Chalk"/"Fire"/"Glass"

Ritalin (Metadate, Methylini)

Preludin ("Ecstasy")

Aderol

Cylert

F. Hallucinogens:

LSD

Psilocybin and Psilocyn

Mescaline and Peyote

DMT

MDMA ("Ecstasy", "XTC", "Adam", "Essence", "Clarity", "Lover's Speed")

G. Inhalants:

Gasoline, glue, paint thinners, spray paint, cleaners, typewriter correction fluid, spray-can propellants, nitrous oxide ("whip-its"), amyl and butyl nitrate ("poppers," "locker room")

H. Caffeine.

I. Nicotine.

J. Opiates

Thebaine

Anexsia

Hydrocodone

Naloxone

Lortab

Heroin

Loret

Hycodan

Oxymorphone

Naltrexone

Hydromorphone

Darvon

Tussionex

Hycomine

Nalbuphine

Tylos

Morphine (Roxanol)

Codeine

Dilaudid	Demerol	Oxycodone
Meperidine	Percodan	Methadone
Pentazocine	Buprenorphine	Fentanyl
Oxycontin	Duragesic patch (Fentanyl)	
Codeine	Vicoden	Percocet
Lomotil	Paragoric	MSIR
MS-Contin		

K. Phencyclidine (PCP, Hog, Tranq, Angel Dust and PeaCe Pill), Sernyl Arylcyclohexylamine

Ketamine (Ketalar, Ketaject, “Special K”, “K”, “Vitamin K”, “Cut Valiums”);
Cyclohexamine
Dizocilpine

III. WHAT DO WE MEAN WHEN WE SAY IT’S A DISEASE?

A. Since 1956, the American Medical Association has considered alcoholism (or chemical dependency) to be a disease, and the American Bar Association’s Commission on Lawyers Assistance Programs has adopted this model as well.

B. Alcoholism is a primary, chronic, disease with genetic, psycho-social 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. (American Society of Addiction Medicine (ASAM), National Council on Alcoholism and Drug Dependency (NCADD), 1990).

C. What are the principal characteristics of the disease?

1. Primary Disease

The disease itself causes the drinking or drug use. It is not secondary to some other disease of mental illness, etc.

2. Chronic

There is no cure for the disease, but it can be treated and controlled.

3. Progressive

The disease always gets worse, it does not get better and there is no turning back and beginning all over again as if one never drank or used.

4. Fatal

This is a fatal disease if not controlled. It always leads to premature death and serious health problems even if the death certificate indicates the cause of death to be one of the complications of the disease, e.g., heart problems, liver failure, bleeding ulcers, cancers, etc.

5. Treatable

The disease can be controlled if the drinking or drug use is stopped. It is much like diabetes in the sense that if body chemistry is stabilized by not drinking or using, then the alcoholic may lead a normal life. Recovery rate among the general population who have undergone appropriate treatment is around 70% and among some professional groups (including lawyers) as high as 90%.

D. What are the diagnostic criteria for substance abuse according to the DSM IV-TR (page 199)?

1. A maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by one (or more) of the following within a 12-month period:
 - a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences, poor performance, suspensions from school, neglect of children).
 - b. recurrent substance use in situations in which it is physically hazardous (e.g. driving, operating a machine, hunting, boating).
 - c. Recurrent substance – related legal problems (e.g. arrests)
 - d. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (arguments with spouse, physical fights).

2. The symptoms have never met the criteria for Substance Dependence/Addiction for this class of substance.
- E. What are the diagnostic criteria for substance dependence (addiction) according to the DSM IV-TR (page 197)?
1. A maladaptive pattern of substance use, 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:
 - a.. Marked tolerance: need for markedly increased amounts of the substance in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.
 - b. Characteristic withdrawal symptoms (increased pulse, respirations, blood pressure, tremors, nausea, vomiting, diarrhea, constipation, sweats). Use of substance to relieve or avoid withdrawal symptoms.
 - c. Substance is often taken in larger amounts or over a longer period than the person intended.
 - d. Persistent desire or one or more unsuccessful efforts to cut down or control substance use.
 - e. A great deal of time spent in activities necessary to get the substance, take the substance, or recover from its effects.
 - f. Important social, occupational, or recreational activities given up or reduced because of substance use.
 - g. 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).

F. Substance Abuse vs. Substance Dependence

- a. Unlike the criteria for substance dependence, the criteria for substance abuse do not include tolerance, withdrawal or a pattern of compulsive use and only include the harmful consequences of repeated use. DSM IV-TR, p. 198.
- b. Substance abuse is more likely in individuals who have begun to use substances recently. DSM IV-TR, p. 206.
- c. Treatment, education and abstinence are critical for one diagnosed with substance abuse for at least three primary reasons:
 - i. to ensure the safety of the individual, the individual's family and the public;
 - ii. because the diagnosis of substance abuse indicates that the abuser is, for practical purposes, "out of control" due to "repeated" use in situations where use is inappropriate, harmful and even life threatening. Such "repeated" use may be tantamount to and easily confused with "compulsive" use which indicates dependence;
 - iii. because substance abuse often evolves into substance dependence. DSM IV-TR, p. 206.

IV. WHAT KIND OF A DISEASE IS IT?

A. It is a genetic and biochemical disease:

Just since 1980, there have been hundreds of studies and scholarly papers (including the discovery of perhaps one of the actual genes) corroborating a genetic or familial pre-disposition to the disease.

B. Two genetic varieties of the disease:

1. Highly heritable.
 - a. More likely in the male line.
 - b. Person can be alcoholic from first use or first drink.

- c. Children as young as 8 years of age or younger can be alcoholic or drug dependent.
- d. If you have one parent who is an alcoholic/addict, you have a 50% chance of being chemically dependent. If you have two parents who are chemically dependent, you have an 80% chance of becoming an alcoholic and/or an addict.

2. Milieu limited.

- a. More likely to come on in 30's or 40's after a more prolonged period of use (average period being 7 years).
- b. Can be associated with crisis events in life and inability to control amount used.

C. Biochemistry issues:

1. Brain chemistry affects how one feels.

How do the alcoholics or drug dependents feel that they want to drink for relief? Alcoholics are stimulus augmenters and live in a world that is too loud.

2. Brain Wave Studies.

Low amplitude "P-d" brain waves are too low or are missing. These waves affects cognitive ability to tolerate, interpret, and utilize stress. "Alpha" waves are also deficient or absent.

3. Brain chemistry.

a. Neurotransmitter and Opioid Deficiencies.

Is there something else missing that affects normally feeling good? In alcohol craving rats, there is a serotonin deficiency. Serotonin is a major "feel good" compound in the brain.

The brain has morphine receptor sites because it makes some form of endogenous morphine -- these are the endorphines we produce, e.g., "runner's high." Spinal fluid of alcoholic is deficient in "feel good" endorphines.

Alcoholic rats are deficient in enkephalines as well -- these are other "feel good" chemicals in the brain.

Some research shows deficiencies in still others like noradrenaline.

- b. At first, alcohol makes the alcoholic feel normal.

The alcoholic therefore begins to feel good or normal, like normal people, after he or she has begun to drink and the alcohol has begun to affect the amount of these feel good chemicals in the brain.

But, this is also the point at which the alcohol becomes a double bind because other chemical reactions going on in the alcoholic's chemical system begin to set up the craving process for more and more alcohol.

- c. Then, the craving process begins. This craving is the alcoholic's allergic response.

When the alcohol is enough to overcome the normal metabolism of acetaldehyde there is production of dopamine (new gene research involves dopamine receptors) resulting in THIQ which when given to rats will cause them to drink themselves to death. In spinal fluid of an alcoholic, the THIQ is 1000 times greater than normal. Conclusion, craving can be explained biochemically.

D. Psychological Aspects of the Disease:

1. There is no alcoholic personality profile -- the alcoholic personality does not exist.
2. But, there is evidence of poor identification with the parent of the same sex as a result of death, or parent's alcoholism, or parent's work-aholism.

This is the parent from whom we should learn our coping skills at the earliest age. Therefore, the alcoholic may not be learning good stress coping skills while also being genetically and biochemically pre-disposed to stimulus augmentation.

E. Social Aspects of the Disease:

1. Our society promotes and condones drinking and drug use.
2. The 10% to 20% of the general population who are at risk for alcoholism or chemical dependency see advertisements, etc., just like the other 80% to 90% who can handle alcohol in moderation.
3. Additionally, peer pressure to use easily available drugs is rampant among children, youth, and teens -- perhaps the single biggest factor for beginning use.

V. HOW WILL THE DISEASE MANIFEST ITSELF?

A. Home and Family:

1. Heavy drinking/using -- high tolerance.
 2. Hide drug/alcohol -- secret use.
 3. Broken promises to quit.
4. Behavior excused by family and friends (enablers, hero, scapegoat, mascot and lost child).
5. Mood swings and inconsistency.
 6. Fights, arguments, violent outbursts, temper.
 7. Drinking or drug use more important than other activities.
 8. Children neglected, abused, or in trouble themselves, often with alcohol or drugs.
 9. Sexual problems: no sex - rejection; impotence; affairs - change in value system.
 10. Withdrawn, isolation and fragmentation of social and family life.
 11. Family isolates itself from social supports.
 12. Financial problems, e.g., get-rich-quick schemes, trouble with IRS and creditors.

13. Spouse in psychotherapy or taking psychoactive medications.
14. Separation or divorce.

B. Community and Professional:

1. Isolation and withdrawal from service clubs, church involvement, community activities, hobbies, leisure activities, old friends.
2. Withdrawal from bar association work and not completing continuing legal education.
3. Embarrassing behavior at clubs, parties, social functions, fundraisers.
4. Neglect of social commitments.
5. Financial difficulties and inappropriate spending.
6. Legal problems, OMVI, arrest, IRS.
7. Exaggerating work accomplishments and finances.
8. Missed legal deadlines (statute of limitations, motions).
9. Late for/missed court appearances/depositions.
10. Intoxicated after lunch.

C. Office Conduct:

1. Disruption of appointment schedule.
2. Hostile, withdrawn, unreasonable behavior to staff and clients.
3. Office staff assumes responsibility generally taken by attorney.
4. Power struggle within office staff.
5. Decrease in efficiency.
6. Stays late after office hours.
7. Absence from office unexplained or due to illness.

8. Complaints by clients to staff regarding behavior - alcohol on breath, slurred speech.
9. Drinking or drug taking at office.
10. "Locked door syndrome" - mood swings.
11. Experiences blackouts - forgotten phone calls.
12. Gossip regarding behavior changes.

D. Physical Status:

1. Deterioration in personal hygiene.
2. Deterioration in clothing and dressing habits.
3. Accidents.
4. Multiple physical signs and complaints.
5. Frequent visits to physicians/psychologists.
6. Pupil and eye change.
7. Inappropriate tremulousness or sweating.

VI. WHAT ARE THE ULTIMATE "PERSONAL COSTS" OF DOING NOTHING?

- A. Loss of physical, emotional, spiritual health for the alcoholic/addict, and usually his or her family.
- B. Codependence and Psychologically Damaging Roles in the alcoholic's/addict's family such as
 - i. the Enabler, who suffers the stress created by continual covering up for alcoholic/addict;
 - ii. the Hero, who is typically an older child who feels he or she has to excel at everything to save the family reputation; this facade masks internal feelings of inadequacy and anger;
 - iii. the Mascot, who acts the role of a clown to divert attention from the alcoholic/addict, but suffers repressed hurt and guilt;

- iv. the Lost Child, who intensely withdraws into a private fantasy life; internalizing loneliness and feeling unimportant; and
- v. the Scapegoat, who tries to take the focus off of the alcoholic/addict by getting into trouble thereby masking an internal sense of fear.¹

- C. Damage to or loss of marriage.
- D. Damage to or loss of parent-child relationships.
- E. Loss of friends.
- F. Sometimes OMVI's.
- G. Sometimes suicide.

VII. WHAT ARE THE ULTIMATE PROFESSIONAL COSTS?

- A. If nothing else, loss of real potential.
- B. Eventually minor or isolated ethical problems - not yet real neglect because isolated.
- C. Eventually it can cause:
 - 1. Actionable misconduct.
 - 2. Patterns of neglect.
 - 3. Competency issues.
 - 4. Loss of professional license, income, etc.
- D. Remember, some of the things most likely to cause professional problems are:
 - 1. Marital problems.
 - 2. Financial problems.
 - 3. Bad judgment.
 - 4. Inappropriate disposition.

¹Information taken from: *The Family Trap* by Sharon Wegscheider, Johnson Institute, 1976.

5. ALCOHOLISM/ADDICTION CAUSES ALL OF THESE.

VIII. WHY WOULD SOMEONE GENERALLY WANT TO AVOID TREATMENT?

A. The nature of the mechanism of disease activation may involve certain activities that, due to the patient's world view or the law, has the patient:

1. Thinking that the disease is sinful.
2. Thinking that the disease is based on weakness.
3. Thinking that it would only happen to an idiot.
4. Involved in criminal activity.
5. Thinking that it happens only to people who are "psychiatrically disturbed."
6. The perception of going to treatment involves a self-assessment more of wrongness than rightness. Note: Other volitional acts of irresponsibility often go uncondemned by others. When the hypertensive is non-compliant with diet, weight, medication, and smoking there is much more understanding when they enter the hospital than the untreated alcoholic/addict.

