

CHEMICAL

DEPENDENCY

AND

INTERVENTION

You may find the below test helpful for yourself or for others to whom you may pass it. We have the keys. Call if you want to open the door.

The Other Bar (statewide anonymous number): 1-800-222-0767. Local meeting and information (714) 683-4030.

Are You An Alcoholic?

To answer this question ask yourself the following questions and answer them as honestly as you can.

Yes No

1. Do you lose time from work due to drinking?
2. Is drinking making your home life unhappy?
3. Do you drink because you are shy with other people?
4. Is drinking affecting your reputation?
5. Have you ever felt remorse after drinking?
6. Have you gotten into financial difficulties as a result of drinking?
7. Do you turn to lower companions and an inferior environment when drinking?
8. Does your drinking make you careless of your family's welfare?
9. Has your ambition decreased since drinking?
10. Do you crave a drink at a definite time daily?
11. Do you want a drink the next morning?
12. Does drinking cause you to have difficulty in sleeping?
13. Has your efficiency decreased since drinking?
14. Is drinking jeopardizing your job or business?
15. Do you drink alone?
16. Have you ever had a complete loss of memory as a result of drinking?
17. Do you drink to escape from worries or trouble?
18. Has your physician ever treated you for drinking?
19. Do you drink to build up your self confidence?
20. Have you ever been to a hospital or institution on account of drinking?

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

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

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

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

THE RESCUE MISSION

San Francisco, California

November 1, 1997

Dear Sir:

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

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

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

Please advise by return mail.

Yours in Faith,

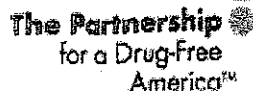
Reverend Elton Manko Jones
Rescue Mission-San Francisco

EMJ/gf

CODEPENDENCY

I. Definitions:

- A. Rescuer, Caretaker, Enabler
- B. "a person who has let someone else's behavior affect him or her and is obsessed with controlling other people's behavior." M. Beattie
- C. "a relationship addiction in which people predictably give their power over to others to such an extent that they neglect their own needs and their lives become increasingly distressed."
- D. "person who intervenes in such a way as to prevent another person from facing the consequences of their actions."
- E. "addicted to another person"



13 MYTHS ABOUT DRUG ABUSE & TREATMENT

3/13/2006 10:39:32 AM

Myth #1: Drug addiction is voluntary behavior.

A person starts out as an occasional drug user, and that is a voluntary decision. But as times passes, something happens, and that person goes from being a voluntary drug user to being a compulsive drug user. Why? Because over time, continued use of addictive drugs changes your brain -- at times in dramatic, toxic ways, at others in more subtle ways, but virtually always in ways that result in compulsive and even uncontrollable drug use.

Myth #2: More than anything else, drug addiction is a character flaw.

Drug addiction is a brain disease. Every type of drug of abuse has its own individual mechanism for changing how the brain functions. But regardless of which drug a person is addicted to, many of the effects it has on the brain are similar: they range from changes in the molecules and cells that make up the brain, to mood changes, to changes in memory processes and in such motor skills as walking and talking. And these changes have a huge influence on all aspects of a person's behavior. The drug becomes the single most powerful motivator in a drug abuser's existence. He or she will do almost anything for the drug. This comes about because drug use has changed the individual's brain and its functioning in critical ways.

Myth #3: You have to want drug treatment for it to be effective.

Virtually no one wants drug treatment. Two of the primary reasons people seek drug treatment are because the court ordered them to do so, or because loved ones urged them to seek treatment. Many scientific studies have shown convincingly that those who enter drug treatment programs in which they face "high pressure" to confront and attempt to surmount their addiction do comparatively better in treatment, regardless of the reason they sought treatment in the first place.

Myth #4: Treatment for drug addiction should be a one-shot deal.

Like many other illnesses, drug addiction typically is a chronic disorder. To be sure, some people can quit drug use "cold turkey," or they can quit after receiving treatment just one time at a rehabilitation facility. But most of those who abuse drugs require longer-term treatment and, in many instances, repeated treatments.

Myth #5: We should strive to find a "magic bullet" to treat all forms of drug abuse.

There is no "one size fits all" form of drug treatment, much less a magic bullet that suddenly will cure addiction. Different people have different drug abuse-related problems. And they respond very differently to similar forms of treatment, even when they're abusing the same drug. As a result, drug addicts need an array of treatments and services tailored to address their unique needs.