IX. WHAT OTHER MECHANISMS ARE ACTIVE THAT HELP THE INDIVIDUAL AVOID TREATMENT?

A. Irrational Beliefs:

1. I can't afford to go to treatment.
2. I'm not that sick.
3. I can quit any time I want.
4. Drinking is not my problem, my wife (my husband) is..., etc.,
5. I'll be branded for life if I go to treatment.
6. I'm not as bad as my partner.
7. My associates drink more than I do!

8. I may be a heavy drinker, but....
9. I may get drunk once in a while, but I'm not an alcoholic.
10. I only use cocaine recreationally.
11. My psychiatrist says I drink because of my anxiety disorder, see he even put me on . . . Valium or Xanax.
12. No way. My dad (my mom) was alcoholic and I'm nothing like him (or her).
13. I think everyone is overreacting.
14. It was 0.22, but the cop was pulling everyone over.
15. I did a lot of drugs experimentally as a kid, but...
16. I promise I'll come in for treatment after we close this deal.
17. Its only marijuana, we all know that its basically harmless.

B. Defense Mechanisms which are normal to all persons can be used by the alcoholic so as to blind himself or herself to reality:

1. Denial – “can't be true” regardless of factual evidence.
2. Minimizing - making something less important.
3. Externalizing - blaming external factors.
4. Rationalizing - giving excuses.
5. Intellectualizing - lengthy intellectual reason and arguments.
6. Displacement - taking it out on others.
7. Active Negativism - refusing to do.
8. Defocusing - wasting time on outside issues.
9. Projection - planning results.

10. Passive Negativism - inaction.

11. Fantasizing - day dreaming.

12. Hopeful Expectation.

13. Manipulating.

14. Undoing.

15. Generalizing.

16. Omnipotent Devaluation.

C. Enablers - Individuals who possess the same irrational beliefs and pathological defense mechanisms as the patient, who nonetheless facilitate the patient's avoidance of treatment.

1. Active Enabling - Purchasing or acquiring the chemical for the individual when he/she is too sick or indisposed to acquire the drug themselves.

2. Passive Enabling - Not acknowledging or exposing the reality of what is going on with the chemically dependent person.

3. Iatrogenic Enabling - The physician who does not diagnose the disease even when obvious or substitutes a second mood altering substance for the primary one. Treating cocaine dependency as a Bipolar illness with Lithium, or Alcoholism as an anxiety disorder with Xanax, Valium or Ativan.

4. Enabling by Omission - The OMVI offender who is referred to a diversion program when the blood alcohol level of record is sufficient to diagnose alcoholism.

X. WHAT CAN BE DONE TO PROMOTE RECOVERY?

A. Speaking to the person - often does not work.

B. Intervention - Collaboration of family, friends and colleagues who identify negative changes in the individual and its impact on relationships and professionalism prompting the impaired individual to seek help. Requires professional assistance - call OLAP.

C. Treatment - Options:

1. Self-help groups (Alcoholics Anonymous [A.A.], Narcotics Anonymous [N.A.], Cocaine Anonymous [C.A.], Al-Anon, Alateen).
 2. Intensive outpatient.
 3. Residential inpatient.
4. Residential inpatient followed by extended follow-up in halfway house care.
 5. Detox-medically managed and monitored detoxification from the substance(s) most often requiring hospitalization.

XI. WHAT MUST BE ACCOMPLISHED AS PART OF ANY RECOVERY PROGRAM REGARDLESS OF THE TECHNIQUE OR TREATMENT MODALITY SELECTED?

- A. Self Diagnosis - You cannot treat what the patient does not think he or she has or needs to be treated.
- B. Education - Appropriate facts about the disease of addiction lessen the general obstacle or resistance to self diagnosis.
- C. Self Treatment - The patient should be empowered with the tools to maintain abstinence and/or avoid relapse.
- D. Self Responsibility - The essence of achieving long term remission via dealing with life's problems through a spiritually based self help/support program.

XII. WHAT IS OLAP's Monitoring PROGRAM?

- A. OLAP will provide the following services for chemically dependent lawyers who are enrolled:
 1. track lawyers through treatment, confirming admission to and successful completion of treatment;
 2. assist the treatment provider in structuring aftercare and discharge planning for lawyers receiving treatment;
 3. provide assistance for the lawyer's entry into appropriate aftercare and professional peer support meetings;
 4. assist the lawyer in obtaining a primary care physician;

5. establish a random urine drug screening program;
6. track the lawyer's aftercare, peer support, and twelve step meeting attendance;
7. provide assistance to the lawyer in obtaining a local mentor attorney, who is in recovery;
8. provide documentation of compliance by the lawyer to those persons and/or agencies as required;
9. provide advocacy for those lawyers who are compliant with the requirements of the program; and
10. inform OLAP of the status of attendance/compliance.

B. OLAP will implement the program in the following manner:

1. Upon entrance by the lawyer into treatment, OLAP will contact the treatment provider requesting a letter documenting admission, progress reports, and documentation of successful completion of treatment. If the lawyer should leave treatment against medical advice or leave treatment before recommended treatment is completed, the treatment provider will be requested to contact OLAP immediately. The lawyer shall provide OLAP with a written release to such treatment provider allowing it to inform OLAP of the lawyer's status at all times.
2. As the lawyer nears the completion of treatment, OLAP will work with the treatment provider in formulating a discharge and aftercare plan as it relates to the lawyer's obligations as a participant in OLAP. This would include arranging a visit to the lawyer by a local OLAP liaison attorney for signing of OLAP contract.
3. As the lawyer nears the completion of treatment, OLAP will provide the treatment provider and the lawyer with a list of OLAP-approved aftercare providers and professional peer support groups to be incorporated into the aftercare plan.
4. OLAP will provide the lawyer with a list of physicians in his or her area who are knowledgeable of chemical dependency and who will provide primary medical care or consultation as required.
5. After the completion of treatment, OLAP will contact the lawyer on a regular, predetermined basis for monitored submission of any of the

following: random urine drug screen, body fluid analysis, and/or breathalyzer test. The urine and/or body fluid test(s) will be forwarded to a National Institute of Alcoholism and Drug Abuse approved laboratory following established legal chain of custody. The results of the tests will be forwarded to OLAP by the laboratory on a predetermined, timely basis. OLAP will be notified of any positive test results. Results of breathalyzer tests will be forwarded to OLAP by the local agency (hospital, treatment center, etc.) that administers the test.

6. Approved aftercare providers will be requested to provide monthly written reports on the lawyer's compliance with attendance.
7. OLAP will provide the lawyer with the name of a local member of the OLAP who will act as a mentor attorney. The lawyer will be required to contact the mentor attorney on a weekly or other basis to report his or her progress in recovery. This contact may be made by phone or in person. The mentor attorney will provide OLAP with status updates on a regular basis.
8. OLAP will provide documentation of the lawyer's compliance and continuing recovery on a regular basis to any persons or agencies in need of such reports.
9. OLAP will provide documentation of the lawyer's compliance and continuing recovery, and may, assume an advocacy role in situations when required. This could include appearances with the lawyer before courts, disciplinary proceedings, agencies, employers, potential employers, law partners, etc.
10. OLAP may take such other actions and impose such additional requirements on the lawyer as it in good faith deems necessary to monitor the lawyer's recovery and to protect and preserve the integrity of the OLAP.

XIII. WHAT IS THE ROLE OF ALCOHOLICS ANONYMOUS [A.A.] AND OTHER PROGRAMS SUCH AS NARCOTICS ANONYMOUS [N.A.], COCAINE ANONYMOUS [C.A.], AND ALLIED PROGRAMS LIKE ALATEEN AND AL-ANON?

It is not our purpose to try to explain entirely how A.A. works, but it is a grassroots approach to alcoholism treatment that actually works where many times all else has failed. There is no general consensus as to why it works. But, it has had a striking effect on society since its advent in 1935. This particular program addressed living, in the word's fullest sense, without alcohol via a 12-step spiritual program. The program has its roots in the Judeo-Christian ethic, but it is not a religion. The religious caveats and moralizing are absent, and many agnostics and atheists are in the program. What the

founders of A.A. discovered is that two or more alcoholics could help each other stay sober and succeed where the individual acting on his own would fail. Thus, while there are strong opinions about A.A., most of which are expressed outside the meetings and outside of the principles on which the program was built, as long as it actually works it must rank as the preeminent approach to the treatment of this particular problem. We would recommend to all of you, if you have not already done so, that you acquaint yourself with the fundamentals of the program.

Further, membership in A.A., N.A., C.A., and Al-Anon, and Alateen (allied programs for the family), has grown by leaps and bounds and the whole family has become part of the treatment and recovery process.

Though acceptance is not complete, there has been a general awakening within society, government, and the medical profession that the problem is treatable, and that A.A. and/or related programs actually work when all else has failed.

As the stigma has faded, industry and business have embraced the concept of early intervention and treatment programs. And, contrary to the experiences of the 50's and 60's, a working relationship has developed between the loosely knit organization of A.A. and a variety of community resources.

XIV. WHAT ARE THE STEPS OF ALCOHOLICS ANONYMOUS?

- A. A suggested plan of recovery and relapse prevention.
 - 1. We admitted we were powerless over alcohol (and all other mood altering substances) - that our lives had become unmanageable.
 - 2. Came to believe that a Power greater than ourselves could restore us to sanity.
 - 3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
 - 4. Made a searching and fearless moral inventory of ourselves.
 - 5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
 - 6. Were entirely ready to have God remove all these defects of character.
 - 7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.
 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
 10. Continued to take personal inventory and when we were wrong promptly admitted it.
 11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
 12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (addicts), and to practice these principles in all our affairs.
- B. What, if any, are the guarantees if one chooses to seek help?
1. We are going to know a new freedom and a new happiness.
 2. We will not regret the past nor wish to shut the door on it.
 3. We will comprehend the word serenity and we will know peace.
 4. No matter how far down the scale we have gone, we will see how our experience can benefit others.
 5. That feeling of uselessness and self-pity will disappear.
 6. We will lose interest in selfish things and gain interest in our fellows.
 7. Self seeking will slip away.
 8. Our whole attitude and outlook upon life will change.
 9. Fear of people and of economic insecurity will leave us.
 10. We will intuitively know how to handle situations which used to baffle us.
 11. We will suddenly realize that a Higher Power is doing for us what we could not do for ourselves.

“Are these extravagant promises? We think not. They are being fulfilled among

us - sometimes quickly, sometimes slowly.” Handbook of Alcoholics Anonymous, 1939.

XV. WHAT CAN I DO?

- A. Recognize that you have a personal and professional duty to act - to help, whether it is you, yourself, or a colleague or family member who has the disease.
- B. OLAP wants to help - and for obvious reasons the earlier the better:
 - 1. Before it reaches even an isolated instance of professional misconduct try to get the person to call OLAP.
 - 2. If he or she won't do so - call OLAP yourself.
 - 3. We want to help get treatment for the person and restore them to active, healthy and happy lives.

XVI. WHAT IS THE LAWYERS ASSISTANCE COMMITTEE OF THE OHIO STATE BAR ASSOCIATION AND ITS COMPANION ORGANIZATION THE OHIO LAWYERS ASSISTANCE PROGRAM, INC?

The Lawyers Assistance Committee of the Ohio State Bar Association was created in 1977. Its members include representatives of the judiciary, practicing bar, and legal education, many of whom are themselves recovering alcoholics, addicts, or persons recovering from mental health issues, while others are not, but serve only out of a special interest and desire to help.

In an effort to provide even greater service to those who have need of its help, the Lawyers Assistance Committee established the Ohio Lawyers Assistance Program, Inc. (OLAP) in 1991, a non-profit corporation qualified to receive tax deductible contributions under Sec. 501(c)(3) of the Internal Revenue Code., William X. Haase, Esq. (deceased), a retired lawyer with both small and large law firm experience, served as its first full-time Executive Director (1991-1999). Scott R. Mote, J.D., a Columbus attorney, was retained in 1996 as Associate Director to assist in OLAP's expanding workload, and became Executive Director July 1, 1999. Both Paul A. Caimi, JD, LCDC-III, ICADC and Stephanie S. Krzmarich, MSW, LISW, CCDC-I were retained in early 2002. Patrick J. Garry, J.D. joined OLAP in 2005, and Megan R. Roberston, MSW, joined OLAP in 2006 to assist in OLAP's continually expanding workload as well as to address mental health concerns in addition to chemical dependency. Through OLAP, the following services are now provided on a full-time basis: (1) confidential advice about individual problems, (2) help in arranging and implementing formal interventions, (3) help in deciding between outpatient and inpatient treatment, and (4) monitoring and aftercare services. Through the

so-called Broadbrush Program, OLAP is also presently providing similar services to assist Ohio lawyers who may be suffering from mental health issues other than chemical dependency issues. Any lawyer who feels that OLAP's services may be of help with regard to a lawyer suffering from a mental health issue is encouraged to contact OLAP.