Myth #6: People don't need treatment. They can stop using drugs if they really want to.

FACT: It is extremely difficult for people addicted to drugs to achieve and maintain long-term abstinence. Research shows long-term drug use actually changes a person's brain function, causing them to crave the drug even more, making it increasingly difficult for the person to quit. Especially for adolescents, intervening and stopping substance abuse early is important, as children become addicted to drugs much faster than adults and risk greater physical, mental and psychological harm from illicit drug use.

MYTH #7: Treatment just doesn't work.

FACT: Treatment can help people. Studies show drug treatment reduces drug use by 40 to 60 percent and can significantly decrease criminal activity during and after treatment. There is also evidence that drug addiction treatment reduces the risk of HIV infection (intravenous -drug users who enter and stay in treatment are up to six times less likely to become infected with HIV than other users) and improves the prospects for employment, with gains of up to 40 percent after treatment.

MYTH #8: Nobody will voluntarily seek treatment until they hit 'rock bottom.'

FACT: There are many things that can motivate a person to enter and complete substance abuse treatment before they hit "rock bottom." Pressure from family members and employers, as well as personal recognition that they have a problem, can be powerful motivating factors for individuals to seek treatment. For teens, parents and school administrators are often driving forces in getting them into treatment once problems at home or in school develop but before situations become dire.

RELATED ARTICLES

[Understanding Addiction](#)

Myths and Facts | Drug Abuse | Treatment

Seventeen percent of adolescents entering treatment in 1999 were self- or individual referrals, while 11 percent were referred through schools.

MYTH #9: You can't force someone into treatment.

FACT: Treatment does not have to be voluntary. People coerced into treatment by the legal system can be just as successful as those who enter treatment voluntarily. Sometimes they do better, as they are more likely to remain in treatment longer and to complete the program. In 1999, over half of adolescents admitted into treatment were directed to do so by the criminal justice system.

MYTH #10: There should be a standard treatment program for everyone.

FACT: One treatment method is not necessarily appropriate for everyone. The best programs develop an individual treatment plan based on a thorough assessment of the individual's problems. These plans may combine a variety of methods tailored to address each person's specific needs and may include behavioral therapy (such as counseling, cognitive therapy or psychotherapy), medications, or a combination. Referrals to other medical, psychological and social services may also be crucial components of treatment for many people. Furthermore, treatment for teens varies depending on the child's age, maturity and family/peer environment, and relies more heavily than adult treatment on family involvement during the recovery process. "[They] must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences)."

MYTH #11: If you've tried one doctor or treatment program, you've tried them all.

FACT: Not every doctor or program may be the right fit for someone seeking treatment. For many, finding an approach that is personally effective for treating their addiction can mean trying out several different doctors and/or treatment centers before a perfect "match" is found between patient and program.

MYTH #12: People can successfully finish drug abuse treatment in a couple of weeks if they're truly motivated.

FACT: Research indicates a minimum of 90 days of treatment for residential and outpatient drug-free programs, and 21 days for short-term inpatient programs to have an effect. To maintain the treatment effect, follow up supervision and support are essential. In all recovery programs the best predictor of success is the length of treatment. Patients who remain at least a year are more than twice as likely to remain drug free, and a recent study showed adolescents who met or exceeded the minimum treatment time were over one and a half times more likely to abstain from drug and alcohol use. However, completing a treatment program is merely the first step in the struggle for recovery that can extend throughout a person's entire lifetime.

MYTH #13: People who continue to abuse drugs after treatment are hopeless.

FACT: Drug addiction is a chronic disorder; occasional relapse does not mean failure. Psychological stress from work or family problems, social cues (i.e. meeting individuals from one's drug-using past), or their environment (i.e. encountering streets, objects, or even smells associated with drug use) can easily trigger a relapse. Addicts are most vulnerable to drug use during the few months immediately following their release from treatment. Children are especially at risk for relapse when forced to return to family and environmental situations that initially led them to abuse substances. Recovery is a long process and frequently requires multiple treatment attempts before complete and consistent sobriety can be achieved.