XVII. HOW DO I ACTUALLY CONTACT OLAP?

- A. Call OLAP at 1-800-348-4343 or 1-800-618-8606.
- B. Anonymity and confidentiality built into procedure.
 - 1. The Ohio Supreme Court promulgated Prof. Cond. R. 8.3(c), providing a privilege for things said to OSBA and local lawyer assistance committee members and OLAP staff:

Any information obtained by a member of a committee or subcommittee of a bar association, or by a member, employee or agent of a nonprofit corporation established by a bar association, designed to assist lawyers with substance abuse or mental health problems, provided the information was obtained while the member, employee, or agent was performing duties as a member, employee or agent of the committee, subcommittee or nonprofit corporation, shall be privileged for all purposes under this rule.

Comment [5] of Prof. Cond. R. 8.3 states:

“Information about a lawyer’s or judge’s misconduct or fitness may be received by a lawyer in the course of that lawyer’s participation in an approved lawyers or judges assistance program. In that circumstance, providing for an exception to the reporting requirements of divisions (a) and (b) of this rule encourages lawyers and judges to seek treatment through such a program. Conversely, without such an exception, lawyers and judges may hesitate to seek assistance from these programs, which may then result in additional harm to their professional careers and additional injury to the welfare of clients and the public.”

- C. Those seeking advice from a local committee or OLAP and those working through them to carry out interventions are covered by the qualified immunity from a lawsuit in R.C. §2305.28.
- D. The following Treatment centers in the state of Ohio are recommended:

TALBOT HALL AT OSU HOSPITALS EAST
1492 East Broad Street
Columbus, Ohio 43205
(614) 257-3760; 1-800-875-4435

CLEVELAND CLINIC FOUNDATION
9500 Euclid Avenue
Cleveland, Ohio 44195
(216) 444-2200
Assessments: (216) 444-5812; 1-800-223-2273

GLENBEIGH HOSPITAL
2863 State Route 45
P.O. Box 298
Rockcreek, Ohio 44084
(440) 563-3400; 1-800-234-1001

You also can contact your local health department or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) at 614-466-3445 for information.

Please contact OLAP about other treatment options both in and out of state.

XVIII. CONCLUSION.

Lawyers are lousy clients. Likewise, they are difficult patients. The reasons are simple enough: they are trained to deal with and solve problems, and they manage and manipulate people. Thus, it is most difficult for the attorney to seek help since by doing so he or she admits failure as a problem solver. This problem is exacerbated by the fact that the attorney has a tendency to block out the realities of his or her particular situation. Complicating this problem further is the tendency of the attorney's or judge's peers to indulge in a conspiracy of silence, and lighten the normal stresses of our profession. Such efforts accomplish nothing and usually are counterproductive. In a word, covering for good old Joe or Jane is folly or worse!

OLAP works in tandem with local bar lawyers assistance committees, which in turn work with local men and women who are associated with the fellowship of Alcoholics Anonymous and other related organizations in addition to mental health providers. We accept referrals from a judge, a partner or law associate, hospitals, the member himself, and in some cases his or her family.

OLAP hopes that the attorney, judge, law student, or law faculty member will be rehabilitated through hospitalization (if necessary), counseling, psychiatric assistance (if

necessary), the application of A.A. principles and mental health support.

NOTE:

These materials on substance abuse originally were edited in 1990 by Prof. Michael Distlehorst, Esq., of the Ethics Institute of Capital University Law School, on behalf of the Lawyer's Assistance Committee of the Ohio State Bar Association, for use in continuing legal education seminars and other programs. The Committee would like to thank the following physicians for advice and consultation in the preparation of various segments of these materials: Dr. Burns Brady, M.D., Dr. Paul Redmond, M.D., and Dr. Craig T. Pratt, M.D.

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Revised in May, 2002 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, MSW, LISW, CCDC-I, Clinical Director and Paul A. Caimi, J.D., LCDC-III, ICADC, Associate Director, Ohio Lawyers Assistance Program, Inc.

Revised in February, 2003 by Scott R. Mote, J.D., Executive Director, Stephanie S. Krznarich, MSW, LISW, CCDC-I, Clinical Director and Paul A. Caimi, J.D., LCDC-III, ICADC, Associate Director, Ohio Lawyers Assistance Program, Inc.

Revised in February, 2007, by Scott R. Mote, J.D., Executive Director, Ohio Lawyers Assistance Program, Inc.

Revised in August, 2007 by Scott R. Mote, J.D., Executive Director, Ohio Lawyers Assistance Program, Inc., and Crystal N. Glover, Intern.

(The Following Materials on Pages 28-30 Come From Alcoholics Anonymous.)

ARE YOU AN ALCOHOLIC?

In order to determine whether or not a person has drifted from "social drinking" into pathological drinking it is well to check over a list of test questions. While these are only "test" questions, it is suggested that they be answered TRUTHFULLY.

It is possible - but not at all probable - that you may fool somebody else. But you must be HONEST WITH YOURSELF; you must want to become and remain sober because alcohol has you "licked" - if you want the help of Alcoholics Anonymous.

	YES	NO
1. Do you require a drink the next morning?	_____	_____
2. Do you prefer to drink alone?	_____	_____
3. Do you lose time from work due to drinking?	_____	_____
4. Is drinking harming your family in any way?	_____	_____
5. Do you desire a drink around the same time daily?	_____	_____
6. Do you get the inner shakes unless you continue drinking?	_____	_____
7. Has drinking made you irritable?	_____	_____
8. Does drinking make you careless of your family's welfare?	_____	_____
9. Have you thought less of your husband, wife, or partner since drinking?	_____	_____
10. Has drinking changed your personality?	_____	_____
11. Does drinking cause you bodily complaints?	_____	_____
12. Does drinking make you restless?	_____	_____
13. Does drinking cause you to have difficulty sleeping?	_____	_____
14. Has drinking made you more impulsive?	_____	_____

		YES	NO
15.	Have you less self-control since drinking?	_____	_____
16.	Has your initiative decreased since drinking?	_____	_____
17.	Has your ambition decreased since drinking?	_____	_____
18.	Do you lack perseverance in pursuing a goal since drinking?	_____	_____
19.	Do you drink to obtain social ease? (In shy, timid, self-conscious individuals)	_____	_____
20.	Do you drink for self-encouragement? (In persons with feelings of inferiority)	_____	_____
21.	Do you drink to relieve marked feelings of inadequacy?	_____	_____
22.	Has your sexual potency suffered since drinking?	_____	_____
23.	Do you show marked dislikes and hatred since drinking?	_____	_____
24.	Has your jealousy, in general, increased since drinking?	_____	_____
25.	Do you show marked moodiness as a result of drinking?	_____	_____
26.	Has your efficiency decreased since drinking?	_____	_____
27.	Has drinking made you more sensitive?	_____	_____
28.	Are you harder to get along with since drinking?	_____	_____
29.	Do you turn to an inferior environment since drinking?	_____	_____
30.	Is drinking endangering your health?	_____	_____
31.	Is drinking affecting your peace of mind?	_____	_____
32.	Is drinking making your home life unhappy?	_____	_____
33.	Is drinking jeopardizing your business-your job?	_____	_____

- | | | YES | NO |
|-----|--|-------|-------|
| 34. | Is drinking clouding your reputation? | _____ | _____ |
| 35. | Is drinking disturbing the harmony of your life? | _____ | _____ |

NOTE: The test questions are not A.A. questions but are the guide used by John Hopkins University Hospital in deciding whether a patient is alcoholic or not.

In addition we in A.A. would ask even more. Here are a few:

- | | | YES | NO |
|-----|--|-------|-------|
| 36. | Have you ever had a partial or complete loss of memory (black-out) for short or longer periods while, or after drinking? | _____ | _____ |
| 37. | Have you ever experienced an inability to concentrate during or after drinking? | _____ | _____ |
| 38. | Have you ever felt "remorse" or guilt after drinking? | _____ | _____ |
| 39. | Has a physician ever treated you for drinking? | _____ | _____ |
| 40. | Have you ever been hospitalized for drinking or an event related to drinking? | _____ | _____ |
| 41. | Have you been charged more than once with an alcohol-related traffic offense? | _____ | _____ |

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

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

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

(The Following Test for cocaine addiction on Pages 31-37 comes from "800 Cocaine" by Mark S. Gold and is reprinted with permission of Bantam Books.)

TEST YOURSELF FOR ADDICTION

The symptoms of cocaine addiction are as plain to see as the signals warning that addiction is perilously close. The questions that follow spell them out in detail. Anyone who answers "yes" to as few as 10 of them is teetering on the thin edge of addiction. An affirmative answer to more than 10 is a clear signal that coke has taken over, that the use is addicted and is in urgent need of treatment if he or she is to have a chance to return to decent health and normal living. As a guide for anyone taking the test, we have provided brief explanations and comments to make clear why an affirmative answer means trouble.

YES NO

- ___ ___ 1. Do you have to use larger doses of cocaine to get the high you once experienced with smaller doses?
(This means you have developed a tolerance to the drug, that is, that you need more of it by a more direct route to achieve the same effect.)
- ___ ___ 2. Do you use cocaine almost continuously until your supply is exhausted?
(This is called binging, and it signals loss of control over drug use.)
- ___ ___ 3. Is the cost of cocaine the major factor limiting your use, and do you wish you could afford more?
(Your internal controls are virtually gone. The drug is in charge, and you will find yourself doing anything to get it.)
- ___ ___ 4. Do you use cocaine two or more times a week?
(If you do, you are in the highest risk group for addiction.)
- ___ ___ 5. Do you have three or more of the following physical symptoms? Sleep problems, nose bleeds, headaches, sinus problems, voice problems, difficulty swallowing, sexual performance problems, nausea or vomiting, trouble breathing or shortness of breath, constant sniffing or rubbing your nose, irregular heart beats, epileptic seizures or convulsions?
(Three or more of these indicate severe loss of bodily functions related to coke abuse - addiction.)

YES NO

- ___ ___ 6. Do you have three or more of the following psychological symptoms? Jitteriness, anxiety, depression, panic, irritability, suspiciousness, paranoia, problems concentrating, hallucinations (seeing things that are not there, hearing voices when there are none), loss of interest in friends, hobbies, sports or other non-cocaine activities, memory problems, thoughts about suicide, attempted suicide, compulsive, repetitious acts like combing the hair, straightening of clothes or ties, tapping the feet for no reason?
(Cocaine abuse is causing psychological problems that are not within the individual's capacity to control.)
- ___ ___ 7. Have any or all of the problems specified in the previous two questions caused you to stop using cocaine for a period ranging from two weeks to six months or longer?
(If not, the acquired disabilities are not strong enough to overcome the addiction.)
- ___ ___ 8. Do you find that you must take other drugs or alcohol to calm down following cocaine use?
(You are trying to medicate yourself so as to maintain your cocaine habit without suffering the terrible side effects of addiction. You are, of course, flirting with becoming addicted to a second drug.)
- ___ ___ 9. Are you afraid that if you stop using cocaine, your work will suffer?
(You are psychologically dependent on the drug.)
- ___ ___ 10. Are you afraid that if you stop using cocaine you will be too depressed or unmotivated or without sufficient energy to function at your present level?
(You are addicted and afraid of the withdrawal symptoms.)
- ___ ___ 11. Do you find that you cannot turn down cocaine when it is offered?
(Use is out of your control.)
- ___ ___ 12. Do you think about limiting your use of cocaine?
(You are on the verge of addiction and trying to ration use of the drug.)
- ___ ___ 13. Do you dream about cocaine?
(This related to compulsive use and the total domination of the drug.)

YES NO

- ___ ___ 14. Do you think about cocaine at work?
(This is also part of the obsession with the drug.)
- ___ ___ 15. Do you think about cocaine when you are talking or interacting with a loved one?
(Obsession with the drug dominates all aspects of living.)
- ___ ___ 16. Are you unable to stop using the drug for one month?
(This is certainly a sign of addiction.)
- ___ ___ 17. Have you lost or discarded your pre-cocaine friends? (You are stacking the deck in favor of cocaine by reducing negative feedback.)
- ___ ___ 18. Have you noticed that you have lost your pre-cocaine values: That is, that you don't care about your job or career, your home and family, or that you will lie and steal to get coke?
(Addiction causes slow but steady changes in personality and the approach to life to reduce intrapsychic conflict.)
- ___ ___ 19. Do you feel the urge to use cocaine when you see your pipe or mirror or other paraphernalia? Or taste it when you are not using it? Or feel the urge to use it when you see it or talk about it?
(This is called conditioning and occurs after long-term, heavy use.)
- ___ ___ 20. Do you usually use cocaine alone?
(When addiction sets in, this is the pattern. Social usage ceases.)
- ___ ___ 21. Do you borrow heavily to support your cocaine habit?
(You can be pretty sure you're addicted if you are willing to live so far above your means to get the drug.)
- ___ ___ 22. Do you prefer cocaine to family activities, food, or sex?
(This is a sure sign of addiction. Cocaine need overrides fundamental human needs for food, sex, social interaction.)
- ___ ___ 23. Do you deal or distribute cocaine to others?
(This kind of change in behavior signals addiction because it is an accommodation to the need for the drug.)

YES NO

- ____ ____ 24. Are you afraid of being found out to be a cocaine user?
(Addicts usually live a double life, preferring not to choose one or another alternative.)
- ____ ____ 25. When you stop using the drug, do you get depressed or crash?
(This a sign of withdrawal - a symptom of addiction.)
- ____ ____ 26. Do you miss work, or reschedule appointments, or fail to meet important obligations because of your cocaine use?
(The drug has taken over your life.)
- ____ ____ 27. Is your cocaine use a threat to your career or personal goals? Has your cocaine use caused you to lose interest in your career? Has the drug caused you to lose interest in or to have violent quarrels with people you love? Has your cocaine use caused you to lose your spouse or loved ones?
(You would hardly sacrifice so much if you were not addicted.)
- ____ ____ 28. Do people keep telling you that you are different or have changed in a significant way?
(Addicted people are indeed different from the way they were pre-cocaine. Such comments are a clue to addiction.)
- ____ ____ 29. Have you used more than 50 percent of your savings for cocaine? Has your cocaine use bankrupted you and caused you to incur large debts? Have you committed a crime to support yourself and your cocaine habit? Have you stolen from work and/or family and friends?
(If you are not addicted, would cocaine be worth these dreadful problems?)
- ____ ____ 30. Do you believe that your cocaine use has some medicinal value in treating a problem you have with energy, motivation, confidence, depression, or sex?
(Users who believe this are the most likely to develop addiction.)
- ____ ____ 31. Do you think you have had withdrawal symptoms when you stopped using cocaine? (Only addicted persons experience withdrawal.)

YES NO

- _____ _____ 32. If you had \$100 to spend would you spend it on cocaine rather than on something for your house or apartment, on a gift for someone you love, on theater, CDs, movies, going out with friends or family?
(Addicts become so fixated on their drug they can think of nothing else, no one else, and no other form of entertainment.)
- _____ _____ 33. Do you think that you are addicted?
(If you think so, you probably are.)
- _____ _____ 34. Do you use cocaine compulsively despite your recognition that the drug is a very real threat to your physical and psychological well-being, relationships, family, and job?
(This is addiction.)
- _____ _____ 35. Did you ever enter psychiatric treatment or therapy for a cocaine-related problem and not tell the doctor or therapist about your cocaine use or how current or recent it is?
(When an addicted person is pressured into getting help, he may not only try to cover up the extent of his drug abuse, but may also use his treatment as a cover for his continued use of the drug.)
- _____ _____ 36. Did you have a cocaine problem that was cured either through your own efforts alone or with the help of friends or with professional treatment?
(The critical word is "cured." No addict is really cured - rather, he has a remission of a chronic disease that can recur should he become a user of cocaine again.)
- _____ _____ 37. Have you ever used cocaine and had hallucinations, a convulsion or seizure, angina (severe pain around the heart), loss of consciousness, the impulse to kill yourself or others? And when any of these side effects passed, did you figure that you would use less next time or use a purer quality of the drug?
(These side effects are related to addictive use, but the addict prefers to ascribe them to overdose or to the adulterants used to make the drug go further. He/she then can continue to use the drug under the illusion that it will be okay the next time.)

YES NO

- ___ ___ 38. Do you leave paraphernalia or a supply of cocaine at work?
(This may be a call for help by a person who feels that his life is out of his control. It is like a suicide note left so that people will find it and prevent the act.)
- ___ ___ 39. Do you sometimes wish that you would be discovered as a user by someone who would see to it that you got into treatment and recovered?
(If so, you know you need help and want it).
- ___ ___ 40. Do you use cocaine three times a week or even more often, and still try to maintain an interest in diet, health, exercise, and fitness?
(The interest may be there, but the fact is that such heavy use of the drug makes it virtually impossible to act on the interest. There is too great a conflict in values.)
- ___ ___ 41. Have you switched from intranasal use to freebasing or intravenous use?
(This usually means that tolerance to the drug has developed, and it is very likely that you will binge and become addicted in short order.)
- ___ ___ 42. Have you been using cocaine more than once a week for three or more years?
(With this much use, any stress, or change in your life, can turn you into a daily user with a high probability of addiction resulting.)
- ___ ___ 43. Do you find yourself choosing friends or lovers because of their access to cocaine or their cocaine use?
(This kind of behavior usually indicates a life out of control.)
- ___ ___ 44. Do you wake up in the morning and wonder how you could have let cocaine gain control over your life?
(You are addicted if you have these thoughts.)
- ___ ___ 45. Do you find it almost impossible to fall asleep without a drink or sleeping pill or tranquilizer?
(You now have a second addiction.)
- ___ ___ 46. Since you started using cocaine, have you ever wondered whether you would be able to live without it ?
(We find that people who raise this question are generally hooked on the drug.)

YES NO

- _____ _____ 47. Have you wondered whether you would be better off dead than continuing to use cocaine?
(This question usually suggests an addiction so profound that the addict feels himself terminally ill.)
- _____ _____ 48. Have you ever wished that you would die of an overdose in your sleep?
(Same as above.)
- _____ _____ 49. Do you use cocaine in your car, at work in the bathroom, on airplanes, or in other public places?
(You are so desperate you want to be caught - and helped.)
- _____ _____ 50. Do you use cocaine and then drive a car within six hours after use?
(Cocaine has impaired your judgment and you are out of control. Don't wait to get help until after you have impaired or killed a pedestrian.)

MENTAL HEALTH CONCERNS IN THE LEGAL PROFESSION

Definitions, Detection and Treatment Alternatives

Understanding Mental Illnesses

What is mental illness?

Mental illness refers to a group of disorders causing severe disturbances in thinking, feeling, and relating. They result in a substantially diminished capacity for coping with the ordinary demands of life (National Alliance for the Mentally Ill). A mental illness is a health condition, much like heart disease or diabetes. It is not caused by bad parenting and is not a character weakness or flaw. These illnesses are due to biochemical disturbances in the brain-they are neurobiological disorders. There are many causes of mental illnesses including:

- *birth trauma
- *chemical imbalances in the brain
- *other biological, environmental, social and cultural factors.

Mental illnesses can affect persons of any age-children, adolescents, adults, and the elderly-and they can occur in any family. Several million people in the U.S. suffer from a serious, long-term mental illness. They are medical diseases of the brain, and are treatable just as heart or lung disease. With proper treatment, many people with a mental illness get well and lead productive lives (Channing L. Bete Co., Inc., 1998).

Know the facts from the fiction

Fiction:

A mental illness means you're crazy.

People with a mental illness can "pull themselves out of it."

Fact:

No, it means you have a mental disorder. Using cruel labels, such as "crazy" or "psycho," only causes pain and discourages people from seeking help.

A mental illness is not caused by personal weakness – nor can it be cured by personal strength. Proper treatment is needed.

People with a mental illness will always be ill.

For some people, a mental illness may be a lifelong condition like diabetes. But, as with diabetes, proper treatment enables many people with a mental illness to lead fulfilling lives.

People with a mental illness are often violent.

People with a mental illness are much more likely to be victims of violence than its cause. With proper treatment, people with a mental illness are no more likely to be violent than the general population.

Mental illness can't affect me.

Mental illnesses can affect anyone. They strike people of all ages, races and income levels, whether or not there is a family history of mental illness.

Mental illnesses are treatable!

Treatment methods usually include a combination of psychotherapy and medication. Psychotherapy can include individual, family and group therapy. It can help people:

- *understand the illness
- *learn how to deal with any problems the illness causes
- *make positive changes in their lives.

Many mental illnesses and their symptoms can be treated with medications. They can help correct chemical imbalances, enabling people who receive treatment to stop suffering and lead productive lives (Channing L. Bete Co., Inc., 1998). Ask your health care provider, mental health professional or call OLAP for assistance.

Common questions

Do most people with mental illness have to be hospitalized?

No. Most people with mental illness are treated as outpatients. However, for some, hospitalization is an effective part of a treatment plan.

What if someone suspect a colleague may be struggling or I know he or she has a mental illness?

Spend time with the person and maintain your relationship (Channing L. Bete Co., Inc., 1998). Let the person know that he or she can count on your support. Advise the person to seek professional help or call OLAP to develop options.

Help is available!

If you or someone you know has signs of a mental illness, or if you'd like more information, contact:

- *your health-care provider, for referrals to psychiatrists, psychologists, etc.
- *community mental health centers and mental health boards
- *Psychiatric hospitals or clinics
- *Crisis hotlines
- *marriage and family therapists
- *local branches of The American Psychiatric and Psychological Association
- *state or local chapters of mental health associations, such as
 - The National Alliance of the Mentally Ill (1-800-950-6264)
 - The National Mental Health Association (1-800-969-6642)
- *psychiatric departments at universities and colleges
- * OLAP (1-800-348-4343) or (1-800-618-8606)

TYPES OF MENTAL ILLNESSES

ANXIETY DISORDERS

The Many Faces of Anxiety

Peggy can't sleep. She's worried about keeping up with her family obligations and wondering how to keep up with the firm's demands. She used to take these things in stride, but now she can't concentrate at work and has stomachaches and restless nights.

John's wife is ill and needs occasional home health care. When her illness began, his family expected him to be as strong and helpful as he'd always been when others needed him. But lately he always seems on edge and is getting behind at the office. He's angry with himself because he feels he's letting the family and his clients down.

Amanda moved with her husband when he joined a new firm eight months ago. She's found a great job and is happy with the new house. But despite her husband's encouragement, she fears meeting his new partners and friends or becoming involved in the community. She's gained weight, and whenever they do go out, her head aches before they even reach their destination.

Fred's practice continues to expand. He's had some high visibility cases, and great results. His eight hour days are 12-14 hours long, and his family is upset that he's never home. He's having trouble staying focused, and is becoming short tempered with his legal assistant, partners and family.

Do you recognize any of these people? Perhaps someone you know is acting the same way. Perhaps you are. The people in these examples want to worry less, to feel more in control of their lives, to do the things they used to do. But something's holding them back. They feel trapped, threatened. And their bodies are reacting with both emotional and physical symptoms. Symptoms like these can get to the point where they interfere with the person's ability to function and enjoy life. They may indicate a persistent underlying anxiety (Bristol-Myers Squibb Company, 1990).

Anxiety You Can't Get Rid Of And Its Consequences

Anxiety is an involuntary or reflex reaction of the body. You probably think of it as that feeling everyone gets at one time or another when they are uneasy or distressed about future events or uncertainties. Like, years ago, on the first day of a new job. Or when you meet new people and want to make a good impression. Most of us have felt anxious at one time in our lives. But the amount of anxiety can change from one person to another. And the same person can react differently if circumstances change.

When the anxious feeling becomes more like dread, when it negatively affects behavior or performance, continues for a long time, and begins to feed on itself instead of having a clear cause, doctors diagnose it as a true disorder that calls for treatment.

High levels of anxiety can result from too much pressure-from family, clients, employers, even friends. And by most accounts, the everyday level of stress is increasing in the U.S. For four percent of Americans, anxiety is a constant condition that interferes with normal activities and makes life miserable. Among attorneys, 30% of men and 20% of women suffer from anxiety disorders. If you or someone you know are bothered by unrealistic excessive worry or unexplained fear that you can't control, you may be suffering from a medical condition called persistent anxiety. It affects both the body and the mind and may cause any of the following feelings:

- *Tension
- *Irritability
- *Restlessness
- *A depressed mood

These emotional feelings may be accompanied by physical symptoms, such as:

- *Gastrointestinal problems
- *Sleeplessness
- *Headaches
- *Muscle Tension
- *Fatigue
- *Difficulty concentrating

Persistent underlying anxiety can also be associated with a long-term medical condition such as heart disease, emphysema, ulcers or asthma. Yet many people with persistent underlying anxiety don't seek care, even when the anxiety has gone on for months-or even years. In fact, some estimates say three out of four get not help, no treatment, and no relief. Often people don't realize that the problems they're having are symptoms of underlying anxiety, or that there are professionals who can help.

You're Not Alone

Individual effort and success are highly respected in the U.S. So when we feel the effects of anxiety, we tend to blame ourselves for not being able to "cope." Rather than recognizing anxiety as a response to a stressful situation, we pretend nothing's wrong, or say, "I'll get over it."

Those with persistent underlying anxiety may notice they often have difficulty getting along with others, and they're tense a lot of the time or they aren't performing everyday tasks as well as they used to. But, many times these people don't consider going to the doctor until physical symptoms come along such as stomach aches, frequent headaches, heart palpitations, sleeplessness, nausea, overeating, or too much drinking or smoking.