SOURCES (unless otherwise noted): Principles of Drug Addiction Treatment: A Research-Based Guide. (October 1999). National Institute on Drug Abuse, National Institute of Health; Alan I. Leshner, Ph.D., former Director of the National Institute on Drug Abuse (2001)



UNDERSTANDING ADDICTION

3/13/2006 10:47:35 AM

Summary of the paper [Addiction is a Brain Disease](#) by Dr. Alan Leshner, former Director of the National Institute on Drug Abuse (2001). The full report is [here](#).

Most scientists now consider addiction a brain disease: a condition caused by persistent changes to brain structure and function. Using drugs repeatedly over time changes brain structure and function in fundamental and long lasting ways that can persist long after the individual stops using them. After a certain amount of a drug is consumed, and that amount is different for everyone, it is as if a switch in the brain is flipped from normal to addict.

Addiction is defined as uncontrollable, compulsive drug craving, seeking and use even in the face of negative health and social consequences. Very few people are able to return to occasional use after becoming addicted.

But, as we know, not everyone who uses drugs becomes addicted. Some people can become addicted more easily and quickly than others. Estimates are that 50 to 70 percent of these differences in susceptibility to addiction are genetic. Still, the author reminds that genes do not doom one to become an addict.

What understanding addiction as a brain disease means

Many people believe that drug addiction is a failure of will. Research contradicts this. However, this does not mean the addict is simply a hapless victim, nor does it absolve the addict of responsibility for his or her behavior. But it does explain why an addict cannot stop using by sheer force of will alone.

The paper draws parallels between addiction and other chronic reoccurring illnesses such as asthma, diabetes and hypertension and reminds us that voluntary behaviors (here the decision to try drugs) are involved in other illnesses. Hypertension, cardiovascular disease, diabetes and some forms of cancer are heavily influenced by the individual's eating, exercise, smoking and other behaviors.

How do you treat addiction?

Research finds that the best forms of treatment heal the entire individual, combining medication, behavioral therapy, social services and rehabilitation.

Another crucial finding on drug treatment is that it does not need to be completely voluntary to work. In fact, studies suggest that increased pressure to stay in treatment -- whether from the legal system, or from family members or employers -- increases the amount of time patients remain in treatment and improves their treatment outcomes.

What you can do to help a person with drug addiction

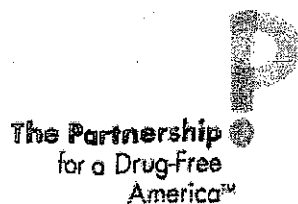
1. Understand that while a person who is addicted to drugs made the choice to try the drug, they did not choose to become addicted. An addicted person's brain is functioning abnormally and their drug use is out of their control. They need and deserve the same medical treatment as anyone else with a chronic illness would receive.
2. Find them a treatment program that treats all of their individual problems together, such as drug addiction, behavioral issues, mental illness and/or life skills.
3. Since treatment does not have to be voluntary to work, consider involving the justice system, employer or other

Read the full report [Addiction is a Brain Disease](#) by Alan I. Leshner

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STAGES OF SUBSTANCE ABUSE

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Experimentation, regular use, risky use, dependence, and addiction are the stages of substance use. Related behaviors can be addressed and treated, if necessary, at any stage – despite popular myths, people do not need to “hit bottom” or become addicted before they can benefit from help.

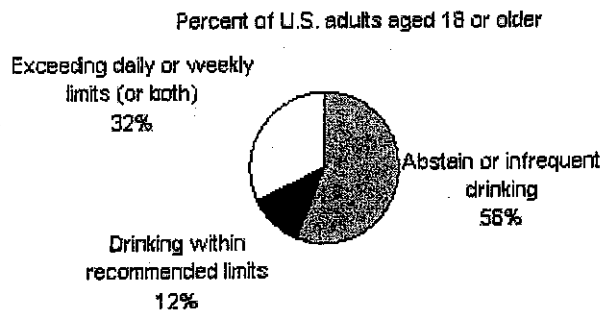
EXPERIMENTATION

Substance use starts with experimentation -- or the voluntary use of alcohol or other drugs. Frequently, the person experimenting is trying to erase another problem. An older person may self-medicate by drinking to cope with depression after losing a spouse. A teenager, angry about his parents' divorce, could start smoking marijuana or huffing inhalants. Experimentation may even include a husband taking his wife's prescription painkillers to cope with a back problem.