Our tendency to dismiss underlying anxiety or keep symptoms to ourselves leads many to suffer in comparative isolation, not realizing that others have suffered the same thing and found relief. If left without treatment, many of the symptoms can get worse. Sometimes the persistent underlying anxiety reaches the point where the person finds it's nearly impossible to function at all.

What can you do about underlying anxiety?

Though many people suffer from persistent underlying anxiety, many find relief. Below are some symptoms of persistent underlying anxiety. Usually several symptoms from each category occur together. When someone has six or more of these symptoms, they should consider talking them over with their doctor or counselor. It is important to note that individual symptoms may be indicative of other medical conditions.

Underlying Anxiety?

Physical Symptoms:

- *Palpitations or accelerated heart rate
- *Shortness of breath or smothering sensations
- *Sweating or cold, clammy hands
- *Dry mouth

- *Dizziness or lightheadedness
- *Nausea, diarrhea, or other abdominal distress
- *Flushes (hot flashes) or chills
- *Frequent urination
- *Trouble swallowing or “lump in the throat”

Tension Symptoms:

- *Restlessness
- *Trembling, twitching or feeling shaky
- *Muscle tension, aches or soreness
- *Easily fatigued

Emotional Symptoms:

- *Excessive worry
- *Difficulty concentrating or “mind going blank”
- *Feeling keyed up or on edge
- *Trouble falling asleep or staying asleep
- *Irritability

Consider the following statements to help you take stock of what you’re feeling and how you’re acting and to assist you to talk to your doctor or a counselor about symptoms you may be experiencing. Mark any of the statements that describe feelings or symptoms you have had, more often than not, for six months or more.

How I feel

- *I’m nervous all the time.
- *I feel like something awful is about to happen.
- *I worry about everything.
- *I feel sad or down.
- *I’m tired, but I can’t relax.
- *I can’t turn off my thoughts.

My Physical Self

- *I often have trouble sleeping.
- *I don’t feel well, but doctors can’t find anything wrong with me.
- *I have a lot of stomach problems.
- *Sometimes my heart beats so fast, it feels like my chest will burst.
- *I’m tired all the time.

How I Act

- *I'm irritable and cranky.
- *I'm restless and can't stay still.
- *I have trouble concentrating and remembering things.
- *I use food, alcohol, street drugs or prescription medications to feel better.
- *I overreact to minor problems.

My Job and Other Activities

- *I used to love my job, but now I dread going to work.
- *My worries intrude on every thing I do.
- *Fear keeps me from doing some things I used to enjoy.
- *Because of my symptoms, my work has started to suffer.
- *I snap at co-workers or clients.
- *I have trouble concentrating on my work or hobbies.

My Relationships

- *Because of my fears, I'm overly protective of my kids.
- *When friends don't call, I think I must have made them mad.
- *I don't mean to be, but I'm hard to get along with.
- *I'd usually rather be alone.
- *My family life is suffering.

How I View My World

- *Much of the time, life seems overwhelming.
- *I worry about things that aren't likely to happen.
- *Just thinking about getting through the day makes me nervous.
- *I know my worries or fears are irrational, but I can't stop them.
- *Everything is out of control.

If you have checked off several of the statements and find them interfering with your ability to be productive and happy, you may be suffering from persistent anxiety.

Treatment That Will Help-Not Make Things Worse

Some people recognize they're anxious and try to help themselves. They might talk things over with friends, or exercise, or start a hobby to take their mind off things. These strategies, however, often aren't completely successful for people with persistent underlying anxiety because they don't address all the factors that, in combination, result in anxiety.

Individualized programs developed with a mental health professional can be effective in treating persistent underlying anxiety, especially if treatment is given early. These treatment programs often address factors such as exercise, nutrition, relaxation strategies, and ways to deal with stressful situations. Treatment options include (Channing L. Bete Co., Inc., 1998):

Cognitive behavioral therapy - this can help the person to:

- *replace irrational thoughts and actions with rational ones.
- *use positive coping skills, such as controlled breathing and other relaxation techniques.

Other types of psychotherapy - these may be used with cognitive behavioral therapy. They can help the person:

- *resolve conflicts connected with his or her anxiety disorder
- *reduce general anxiety
- *express feelings

These types of therapy may also involve self-help groups and/or family therapy.

Medication - this can be used with other treatments to help reduce symptoms. (Be sure to talk with a healthcare provider about all risks and benefits of medication.)

The goals of an anxiety treatment program are:

- *To relieve physical and emotional symptoms of persistent underlying anxiety
- *To restore the capacity to function normally
- *To better understand what situations contribute to underlying anxiety and how to deal with them in order to feel better.

It is important to be aware that under the topic Anxiety Disorders there are many subcategories and classifications. For simplicity, we have provided the criteria from The DSM-IV-TR to diagnosis a Generalized Anxiety Disorder to serve as a basic frame of reference. Contact OLAP, see a professional in the field to get an accurate diagnosis for yourself, or refer a friend for whom you have concerns.

Diagnostic Criteria for Generalized Anxiety Disorder (DSM-IV-TR, p.476)

- A. A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.
 - (1) restlessness or feeling keyed up or on edge
 - (2) being easily fatigued
 - (3) difficulty concentrating or mind going blank
 - (4) irritability
 - (5) muscle tension
 - (6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, i.e. the anxiety or worry is not about having a Panic Attack, being embarrassed in public, being contaminated, being away from home or close relatives, gaining weight, having multiple physical complaints, or having a serious illness, and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (i.e. drug of abuse, a medication) or a general medical condition (i.e. hyperthyroidism) and does not occur exclusively during a mood disorder, Psychotic Disorder, or a Pervasive Developmental Disorder.

Generalized anxiety disorder (GAD) is much more than the normal anxiety people experience day to day (National Institute of Mental Health). It's chronic and exaggerated worry and tension, even though nothing seems to provoke it. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work. Sometimes, though, the source of the worry is hard to pinpoint. Simply the thought of getting through the day provokes anxiety.

Obsessive Compulsive Disorder (OCD)

What is OCD?

Obsessive-compulsive disorder (OCD), one of the anxiety disorders, is a potentially disabling condition that can persist throughout a person's life (National Institutes of Health,

1994). The individual who suffers from OCD becomes trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but extremely difficult to overcome. OCD occurs in a spectrum from mild to severe, but if severe and left untreated, can destroy a person's capacity to function at work, at school or even in the home.

Example of OCD:

During his last year at law school, John became aware that he was spending more and more time preparing for classes, but he worked hard and graduated in the top of his class. He accepted a position at a prestigious law firm in his hometown and began work with high hopes for the future. Within weeks, the firm was having second thoughts about John. Given work that should have taken two or three hours, he was going over and over the research, spending a week or more on a task. He knew it was taking too long to get each job done, but he felt compelled to continue checking.

Key Features of OCD:

Obsessions

These are unwanted ideas or impulses that repeatedly well up in the mind of the person with OCD. Persistent fears that harm may come to self or a loved one, and unreasonable belief that one has a terrible illness, or an excessive need to do things correctly or perfectly, are common (National Institutes of Health, 1994). Again and again the individual experiences a disturbing thought, such as, "My hands may be contaminated-I must wash them"; "I may have left the gas on"; or "I am going to injure my child." These thoughts are intrusive, unpleasant, and produce a high degree of anxiety. Often the obsessions are of a violent or a sexual nature, or concern illness.

Compulsions

In response to their obsessions, most people with OCD resort to repetitive behaviors called compulsions. The most common of these are washing and checking. Other compulsive behaviors include counting (often while performing another compulsive action such as hand washing), repeating, hoarding, and endlessly rearranging objects in an effort to keep them in precise alignment with each other (National Institutes of Health, 1994). These behaviors generally are intended to ward off harm to the person with OCD or others. Some people with OCD have regimented rituals while others have rituals that are complex and changing. Performing rituals may give the person with OCD some relief from anxiety, but it is only temporary.

Insight

People with OCD usually have considerable insight into their own problems. Most of the time, they know that their obsessive thoughts are senseless or exaggerated, and that their compulsive behaviors are not really necessary. However, this knowledge is not sufficient to enable them to stop obsessing or the carrying out of rituals.

Resistance

Most people with OCD struggle to banish their unwanted, obsessive thoughts and to prevent themselves from engaging in compulsive behaviors. Many are able to keep their obsessive-compulsive symptoms under control during the hours when they are at work or attending school. But over the months or years, resistance may weaken, and when this happens, OCD may become so severe that time-consuming rituals take over the sufferer's lives, making it impossible for them to continue activities outside the home (National Institutes of Health, 1994).

Shame and Secrecy

OCD sufferers often attempt to hide their disorder rather than seek help. Often they are successful in concealing their obsessive-compulsive symptoms from friends and coworkers. An unfortunate consequence of this secrecy is that people with OCD usually do not receive professional help until years after the onset of their disease. By that time, they may have learned to work their lives-and family members' lives-around rituals.

Long-Lasting Symptoms

OCD tends to last for years, even decades. The symptoms may become less severe from time to time, and there may be long intervals when the symptoms are mild, but for most individuals with OCD, the symptoms are chronic.

What Causes OCD?

The old belief that OCD was the result of life experiences has given way before the growing evidence that biological factors are a primary contributor to the disorder. The fact that OCD patients respond well to specific medications that affect the neurotransmitter serotonin suggests the disorder has a neurobiological basis. For that reason, OCD is no longer attributed to attitudes a patient learned in childhood—for example, an inordinate emphasis on cleanliness, or a belief that certain thoughts are dangerous or unacceptable. Instead, the search for causes now focuses on the interaction of neurobiological and environmental influences.

OCD is sometimes accompanied by depression, eating disorders, substance abuse disorder, a personality disorder, attention deficit disorder, or another of the anxiety disorders. Co-existing disorders can make OCD more difficult both to diagnose and to treat.

Do I have OCD?

A person with OCD has obsessive and compulsive behaviors that are extreme enough to interfere with everyday life. People with OCD should not be confused with a much larger group of individuals who are sometimes called “compulsive” because they hold themselves to a high standard of performance and are perfectionistic and very organized in their work and even in recreational activities. This type of “compulsiveness” often serves a valuable purpose, contributing to a person’s self-esteem and success on the job. In that respect, it differs from the life-wrecking obsessions and rituals of the person with OCD.

Could it be Obsessive-Compulsive Disorder (OCD) ?

Obsessive behavior is quite common. In fact, Felix Unger of television’s “Odd Couple” made famous an obsession with cleanliness. Many people have similar obsessive behaviors, such as persistently organizing their desk in a certain way or washing their hands frequently. However, this behavior is not OCD.

OCD is much more extreme than these idiosyncrasies.

OCD takes control of the lives of people of all ages – adults, teenagers, and young children. While children and adults experience many of the same obsessions and compulsions, children often express their disorder in special ways.

While only a doctor, psychiatrist, psychologist or licensed independent social worker can diagnose OCD, the following summary can help you begin to understand what’s OCD – and what’s not.

Ask Yourself

Yes	No	
_____	_____	Do you have thoughts that make you anxious and that you can’t get rid of?
_____	_____	Do you have a tendency to keep things extremely clean or to wash your hands very frequently, more than other people you know?
_____	_____	Do you check things over and over to make sure they were done correctly?

What's OCD

Cleaning/Washing

A man who washes his hand 100 times a day, until they are red and raw

Checking/Questioning

A woman who locks and relocks her door before going to work every day – for half an hour

Collecting/Hoarding

A man who stores 19 years of newspapers “just in case” with no system for filing or retrieval

Counting/Repeating

A college student who must tap on the door frame of every classroom 14 times before entering

Arranging/Organizing

A women who spend hours alphabetizing every item in her kitchen cabinets and must have all clothing organized by color

What's NOT

Cleaning/Washing

A women who unfailingly washes her hands before every meal

Checking/Questioning

A woman who double checks that her apartment door and windows are locked each night before she goes to bed

Collecting/Hoarding

A women who dedicates all her spare time and money to building her art collection

Counting/Repeating

A musician who practices a difficult passage over and over again until it's perfect

Arranging/Organizing

An office manager who won't leave the office until his desk is clear and his in-box empty

Comprehensive information on OCD is available by calling **1-800-639-7462 (NEWS-4-OCD)** and by visiting the OCD website at <http://www.ocdresource.com>.

A Screening Test of Obsessive-Compulsive Disorder

People who have Obsessive-Compulsive Disorder (OCD) experience recurrent, unpleasant thoughts (obsessions) and feel driven to perform certain acts over and over again (compulsions). Although sufferers usually recognize that the obsessions and compulsions are senseless or excessive, the symptoms of OCD often prove difficult to control without proper treatment. Obsessions and compulsions are not pleasurable; on the contrary, they are a source of distress. The following questions are designed to help people determine if they have symptoms of OCD and could benefit from professional help.

Part A. Please check YES or NO.