In all of these cases, the substance *seems* to solve the problem. So the person takes more, and moves from experimentation to regular use, the next stage. Some people will stay in this stage indefinitely, will not develop a problem, and will probably stop by themselves. But others will start using substances in a manner that is risky or hazardous to themselves or to others. Smoking marijuana and driving is an example of a risky behavior. Or having unprotected sex. So is binge drinking (having more than the recommended amount of alcohol at one occasion).

REGULAR TO RISKY USE

If, when, and how the transition from regular to risky use happens differs for every individual. And while it doesn't happen to everyone, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that nearly one-third of Americans engage in risky drinking patterns.



As a result, what constitutes “risky behavior” by another person can be difficult to gauge — unless it's obvious, of course. If someone's behavior worries you, you owe it to yourself and them to say something. The slope from risky behavior to dependence is slippery, and there are interventions for risky users that can reduce harm.

Alcohol or drug dependence follows risky behavior. According to Maryann Amodeo, Director of the Alcohol and Drug Institute for Policy, Training and Research at Boston University, the characteristics of dependence include:

1. repeated use of alcohol or other drugs leading to failure to fulfill major responsibilities related to work, family, school or other roles
2. repeatedly drinking or using drugs in situations that are physically hazardous, such as driving while intoxicated or using heavy machinery when intoxicated
3. repeated legal problems

At this stage, alcohol or other drug use may not yet be compulsive and out of control. Many dependent people are able to work, maintain family relationships and friendships, and limit their use of alcohol or other drugs to certain time periods, such as evenings or weekends. But it's also difficult for them and for others to see the effect their substance use may be having on themselves, friends, and family members. And again, there are appropriate interventions for substance users in this stage, and

Stages of Substance Abuse | Warning Signs | Help

those around them.

ADDICTION

The last phase of the spectrum of substance use problems is addiction. Addiction is a medical condition involving serious psychological and physical changes from repeated heavy use of alcohol, other drugs, or both. The symptoms of addiction are: uncontrollable alcohol or other drug craving, seeking, and use that persists even in the face of negative consequences. It is a progressive illness, meaning it gets worse over time if left untreated. It is also chronic, or long-standing (versus acute, or short-term).

Addiction is also a treatable illness. Recovery rates for people who go through treatment are very similar to those who get treatment for other chronic diseases such as diabetes and asthma. There are a number of treatment methods and community resources, including outpatient or residential treatment programs and twelve-step groups. These approaches can be customized to fit the needs of the individual and family. Learn more about understanding addiction.

And remember: substance use can be addressed before it becomes an addiction or a dependence.

[Source: Mary Ann Amodeo/Join Together]

SIGNS SOMEONE IS USING DRUGS OR ALCOHOL

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If you notice unexplained changes in physical appearance or behavior, it may be a sign of substance use – or it could be a sign of another problem. You will not know definitively until a professional does a screening.

Physical Signs

- Change in sleeping patterns
- Bloodshot eyes
- Slurred or agitated speech
- Sudden or dramatic weight loss or gain
- Skin abrasions/bruises
- Neglected appearance/poor hygiene
- Sick more frequently
- Accidents or injuries

Behavioral Signs

- Hiding use; lying and covering up
- Sense that the person will "do anything" to use again regardless of consequences
- Loss of control or choice of use (drug-seeking behavior)
- Loss of interest in previously enjoyed activities
- Emotional instability
- Hyperactive or hyper-aggressive
- Depression
- Missing school or work
- Failure to fulfill responsibilities at school or work
- Complaints from teachers or co-workers
- Reports of intoxication at school or work
- Furtive or secretive behavior
- Avoiding eye contact
- Locked doors
- Going out every night
- Change in friends or peer group
- Change in clothing or appearance
- Unusual smells on clothing or breath
- Heavy use of over-the-counter preparations to reduce eye reddening, nasal irritation, or bad breath
- Hidden stashes of alcohol
- Alcohol missing from your supply
- Prescription medicine missing
- Money missing
- Valuables missing
- Disappearances for long periods of time
- Running away
- Secretive phone calls

RELATED ARTICLES

[Signs of Abuse Related to Particular Substances](#)

[How to tell if your child is using an illicit substance](#)

[Is Your Child Using?](#)

Intervention Quick Guide

The word "Intervention" is commonly misunderstood. Our Intervention Quick Guide was created to help clarify the term intervention - and to offer information on how to go about conducting one.