Yes No

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

- | | | | |
|----|--|-------|-------|
| 1. | concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS? | _____ | _____ |
| 2. | overconcern with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly? | _____ | _____ |

- | | Yes | No |
|--|-------|-------|
| 3. images of death or other horrible events? | _____ | _____ |
| 4. personally unacceptable religious or sexual thoughts? | _____ | _____ |
| Have you worried a lot about terrible things happening, such as: | | |
| 5. fire, burglary, or flooding the house? | _____ | _____ |
| 6. accidentally hitting a pedestrian with your car or letting it roll down hill? | _____ | _____ |
| 7. spreading an illness (giving someone AIDS)? | _____ | _____ |
| 8. losing something valuable? | _____ | _____ |
| 9. harm coming to a loved one because you weren't careful enough? | _____ | _____ |
| Have you worried about acting on an unwanted and senseless urge or impulse, such as: | | |
| 10. physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests? | _____ | _____ |
| Have you felt driven to perform certain acts over and over, such as: | | |
| 11. excessive or ritualized washing, cleaning, or grooming? | _____ | _____ |
| 12. checking light switches, water faucets, the stove, door locks, or emergency brake? | _____ | _____ |
| 13. counting; arranging; evening-up behaviors (making sure socks are same height)? | _____ | _____ |
| 14. collecting useless objects or inspecting the garbage before it is thrown out? | _____ | _____ |
| 15. repeating routine actions (in/out of chair, going through doorway, re-lighting cigarette) a certain number of times until it feels <i>just right</i> ? | _____ | _____ |
| 16. need to touch objects or people? | _____ | _____ |
| 17. unnecessary re-reading or re-writing; re-opening envelopes before they are mailed? | _____ | _____ |
| 18. examining your body for signs of illness? | _____ | _____ |
| 19. avoiding colors ("red" means blood), numbers ("13" is unlucky), or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts? | _____ | _____ |
| 20. needing to "confess" or repeatedly asking for reassurance that you said or did something correctly? | _____ | _____ |

If you answered YES to 2 or more of the above questions, please continue with Part B below.

Part B. The following questions refer to the repeated thoughts, images, urges, or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer. Circle the most appropriate number from 0 to 4.

1. On average, how much time is occupied by these thoughts or behaviors each day?	0 None	1 Mild (less than 1 hour)	2 Moderate (1 to 3 hours)	3 Severe (3 to 8 hours)	4 Extreme (more than 8 hours)
2. How much distress do they cause you?	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme (disabling)
3. How hard it is for you to control them?	0 Complete Control	1 Much Control	2 Moderate Control	3 Little Control	4 No Control

4. How much do they cause you to avoid doing anything, going any place, or being with anyone?	0 No avoidance	1 Occasional avoidance	2 Moderate avoidance	3 Frequent and extensive	4 Extreme (housebound)
5. How much do they interfere with school, work or your social or family life?	0 None	1 Slight interference	2 Definitely interferes with functioning	3 Much interference	4 Extreme (disabling)
Sum on Part B (Add items 1 to 5)					_____

Scoring: If you answered YES to 2 or more of the questions in Part A **and** scored 5 or more on Part B, you may wish to contact OLAP, your physician, a mental health professional, or a patient advocacy group (such as the Obsessive Compulsive Foundation, Inc.) to obtain more information on OCD and its treatment. Remember, a high score on this questionnaire does not necessarily mean you have OCD – only an evaluation by an experienced clinician can make this determination.

Prevalence

Community studies have estimated a lifetime prevalence of 2.5% and a 1-year prevalence of 0.5% - 2.1% in the general adult population. Among attorneys, 21% of men and 15% of women suffer from OCD.

Although Obsessive-Compulsive Disorder symptoms typically begin during the teenage years or early adulthood, recent research shows that some children develop the illness at earlier ages, even during the preschool years. Studies indicate that at least one-third of cases of Obsessive-Compulsive Disorder in adults began in childhood.

Diagnostic Criteria For Obsessive-Compulsive Disorder (DSM-IV-TR, p. 462-463)

Superstitions and **repetitive checking behaviors** are commonly encountered in everyday life. A diagnosis of Obsessive-Compulsive Disorder should be considered only if they are particularly time consuming or result in clinically significant impairment or distress.

- A. Either obsessions or compulsions.

Obsessions as defined by (1), (2), (3), and (4):

- (1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress;

- (2) the thoughts, impulses, or images are not simply excessive worries about real-life thoughts;
- (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action;
- (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion).

Compulsions as defined by (1) and (2):

- (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly;
- (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

- B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.
- C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.
- D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Abuse Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).
- E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Working Together

Though the method of “talking things over” usually won’t by itself solve anxiety problems, it will help a physician or mental health professional determine what will work for you. Together you can try to pinpoint original sources of your anxiety and consider what changes you can make that will reduce stress. The important thing to realize is that persistent underlying anxiety is a disorder—a treatable disorder. In some cases, a chemical imbalance exists which actually causes the anxiety. The goal of treatment, then, is to return the chemical balance to the brain to normal levels. Treatment may consist of medication, relaxation techniques, counseling therapy, exercise, dietary changes or a combination of two or more of these. There is no quick fix for persistent anxiety, but you can get help to feel better. With proper diagnosis and treatment, patients often report relief within a few weeks and progressive improvement after that.

Help is available

If you or someone you know has signs of an anxiety disorder, you can contact:

- *your health-care provider
- *mental health clinics
- *mental health professionals
- *the National Institute of Mental Health at 1-888-826-9438
- *the Anxiety Disorders Association of America at 1-301-231-9350
<http://www.adaa.org>
- *the National Alliance for the Mentally Ill at 1-800-950-6264
<http://www.nami.org>
- *the National Mental Health Association at 1-800-969-6642
- *the Obsessive Compulsive Foundation (OCF) at 1-203-878-5669 or 1-203-874-3843
<http://pages.prodigy.com/akwillen.ocf.html>
- *the Obsessive Compulsive Information Center at 1-608-827-2390
- *the OCD Resource Center at 1-800-NEWS-4-OCD (1-800-639-7462)
<http://www.ocdresource.com>
- *OLAP 1-800-348-4343 or 1-800-618-8606

You can join the millions of people who are no longer “worried sick.”

DEPRESSION

What is depression?

It's a mental illness that affects the mind and the body. Depression can cause many symptoms. For instance, people who are depressed may:

- *pull away from people and activities
- *lose interest and pleasure in life
- *feel sad, disappointed, confused or anxious
- *suffer aches and pains, fatigue, poor digestion, sleep problems, etc.

Most people feel down from time to time-it's a natural response to stress and tension. But with depression, these feelings are severe or long lasting.

Depression is common

Millions of people suffer from depression each year. In 2000, the World Health organization ranked depression as the 4th greatest public health problem. A National Comorbidity Study found that the lifetime risk of experiencing a depressive episode is approaching 15%

- 10-25% for adolescent and adult women
- 5-12% for adolescent and adult men

Terry L. Harrell JD, MSW, LCSW (Executive Director, Indiana Judges and Lawyers Assistance Program) cited in her presentation March of 2002, a study from John Hopkins University. Individuals from 28 different occupations were studied, and it was discovered lawyers had the highest rates of depression. In the State of Washington, 801 lawyers were examined and the results found 19% suffered from depression. A survey of 2,500 lawyers in North Carolina found that 25% reported symptoms of clinical depression. OLAP is aware of 6suicides since January 2000.

Depression

Depression is more than a day of feeling low. It is a long-lasting, often recurring illness as real and disabling as heart disease or arthritis. Adults who experience clinical depression may feel an oppressive sense of sadness, fatigue, and guilt. Performing on the job may be difficult . . . going out with friends may be unthinkable . . . merely getting out of bed may be impossible. The person who has depression feels increasingly isolated from family and colleagues – helpless, worthless, and lost.

Depression is a very common emotional illness. It affects about 10 percent of the adult U.S. population. One in four women and one in ten men will experience a depressive episode in their lifetime. Among attorneys, 21% of men and 16% of women suffer from depression.

What Causes Depression?

We now know that depression results from an interaction of several factors – environmental, biological, and genetic.

Environmental Factors. Stress resulting from work, the loss of a job or client, death of a family member, divorce, or ongoing health of family problems can trigger depression.

Biological Factors. Depression may also be tied to disturbances in the biochemicals that regulate mood and activity. These biochemicals, called neurotransmitters, are substances that carry impulses or messages between nerve cells in the brain. An imbalance in the amount or activity of neurotransmitters can cause major disruptions in thought, emotion, and behavior.

Some people develop depression as a reaction to other biological factors such as chronic pain, medications, hypothyroidism, or other medical illnesses.

Genetic Factors. Because depression appears to be linked to certain biological factors, people can inherit a predisposition to develop depression. In fact, 25 percent of those people with depression have a relative with some form of this illness.

There is Help . . .

Doctors know more about depression than perhaps any other emotional illness. Because of research and medical advancements, 80 to 90 percent of those with a depressive disorder can be treated successfully.

Evaluation. A complete evaluation with a qualified professional is the first step in seeking treatment. Only a licensed physician, psychologist or licensed independent social worker can diagnose a person with a psychiatric disorder. During the diagnostic assessment, the evaluation will determine if any other factors are contributing to or even causing the depressive symptoms.

Professional Counseling. Various psychotherapies or “talk therapies” commonly used in the treatment of depression focus on the causes and effects of the illness. Interpersonal therapy helps people deal with problems in personal relationships. Cognitive therapy helps patients change negative thoughts or perceptions, such as high achievers who are convinced they are failures.

Medication. Sometimes used in combination with psychotherapy, medication can correct the biochemical imbalances that may cause depressive episodes. When carefully prescribed and monitored by a physician, medications can relieve symptoms in three to six weeks.

Facts on Depression

What is Depression?

- Depression is a common and sometimes serious disorder of mood that is pervasive, intense and attacks the mind and body at the same time.
- Depression may be associated with an imbalance of chemicals (neurotransmitters) in the brain that carry communications between nerve cells that control mood and other basic bodily functions.
- Other factors may also come into play, such as negative life experiences such as stress or loss, other medical illnesses, medicines, and certain personality traits and genetic factors.

Types of Depression

- Major depression is a common type of depression and is characterized by at least five of the key symptoms (see list below).
- Dysthymia is a milder, chronic form of depression that lasts two years or more.
- Bipolar depression is the depressive phase of manic-depressive illness (bipolar disorder), in which there are both extreme highs and extreme lows of mood. Bipolar depression symptoms are similar to those of major depression, and may involve excessive sleep and appetite with very low energy.
- Seasonal Affective Disorder is a type of depression that follows seasonal rhythms, with symptoms occurring in the winter months and diminishing in spring and summer, and can occur in major depression or bipolar disorder.

What are the Symptoms of Depression?

- persistent sad or empty mood
- loss of interest or pleasure in ordinary activities
- changes in appetite or weight
- inability to sleep or oversleeping
- restlessness or sluggishness
- decreased energy or fatigue
- difficulty concentrating or making decisions
- feelings of guilt, hopelessness or worthlessness
- thoughts of death or suicide

Treatment of Depression

- More than 80% of people with depression improve with treatment within several months, although it may be necessary to try multiple forms of treatment until the right ones are found.
- Antidepressant medications may take several weeks to be effective.
- Psychotherapy, sometimes called talking therapy, is aimed at helping the person develop new ways of thinking, improving relations with other people, or resolving current conflicts or those remaining from childhood.
- Electroconvulsive therapy (ECT), contrary to popular mythology, is a very safe and effective form of treatment. It is generally used for individuals with severe depression and for patients who cannot tolerate medication because of a medical condition or are at high risk for suicide.
- Self-help groups can provide a supportive environment for individuals with depression, their family and friends.

Economic and Social Costs of Depression

- Depression costs nearly \$50 billion annually in the United States alone.
- \$24 billion is comprised of lost productivity and worker absenteeism.
- Treatment for depression reduces overall costs by reducing hospitalizations, medical expense, and disability.
- By the year 2020, unipolar major depression will be the second most burdensome illness in the world in terms of lost years of healthy life.
- Heart attack survivors and those with congestive heart failure with major depression have a 3-4 times greater risk of dying within six months than those who do not suffer from depression.

Depression and Seniors

- Depression symptoms occur in approximately 15 percent of community residents over age 65, with an even higher prevalence in nursing home residents.
- Chronically depressed seniors have an 88% higher risk of contracting all forms of cancer than do nondepressed seniors.
- Concurrent medical conditions and early dementia can compromise accurate recognition of depression in seniors.
- Common medical illnesses associated with late-life depression include cancer, Parkinson's disease, heart disease, stroke, and Alzheimer's dementia.
- A third of widows/widowers meet criteria for a major depressive episode in the first month after death, and half of these remain clinically depressed one year later.

Adolescent and Child Depression

- As many as one in 33 children and one in eight adolescents may have clinical depression.
- Children who are depressed may not show outward signs of being sad, but may spend a great deal of time alone and talk of death or suicide.
- Early onset of major depression (first episode prior to age 20) is associated with a greater likelihood of a more recurrent pattern in adulthood and with development of manic-depression.
- Children of parents with a history of major depression or bipolar disorder are at a markedly higher risk for major depression, including prepubertal onset illness.