So, what is an "Intervention"?

Talking to the person you're concerned about is called an "intervention". There are two types of interventions - informal and formal.

An **informal intervention** means having a personal discussion with the person you're concerned about. This could be as simple as asking a few questions or making a couple of observations.

A **formal intervention** means having a structured conversation with the person. This involves bringing together a group of people with the substance user to explore how his or her use has affected all their lives. The formal intervention is usually used when the person has repeatedly refused to get help.

The point of any intervention is to ask the person to take concrete steps to address the problem and lead them to the help they need (i.e. go for an evaluation, attend counseling, enter in- or out-patient treatment.)

The key thing is not to wait for your loved one to "bottom out," have a car crash or develop some serious health problem before you address your concerns. **Do something now.** Remember, **addiction is treatable.** And there are sensitive, trained healthcare providers who can help you decide how to proceed.

In any intervention - informal or formal - it's important to approach your loved one when he or she is not high or drunk - and when you're not deeply upset.

Here are some additional tips:

- Stay calm
- Couch your comments in concern
- Avoid labeling the person an "alcoholic" or "addict"
- Cite specific incidents resulting from the person's substance abuse ("You were recently arrested for DWI.")
- Stick to what you know firsthand, not hearsay
- Talk in "I statements," explaining how the person's behavior has affected you ("When you drive drunk, I don't sleep all night.")
- Be prepared for denial and resentment
- Be supportive and hopeful about change

What Are the Necessary Steps for a Formal Intervention?

A formal or structured intervention is a group meeting designed to help the substance user understand the problem and the need to take action and seek treatment.

The first step in a formal intervention is to **gather all the significant people** in a substance user's life, such as immediate and extended family members, physicians, friends, employers, coworkers, religious advisors, neighbors - anyone who can describe the physical and emotional changes and damages they see and experience.

Next this group **meets with a professional**, such as a family therapist or substance use counselor, to learn how to express their concern in a constructive way. The professional educates them about what to expect during the intervention and afterwards, and how they can organize their comments to avoid blaming and to increase the chance that the person will hear their messages.

Then, the group of concerned individuals and their professional guide **meet with the substance user for a conversation**. They express caring and concern, presenting facts about the impact that the substance use has had on them. They convey that they are unwilling to continue to overlook the damage that substance use is having on the person in need and on many others. They press the person to admit that a substance use problem exists and that it is causing many other problems.

The goal of an intervention is to get the person to agree to get help (attend a treatment program) immediately. Just promising to stop is considered an unacceptable outcome. Participants must clearly spell out the consequences each will impose if the person refuses treatment. These types of ultimatums can have life-shattering implications, which is why including a professional guide is so important.

10 Tips for a Formal Intervention

Goal: to have the person begin treatment immediately.

1. Enlist a professional to help plan the intervention.
2. Bring together the people most significant to the user (3 to 6 is best, no children) - the people who are concerned and who have clout with him or her. Only include people who are comfortable with the process.
3. Have a plan - decide who is going to say what.
4. Make all arrangements for the person to begin treatment immediately following the intervention. Know the insurance details and which hospital or treatment facility.

5. Identify the objections you might hear from the substance user and be prepared to answer each one.
6. Decide what consequences you're prepared to follow through with if the person refuses to enter treatment. For a teenager, it might be: "We will file a petition with the court to have you placed in treatment." For a spouse: "I will no longer cover up for you," or even: "I won't remain in this relationship with you."
7. Be prepared to follow through with these consequences if treatment is refused.
8. Tell the person that you care about him or her but explain what you are concerned about. Bring a list of examples. Be truthful and clear. Example: We love you very much, but...
9. Rehearse the intervention at least once. Know your roles.
10. Get a commitment from the person that they're willing to get help and get them there immediately.

Mandating Treatment

The vast majority of people who enter substance abuse treatment do so because of external pressure. Research has shown that required, or mandated, treatment is an effective motivator. Keep in mind that involuntary treatment can work just as well as voluntary treatment.