Depression and Women

- Twice as many women as men suffer from depression, however, the risk for bipolar disorder is similar in men and women.
- The difference in the incidence of depression between women and men begins to appear in adolescence and becomes more pronounced with age.
- There is some evidence that married women and those who stay home with small children have higher rates of depression.
- Exercise is often suggested for women (and men) who feel depressed because it may elevate certain mood-elevating chemicals in the blood and can contribute to a feeling of well-being, self-discipline, control, and positive self-esteem.

Depression and Suicide

- Major depression and bipolar disorder are the psychiatric diagnoses most commonly associated with suicide.
- About two-thirds of people who complete suicide have a depressive disorder at the time of their deaths.
- Suicide is the ninth leading cause of death in the U.S.
- Each year, almost 5,000 young people, ages 15-24, kill themselves.
- Suicide rates among youth have increased more than 300% since the 1950's.
- Four times as many men kill themselves, as do women, but three to four times as many women attempt suicide as do men.

Verbal and Behavioral Clues Someone May Be Contemplating Suicide

Verbal Clues

1. “I’m going to kill myself.”
2. “I’m not the man I used to be.”
3. “My family would be much better off without me.”
4. “You won’t be seeing me around anymore.”
5. “Ever since I retired I’ve felt I’m in the way all the time.”
6. “I just can’t stand it any longer.”
7. “It’s too much to put up with.”
8. “Life has lost its meaning for me.”
9. “Nobody needs me anymore.”
10. “If (such and such) happens, I’ll kill myself.”
11. “If (such and such) doesn’t happen, I’ll kill myself.”
12. “I’m getting out.”
13. “Here, take this (valued possession): I won’t be needing it anymore.”

Behavioral Clues

14. A previous suicide attempt (particularly if it occurred recently and would have been serious enough to have caused death).
15. Giving away a valued personal possession.
16. Buying a gun (especially when the person never wanted guns in the home before).
17. Putting personal and business affairs in order as though preparing to take a long journey.
18. Inquiring about how one donates his/her body to a medical school.
19. A person planning his/her funeral shortly after the death of a loved one.
20. A poor adjustment to the recent loss of one or more loved ones.
21. A person who has always resisted having a last will and testament.
22. Composing a suicide note – some families discover the notes long enough in advance of the suicide to do something about it.
23. A sudden, unexplained recovery from a severe depression – such people may be expressing great relief since they “resolved” all of their problems by deciding to kill themselves.
24. Any unexplainable change in a usual behavioral pattern (e.g., a person who never liked to drink suddenly begins drinking to excess; a “penny-pincher” suddenly donates a large sum of money to a charity).
25. Suddenly resigning from organizations such as clubs, church groups, or fraternal orders.
26. Crying for no apparent reason.
27. Poor sleeping habits.
28. Loss of appetite.

- 29. Loss of sex drive.
- 30. Loss of ability to concentrate.

SUICIDE HOTLINE IN COLUMBUS, OHIO AREA: 614-221-5445
NATIONAL SUICIDE HOTLINE: 1-800-SUICIDE, 1-800-784-2433

Major Depressive Episode

A. According to the DSM-IV-TR (p.356), a major depressive episode is considered if five (or more) the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

- (1) depressed mood most of the day, nearly everyday, as indicated by either subjective reports (i.e. feels sad or empty) or observation made by others (i.e. appears tearful). **Note:** In children and adolescents, can be irritable mood.
- (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly everyday (as indicated by either subjective account or observation by others).
- (3) significant weight loss when not dieting or weight gain e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly everyday. **Note:** In children, consider failure to make expected weight gains.
- (4) insomnia or hypersomnia nearly every day.
- (5) psychomotor agitation or retardation nearly every day (observed by others, not merely subjective feelings of restlessness or being slowed down).
- (6) fatigue or loss of energy nearly every day.
- (7) feelings of worthlessness or excessive or inappropriate (disproportionate) guilt nearly every day.
- (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

- (9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode

Mixed Episode:

- (1) The criteria are met for a Manic Episode and for a Major Depressive Episode nearly every day during at least a 1-week period.
- (2) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
- (3) The symptoms are not due to the direct physiological effects of a substance (i.e. drug of abuse, a medication, or other treatment) or a general medical condition (i.e., hyperthyroidism).
- (4) The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- (5) The symptoms are not due to the direct physiological effects of a substance (i.e. a drug of abuse, a medication) or a general medical condition (i.e. hypothyroidism).
- (6) The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
- (7) The DSM-IV-TR distinguishes a major depression from a dysthymic disorder based upon the length of the event. For example, a person who has dysthymia is depressed for at least 2 years.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Dysthymic Disorder (DSM-IV-TR, pgs. 380 - 381)

- A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years. (In children and adolescents, mood can be irritable and duration must be at least 1 year.)
- B. Presence, while depressed of two (or more) of the following:
 - (1) poor appetite or overeating
 - (2) insomnia or hypersomnia
 - (3) low energy or fatigue
 - (4) low self-esteem
 - (5) poor concentration or difficulty making decisions
 - (6) feelings of hopelessness
- C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. No major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents), i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder in Partial Remission.
- E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

- F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.
- G. The symptoms are not due to the direct physiological effects of a substance (i.e. a drug of abuse, a medication) or a general medical condition (i.e. hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The mood is often described by the person as depressed, sad, hopeless, discouraged, or “down in the dumps” (DSM-IV-TR, pg. 349). In some individuals who complain of feeling “blah,” having no feelings, or feelings anxious, the depressed mood can be inferred from the person’s facial expression and demeanor. Some individuals emphasize somatic complaints (i.e. bodily aches and pains) rather than reporting feelings of sadness. Many individuals report or exhibit increased irritability (i.e. persistent anger, a tendency to respond to events with angry outbursts or blaming others, or an exaggerated sense of frustration over minor matters).

Please see a mental health professional if you or someone you know may be experiencing a depressive disorder. There are specific criteria and conditions that must be met before an accurate diagnosis can be made. Just as in law there are areas of expertise the same is true in mental health. If you have questions or need referral resources contact OLAP.

Criteria for Manic Episode (DSM-IV-TR, p. 362)

- A. A distinct period of abnormally and persistently elevated expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 - (1) inflated self-esteem or grandiosity
 - (2) decreased need for sleep (i.e. feels rested after only 3 hours of sleep)
 - (3) more talkative than usual or pressure to keep talking
 - (4) flight of ideas or subjective experience that thoughts are racing
 - (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

- (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
 - (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (i.e., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
- C. The symptoms do not meet criteria for a Mixed Episode.
 - D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
 - E. The symptoms are not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or other treatment) or a general medical condition (i.e., hyperthyroidism).

BIPOLAR DISORDER

Bipolar Disorder (DSM-IV-TR, p.400-401)

There are many types of bipolar disorder. In bipolar disorder, formerly known as manic depression, episodes of major depression alternate with periods of elation or mania. For the sake of simplicity we shall refer to it generally to give you a foundation of the disorder.

What is Bipolar Disorder?

Bipolar disorder, formerly known as manic-depressive illness, is a treatable illness involving episodes of serious mania and depression: mood swings from overly “high” and irritable to sad and hopeless, and then back again, with periods of normal mood in between (National Institute of Mental Health, 1995). The mood extremes may be of varying severity; the mood changes may occur gradually or rapidly. A lifetime illness that typically begins in adolescence or early adulthood, bipolar disorder is often not recognized as an illness, causing needless suffering for years or even decades.

Effective treatment for this illness can alleviate suffering and usually prevent its devastating complication, which can include marital breakups, financial and occupational difficulties or losses, alcohol and drug abuse and suicide.

Facts About Bipolar Illness:

- *Over 2 million Americans suffer from this distressing and disruptive illness.
- *Like other serious illnesses, bipolar disorder also impacts family, friends, and co-workers.
- *Families of those affected may have to cope with the resulting behavior problems (i.e. wild spending) and their lasting consequences.
- *Bipolar illness often runs in families. Research continues to look for the inherited genetic defect associated with the illness.
- *Symptoms of bipolar disorder may prevent those affected from recognizing their illness
- *To ensure proper treatment and personal safety, commitment into a hospital may be necessary for a person in a severe episode
- *Suicidal thoughts, remarks, or behaviors should always be given immediate attention by a qualified professional. It is not true that if a person talks about suicide, they will not kill themselves. With appropriate treatment, it is possible to overcome suicidal tendencies.
- *Bipolar disorder is a lifetime illness-to keep moods stable, ongoing treatment is needed, even when the person is feeling better

Symptoms of Depression

- Sad or “empty” mood
- Loss of interest or pleasure
- Decreased energy, fatigue
- Sleep disturbances
- Eating disturbances
- Difficulty concentrating, remembering, making decisions
- Feeling guilty, worthless, helpless, or hopeless
- Thoughts of death or suicide, suicide attempts
- Irritability, excessive crying

Symptoms of Mania

- Excessively “high” mood
- Irritability
- Decreased need for sleep
- Increased energy and activity
- Increased talking, moving, sexual activity
- Racing thoughts
- Disturbed ability to make decisions
- Grandiose notions
- Being easily distracted

Descriptions offered by patients themselves offer valuable insights into the various mood states associated with bipolar disorder (National Institute of Mental Health, 1995):

Depression: *I doubt completely my ability to do anything well. It seems as though my mind has slowed down and burned out to the point of being virtually useless...[I am] haunted [ed]...with the total, the desperate hopelessness of it all...Others say, "It's only temporary, it will pass, you will get over it," but of course they haven't any idea of how I feel, although they are certain they do. If I can't feel, move, think, or care, then what on earth is the point?*

Hypomania: *At first when I'm high, it's tremendous...ideas are fast...like shooting stars you follow until brighter ones appear...all shyness disappears, the right words and gestures are suddenly there...uninteresting people, things, become intensely interesting. Sensuality is pervasive, the desire to seduce and be seduced is irresistible. Your marrow is infused with unbelievable feelings of ease, power, well-being, omnipotence, euphoria... you can do anything...but, somewhere this changes.*

Mania: *The fast ideas become too fast and there are far too many...overwhelming confusion replaces clarity...you stop keeping up with it—memory goes. Infectious humor ceases to amuse. Your friends become frightened...everything is now against the grain...you are irritable, angry, frightened, uncontrollable, and trapped.*

Recognition of the various mood states is essential so that the person who has manic-depressive illness can obtain effective treatment and avoid the harmful consequences of the disease, which include destruction of personal relationships, loss of employment, and suicide.

Bipolar Illness is Often Unrecognized

An early sign of bipolar illness may be hypomania—with high energy, moodiness, and impulsive or reckless behavior. Hypomania may feel good to the person who experiences it, so that he or she will deny that anything is wrong. In early stages, symptoms may appear as other problems: alcohol or drug abuse, or poor performance at work or school. Left untreated, bipolar disorder tends to worsen so that the person experiences more severe episodes of mania or depression.

Treatment Is Effective (National Institute of Mental Health, 1995)

*Almost all those with bipolar disorder, even in severe forms, can stabilize mood swings with proper treatment.

*One medication, lithium, is usually very effective in controlling mania and preventing recurrence of both manic and depressive episodes.

*In episodes that do not respond to lithium, treatment with the carbamazepine or valproate (anticonvulsants) may be effective.

*Antidepressants may be combined with the treatments above to treat depressive episodes.

*Electroconvulsive therapy (ECT) may treat severe episodes that do not respond to medications.

*As an addition to medication, psychotherapy can often provide critical support, education, and guidance to patient and family.

Getting Treatment

Anyone with bipolar disorder should be under the care of a psychiatrist skilled in its diagnosis and treatment. Other mental health professionals, such as psychologists and psychiatric social workers, can provide the individual and his or her family with support, education, understanding and help with monitoring symptoms and maintaining treatment.

Bipolar Disorder Not Otherwise Specified (DSM-IV-TR, p.400-401)

The Bipolar Disorder Not Otherwise Specified Category includes disorders with bipolar features that do not meet criteria for any specific Bipolar Disorder. Examples include:

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that meet symptom threshold criteria but not minimal duration criteria for Manic, Hypomanic, or Major Depressive Episodes
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms
3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder Not Otherwise Specified
4. Hypomanic Episodes, along with chronic depressive symptoms, that are too infrequent to qualify for a diagnosis of Cyclothymic Disorder
5. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

ADULT ATTENTION DEFICIT DISORDER

Characteristics of Adults with AD/HD

Occasionally, we may all have difficulty sitting still, paying attention or controlling impulsive behavior. For some people, the problem is so pervasive and persistent that it interferes with their daily life, including home, academic, social, and work settings.

Adults with AD/HD may be easily distracted, have difficulty sustaining attention and concentrating, are often impulsive and impatient, may have mood swings and short tempers, may be disorganized and have difficulty planning ahead (CHADD, 2002). They may also feel fidgety and restless internally.