Why would people change if they are being forced? Wouldn't they change faster if they sought treatment voluntarily? Perhaps. But by mandating treatment, people are left with a choice: enter treatment, or lose something important to them. For example:

- Individuals arrested for driving while intoxicated may be ordered by the court to attend a driver education program and receive weekly counseling to avoid jail and keep their driver's license.
- Mothers whose ability to care for their children is compromised due to substance use disorders may be required to attend treatment so their children are not placed in foster care.
- Employees found using substances on the job may be required to attend substance abuse treatment or lose their job.

The threat of losing important relationships, good health, or reputation may motivate some to enter treatment, even if they are not enthusiastic about doing so. For this reason, the person in need should clearly hear that friends and family members will lose trust, respect, and even regular contact if the substance use continues.

What About Requiring Abstinence?

Some families tell the person to stop all drinking and drug use. However, complying can be difficult - uncontrollable alcohol or other drug craving, seeking, and use is the hallmark of addiction. If you decide to give an ultimatum, require treatment, not abstinence. People who engage in treatment will be better able to achieve abstinence, because they will be given the medical attention and emotional support they need to maintain abstinence over the long term.

What About People Who Recover Without Going to Treatment?

While treatment is not absolutely necessary for recovery, a person's ability to recover without treatment varies widely. Some people use prayer, self-help groups, active church participation, the power of example, or a very supportive employer or group of friends to recover. Others don't have the same network or life philosophy. A health care professional or substance use counselor will be able to help you make treatment decisions.

What If My Loved One Relapses?

Since addiction is a chronic disease, relapses do occur. If this happens, don't lose hope. A relapse doesn't mean that the person isn't trying, or that his/her recovery is "failing." The majority of people with addictions who are in recovery suffer at least one relapse along the way.

If relapse occurs, get back in touch with the professional or self-help group that you've worked with in the past, and prepare to intervene again. But remember, ultimately you are not in control of whether your loved one stays in recovery. You can only control how you react to his or her behavior - and how you conduct your own life.

Intervention Resources

For more information about formal interventions, or to find someone who can help you, contact The National Council on Alcoholism and Drug Dependence National Intervention Network at 1-800-654-4619 or www.ncadd.org/programs/nin/index.html or the Intervention Resource Center at 1-888-421-4321 or www.interventioninfo.org.

For more on informal interventions, visit our [Helping Others with a Problem](#) section.

Find out more about [Treatment](#) and [Recovery](#).

[Sources: Mary Ann Amodeo, Ph.D., Join Together, Herbert D. Kleber, M.D., and "Moyers on Addiction: How to Approach an Intervention" by Donna Boundy, from the companion web site to the 5 part PBS series [MOYERS ON ADDICTION: CLOSE TO HOME](#) Used with permission.]



"I Can Quit Whenever I Want"

BY PER OLA AND EMILY D'AULAIRE

Attorney Jim Heiting's drinking was going to kill him—and possibly others—if he didn't come to terms with his addiction

"I Can Quit Whenever I Want"

BY PER OLA AND EMILY D'AULAIRE

JIM HEITING, 17, was a top student at Corona High, 60 miles east of Los Angeles. Bright and athletic, the blue-eyed blond played varsity sports and was president of his senior class.

Then one evening after a football game, Jim and some friends drove to a deserted street amid orange groves. One of the boys produced a quart of mixed beverages. "One inch from every bottle in my parents' liquor cabinet," he boasted.

The youngsters started passing around the bottle. Jim, whose parents sipped wine only on occasion, had never had a drink of alcohol before. But when the bottle reached him, he thought, *Why not? Everyone else is taking slugs.*

The potent mixture burned his

throat; the second swallow hurt less. As the bottle continued around, he soon felt a warm sense of abandon.

FOR MANY, an occasional drink adds enjoyment to social gatherings. Yet for some, it can eventually lead to dependency. The process starts slowly and unthreateningly, as it did for Jim.

Ethanol, as potable alcohol is called, irritated the mucous membranes in Jim's throat. Increased mucus secretions gradually diluted this effect and caused the sensation to dwindle, then disappear.

When the ethanol molecules hit Jim's stomach, about ten to 15 percent were absorbed through the stomach wall. The rest traveled rapidly to the small intestine, where millions of ethanol molecules entered his bloodstream. Much of

the ethanol was detoxified by his liver, but enough reached his brain to produce his feelings of well-being.

THAT EVENING Jim became roaring drunk. He and his friends headed for downtown Corona at 80 m.p.h., and they eventually parked on a side street. Walking by a church, Jim heaved a metal pole through the sign announcing Sunday worship. Everyone laughed when the glass shattered.

A few minutes later, though, Jim leaned over and vomited. Then he staggered a few paces, fell and passed out. His friends drove him home. Jim's parents were gone for the evening, so his escapades went undiscovered.

ALCOHOL WORKS like a sedative drug. It affects higher thought processes first, and at greater concentrations begins to affect areas that regulate basic life functions.

The effects of increasing blood alcohol concentration (BAC), the percentage of alcohol in the blood, vary from person to person. But the first consequences are impairment of judgment and, in some cases, a loss of inhibitions. Following this, reaction time slows, after which vision, speech and balance are affected. Stumbling and loss of muscle control occur at an even higher BAC, and eventually death from respiratory arrest can occur.

JIM WOKE UP the next morning with a queasy stomach and a headache, and his mouth felt like dry cotton. But he had enjoyed what he could

remember of that night in 1966: the camaraderie and rebelliousness.

ALCOHOL DILATES blood vessels throughout the body. Widened vessels in the skin produced the warm feeling that Jim experienced the night before. Found in alcohol, chemical byproducts called congeners, sometimes combined with dilation of blood vessels in the neck and head, led to Jim's headache.

In Jim's stomach the alcohol attacked his mucin, a protective layer that keeps hydrochloric acid from eating away the lining. This caused Jim's nausea and vomiting.

JIM ENROLLED in Riverside University near his home, where he started guzzling beer at weekend parties. "I've got a hollow leg," he would boast. "I can drink anyone under the table."

Despite his weekend drinking, he got good grades and became the class valedictorian.

THOSE PRONE TO alcoholism can typically "hold their liquor" better than others. In a study at the University of California at San Diego, male college students who were drinkers but not alcoholics were given the equivalent of three to five drinks. Those who were sons of alcoholics showed a less-intense response to all the effects of alcohol compared with the sons of nonalcoholics.

Does this mean that alcoholism always and only runs in certain families? Not necessarily. There are peo-

"I CAN QUIT WHENEVER I WANT"

ple with nonalcoholic parents who develop the illness with repeated exposure to alcohol. But it's far more likely to happen to someone with a family history of the disease.

IN THE FALL of 1971, at age 22, Jim married Cindy Hudd, an attractive blonde. In the spring of 1972 he entered Western State University College of Law in Fullerton, Calif.

To pay for school, Jim worked afternoons in a modular-home factory. After attending evening classes, he tackled a graveyard shift at a wire mill.

By the time he clocked out at 7 a.m., he was too keyed up to sleep. So, sitting in bed, he'd down a 40-ounce bottle of malt liquor. "It's my sleeping medication," he assured Cindy.

Then in the summer of 1973 Jim and Cindy, along with their new son Jo-Jo, drove to Yosemite. While sipping a beer in a restaurant, Jim noticed a pamphlet that contained ten questions to help the reader recognize a drinking problem.

Jim had checked "yes" to six questions when he saw the warning at the bottom: "If you answered 'yes' to more than three questions, you're probably an alcoholic." Startled, Jim thought, *I must've misinterpreted them.*

On a second run-through, he answered yes only three times. *I can quit whenever I want*, he told himself.

One weekend soon after, Jim and

a friend split a half-pint of whiskey, then hiked into the San Bernardino Mountains. Jim was so drunk he later couldn't remember a thing.

ONE OF THE FOREMOST psychological consequences of alcoholism is denial of the problem. As for Jim's inability to recall the hike, alcohol interferes with short-term memory. While numerous theories exist, scientists still don't know exactly how alcohol produces such changes in brain function.

JIM WAS NOW painfully aware that he had a problem, and vowed each morning not to drink that day. To keep that promise, he left all his cash and credit cards on the bedside table. But as the day wore on, he'd start thinking about a drink. At five o'clock he'd casually ask one of his law clerks, "Got ten dollars I can borrow? I could use something to eat." Then he'd buy a bottle of gin and guzzle it on the way home.