In addition, adults may also experience career difficulties. They may lose jobs due to poor job performance, attention and organizational problems, or interpersonal relationships. As a result, some adults experience periods of sadness or depression. These core symptoms of AD/HD frequently lead to associated problems and consequences that often co-exist with adult AD/HD. These may include:

1. Problems with self-control and regulating behavior
2. Poor working memory
3. Poor persistence of efforts toward tasks
4. Difficulties with regulation of emotions, motivation and arousal
5. Greater than normal variability in task or work performance
6. Chronic lateness and poor time perception
7. Easily bored
8. Low self-esteem
9. Anxiety
10. Depression
11. Mood swings
12. Employment difficulties
13. Relationship problems
14. Substance abuse
15. Risk-taking behaviors
16. Poor time management

On the other hand, adults who are diagnosed and treated adequately can thrive professionally. This is especially true once individuals find jobs that rely on their strengths rather than their deficits.

Adults with AD/HD may benefit from learning to structure their environment (CHADD, 2002). Plus, medications effective in childhood AD/HD also appear helpful for adults who have AD/HD. Vocational counseling is often an important intervention. Short-term psychotherapy can help adults identify how his or her disability might be associated with a history of problems at work and difficulties in personal relationships. Extended psychotherapy can help address mood swings, stabilize relationships and alleviate guilt and discouragement.

The DSM-IV-TR provides specific criteria that must be met before an individual can be diagnosed with attention deficit disorder. Below is a description of the diagnostic features (pg. 85-86) and the criteria for a formal diagnosis to be made (pg. 92-93).

Attention-Deficit/Hyperactivity Disorder

Diagnostic Features

The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development (Criterion A).

Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individuals with the Predominantly Inattentive Type (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Development Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

Inattention may be manifest in academic, occupational, or social situations. Individuals with this disorder may fail to give close attention to details or may make careless mistakes in schoolwork or other tasks (Criterion A1a). Work is often messy and performed carelessly and without considered thought. Individuals often have difficulty sustaining attention in tasks or play activities and often find it hard to persist with tasks until completion (Criterion A1b). They often appear as if their mind is elsewhere or as if they are not listening or did not hear what has just been said (Criterion A1c). There may be frequent shifts from one uncompleted activity to another. Individuals diagnosed with this disorder may begin a task, move on to another, then turn to yet something else, prior to completing any one task. They often do not follow through on requests or instructions and fail to complete schoolwork, chores, or other duties (Criterion A1d). Failure to complete tasks should be considered in making this diagnosis only if it is due to inattention as opposed to other possible reasons (e.g., failure to understand instructions, defiance). These individuals often have difficulties organizing tasks and activities (Criterion A1e). Tasks that require sustained mental effort are experienced as unpleasant and markedly aversive. As a result, these individuals typically avoid or have a strong dislike for activities that demand sustained self-application and mental effort or that require organizational demands or close concentration (e.g., homework or paperwork) (Criterion A1f). This avoidance must be due to the person's difficulties with attention and not due to a primary oppositional attitude, although secondary oppositionalism may also occur. Work habits are often disorganized and the materials necessary for doing the task often scattered, lost, or carelessly handled and damaged (Criterion A1g.) Individuals with this disorder are easily distracted by irrelevant stimuli and frequently interrupt ongoing tasks to attend to trivial noises or events that are usually and easily ignored by others (e.g., a car honking, a background conversation) (Criterion A1h). They are often forgetful in daily activities (e.g., missing appointments, forgetting to bring lunch) (Criterion A1i). In social situations, inattention may be expressed as frequent shifts in conversation, not listening to others, not keeping one's mind on conversations, and not following details or rules of games or activities.

Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2):

- (1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

- (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
- (b) often has difficulty sustaining attention in tasks or play activities
- (c) often does not seem to listen when spoken to directly
- (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- (e) often has difficulty organizing tasks and activities
- (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- (g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, book, or tools)
- (h) is often easily distracted by extraneous stimuli
- (i) is often forgetful in daily activities

- (2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

- (a) often fidgets with hands or feet or squirms in seat
- (b) often leaves seat in classroom or in other situations in which remaining seated is expected
- (c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- (d) often has difficulty playing or engaging in leisure activities quietly
- (e) is often “on the go” or often acts as if “driven by a motor”
- (f) often talks excessively

Impulsivity

- (g) often blurts out answers before questions have been completed
 - (h) often has difficulty awaiting turn
 - (i) often interrupts or intrudes on others (e.g., butts into conversations or games)
- B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
- C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
- D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.
- E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Which Conditions most Commonly Co-Exist with AD/HD?

AD/HD may co-exist with one or more disorders. The most common disorders to occur with AD/HD are (1) Disruptive Behavior Disorders; (2) Mood Disorders; (3) Anxiety Disorders; (4) Tics and Tourette's Syndrome; and (5) Learning Disabilities (CHADD, Fact Sheet #5, 2002). About 40% of individuals with AD/HD have oppositional defiant disorder. Among individuals with AD/HD, conduct disorders also common, occurring in 25% of children, 45-50% of adolescents and 20-25% of adults. The most careful studies suggest that between 10-30% of children with this disorder, and 47% of adults, also have depression. Typically, AD/HD occurs first and depression occurs later. Up to 25% of individuals who suffer with AD/HD also may manifest bipolar disorder. Up to 30% of children and 25-40% of adults will also have an anxiety disorder. Only about 7% of those with AD/HD have tics or Tourette's syndrome, but 60% of those with Tourette's syndrome have AD/HD. Depending on how learning disorders are defined, up to 50% of children with AD/HD have a co-existing learning disorder. Individuals with learning disabilities may have a specific problem reading or calculation, but they are not less intelligent than their peers are. There appears to be conflicting reports of the co-occurrence of substance use or chemical dependency among those who have this disorder.

The Prognosis

AD/HD has been recognized and treated in children for almost a century, but the realization that AD/HD often persists into adulthood has only come over the last few decades (CHADD Fact Sheet #1, 2002). The prevailing belief among professionals for many years was that children and adolescents would outgrow their symptoms of AD/HD by puberty, and certainly by adulthood. However, contemporary research has shown that as many as 67% percent of children will continue to experience symptoms of AD/HD in adulthood (Barkley, 2001). AD/HD in adults is sometimes viewed as a ‘hidden disorder’ because the symptoms of AD/HD are often obscured by psychological difficulties. It is a complex and difficult disorder to diagnose, and should only be diagnosed by an experienced and qualified professional. AD/HD is first recognized in some adults because of problems with depression, anxiety, substance abuse or impulse control. Others recognize that they may have AD/HD only after their child is diagnosed. Despite increased awareness and identification of the disorder in adults, many adults remain unidentified and untreated. However, with early identification and treatment, children and adults can be successful. In adulthood, roughly one third of individuals with AD/HD lead fairly normal lives while half still have symptoms that may interfere with their family relationships or job performance (Weiss, 1985). However, severe problems persist in about ten percent of adults.

After Diagnosis, What Then?

Although there is no cure for AD/HD, many treatments can effectively assist in managing its symptoms (CHADD fact sheet No. 7, 2000). Chief among these treatments is the education of adults with AD/HD and their family members about the disorder’s nature and management. However, well-controlled research comparing different types of treatment has found overwhelmingly that the greatest improvement in the symptoms of AD/HD results from treatment with stimulant medication combined with counseling. Evidence shows that some tricyclic antidepressants may also be effective in managing symptoms of AD/HD as well as co-existing symptoms of mood disorder and anxiety. Just as there is no single test to diagnose AD/HD, no single treatment approach is appropriate for everyone. Treatment needs to be tailored to the individual and should address all areas of need. There may be a variety of behavioral, social, academic, vocational or relationship concerns for the adult with AD/HD. For some, just getting the diagnosis and understanding that there was a reason for many past difficulties can be extremely helpful. Adults with AD/HD may also benefit from counseling about the condition, vocational assessment and guidance to find the most suitable work environment, time management and organizational assistance, coaching, academic or workplace accommodations and behavior management strategies.

In summary, some common components of treatment for adult AD/HD include:

1. Consultation with appropriate medical professionals
2. Education about AD/HD
3. Medication
4. Support groups
5. Behavior skill-building such as list-making, day planners, filing systems and other routines
6. Coaching
7. Vocational counseling
8. Assistance with making appropriate educational vocational choices
9. Supportive individual and/or marital counseling
10. Perseverance and hard work
11. Appropriate academic or workplace accommodations

A combined treatment approach, maintained over a long period of time, can assist in the ongoing management of the disorder and help these adults lead more satisfactory and productive lives.

For more information contact Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD at 1-800-233-4050, fax (301) 306-7090 or visit their website at www.chadd.org

DUAL DIAGNOSIS

What is dual diagnosis?

It means that a person has a mental illness and an alcohol or other drug use problem. Some people with a dual diagnosis may have problems that don't involve using alcohol or other drugs. For example, they may have problems with gambling or eating.

Mental Illness

Mental illness refers to different kinds of brain disorders. For example:

*Depression- lasting feelings of sadness or helplessness

*Bi-polar disorders- extreme mood swings (highs and lows)

*Schizophrenia- a partial or complete break from reality

An alcohol or other drug use problem refers to the use of alcohol or other drugs in a harmful or dangerous way-or the use of any illegal drug (Channing L. Bete Co., Inc., 1998).

Disorder/Drugs of Abuse

DISORDER	DRUGS OF ABUSE					
	Alcohol	Marijuana	Cocaine	Amphetamines	Barbiturates	Alcohol & Drugs
Schizophrenia	59%	66%		44%		73% male 39% female
Major Depression	34%				52%	
Bipolar Disorder	50%		39%			66%
Dual Disorder			60%			

Source: Moller, Mary D., MSN, ARNP, CS, Murphy, and Bohen, Sonata, MSN, ARNP, CS, Millene Freeman: *Recovery from Psychosis: A Wellness Approach*, P.R.N., Inc., Spokane, 1998

Murphy, Millene Freeman, Moller, Mary D.: *My Symptom Management Wordbook: A Wellness Expedition*, Fineline Printing, Richfield, Utah, 1998

Both problems can be successfully treated!

Why learn about dual diagnosis?

Because more than 1 million people in the U.S. have both a mental illness and an alcohol or other drug use problem (Channing L. Bete Co., Inc., 1998)!

Many individuals with these disorders don't know they have them. At the same time discovering the problems can be difficult.

Families, friends and co-workers are affected when someone in their life has a dual diagnosis.

Learning about dual diagnosis can help people get control over their lives.

Why do some people have a dual diagnosis?

There are many possible reasons why an individual has a dual diagnosis. For example experts think that:

A person may have a mental illness first. For example, the person may turn to alcohol or other drugs because of:

- *sadness
- *anxiety
- *fear of other people.

But, using alcohol and other drugs is never a solution to problems- for anyone. It just makes problems harder to solve, and creates new ones, such as addiction.

A person may have an alcohol or other drug use problem first. As the individual uses alcohol or other drugs:

- *the brain and other organs may be affected
- *the person may begin to act differently.

Over time, the person may develop a mental illness. A person may have both at the same time. In this case one may not directly cause the other. Concurrently, one can affect the other.

No matter what the cause, the problem can be treated.

Look for warning signs

Someone with a dual diagnosis may:

- *Use alcohol or other drugs (even those prescribed by a physician) to try to control feelings or avoid problems
- *Have mood swings (going from very happy to very sad)
- *Need more alcohol or other drugs to get the same feeling
- *Try again and again to cut down or control use of alcohol or other drugs
- *Feel sad for long periods
- *Lack interest in people or activities that used to be enjoyable
- *Be extremely angry
- *Talk about suicide

These signs may indicate problems other than a dual diagnosis. But, if you or someone you know may have a problem, talk to someone who can help. For example: your doctor, a psychiatrist, psychologist, therapist, counselor, social worker, hospitals, mental health centers, self-help groups for people with a dual diagnosis, AA-Alcoholics Anonymous, NA-Narcotics Anonymous, or CA-Cocaine Anonymous. Check the Yellow pages of your phone book under “Drug Abuse,” “Alcoholism” or “Mental Health” for names of organizations and sources of help in your area. **Another excellent resource is the Ohio Lawyers Assistance Program (OLAP)**

hot line. We at OLAP have a list of preferred providers of care and support staff to assist you or someone you are concerned about.

Getting help makes sense

A team of professionals will plan your treatment, if you have a dual diagnosis. Your plan may:

- *treat both alcohol or other drug use problems and mental illness
- *include medicine for your mental illness, if necessary
- *help meet any special needs you have (such as changes in diet and daily routine)
- *teach you about your condition and how you can work to improve it
- *involve several sources of support

Your treatment may include:

- *Care as a patient in a hospital or other facility. Hospitalization maybe needed to recover from alcohol or other drug use, or to follow treatment.
- *Outpatient services-going to meetings or seeing a healthcare provider on a regular basis.
- *Counseling-talking to a trained person who can help, one-on-one.
- * Taking part in treatment groups and self-help groups (Channing L. Bete Co., Inc., 1998).

OLAP has some support groups and is building more. They are facilitated by a mental health professional and attended by fellow attorneys who experience the challenge of addressing mental health concerns. Please contact OLAP for more information.

Remember, recovery takes time. But once you get help you can expect to enjoy life more and feel better about yourself!