On the afternoon of April 6, 1986, Jim was weaving homeward on a motorcycle he'd bought to reward himself for winning a difficult case. He had well over a pint of gin under his belt. Accelerating sharply around a van, Jim passed the vehicle, then cut directly in front of it.

The bike's rear tire suddenly skidded sideways on the rain-slicked road. He overcorrected and the bike flipped, slamming on top of him. The impact broke his collarbone and every rib on his left side. It

also punctured a lung and bruised his heart.

Even after Jim's recovery, Cindy worried about his health. His eyes now had a yellow hue, and his belly and ankles were swollen. "You're killing yourself," she told him.

As THE LIVER detoxifies alcohol, it uses part of the alcohol as fuel. This takes the place of the fat that it normally relies on for energy. Fat then accumulates, and some liver cells die. The resulting scars in the liver disrupt normal flow through the blood vessels, which produces varicose veins.

In addition, bile backs up in the bloodstream, causing a yellow hue in the eyes and skin. Fluids also back up beyond what the kidneys can handle, resulting in puffy ankles or a swollen belly. After years of heavy drinking, the liver can become so scarred that it no longer functions—full-blown cirrhosis—and it shuts down. The patient dies.

Alcohol also increases the levels of triglycerides in the bloodstream, causing narrowing of the arteries. It can cause the pancreas to become severely inflamed. And it can elevate blood pressure and inflame the heart muscle. The most recent available statistics show that alcohol caused an estimated 100,000 preventable deaths in one year alone in the United States, and an additional 17,699 alcohol-related traffic fatalities.

AROUND 9:30 P.M. on July 17, 1986, almost 20 years after his high-school binge, Jim polished off a pint of

bourbon and started driving to a friend's house. Suddenly he blacked out. His Jeep Cherokee barreled across a median strip and rammed into an oncoming car.

Jim suffered only an injured knee and shoulder. But when he saw the small sports car he had hit, his world came crashing in on him. The only person in the Mustang, Lucinda Wales, a 27-year-old mother of two, had somehow survived. However, both her legs were broken, her left femur was crushed and her right knee was shattered. Her right ankle, right wrist, left arm, jaw and cheek were also in fragments. Her bladder and kidneys had severe damage. Over the next four years she would undergo more than 20 operations.

Police slapped handcuffs on Jim. A test revealed he had more than three times the legal amount of alcohol in his blood. He spent the night in jail before being released on his own recognizance. Meeting with a criminal-defense lawyer, he was told, "I'll represent you on one condition: you enroll in a treatment center."

On September 1, 1986, Jim drove to the Betty Ford Center, an addiction-rehabilitation facility in Rancho Mirage.

TESTS SHOWED that Jim's blood pressure was elevated, his liver enlarged. His ability to think was impaired, a sign of alcohol-induced brain damage. The first few days he trembled from head to toe as withdrawal kicked in.

"I CAN QUIT WHENEVER I WANT"

CAT scans of alcoholics' brains show cerebral shrinking, a deterioration that slowly starts to reverse with the absence of alcohol if the condition hasn't progressed too far. In Jim's case it hadn't. He was lucky. Some victims suffer permanent brain damage to the point that they need to be institutionalized for life.

OVER THE NEXT MONTH counselors helped Jim understand that only by committing himself totally to the battle would he be able to free himself from the bottle.

When Jim "graduated" from the Betty Ford Center one month later, he feared a relapse. Seeing the "Welcome Home" banner that Cindy and the boys had strung across the garage door, he panicked. *If I go inside, what's to keep me from heading for the liquor cabinet?* "I can't stay," he told Cindy, bolting for his car.

That night Jim attended an Alcoholics Anonymous meeting, where he found the support he needed to go home and try the reunion again.

AFTER HIS SOBRIETY was established, Jim's blood pressure came down and his liver began to revert to normal size. Tests showed that his cognitive func-

tions also began to return toward their former level. The only lingering physical reminder was bone pain from his two accidents.

WHEN HIS DAY in court came, Jim pleaded guilty to felony drunk driving and served a sentence of over six months. On January 15, 1988, he was released. Later that year he started a local chapter of The Other Bar, an organization of recovering lawyers and judges. "I've taken so much from people," he told Cindy. "I need to give something back."

However, Jim had memories that wouldn't go away. In July 1995 he mustered the courage to phone Lucinda Wales and arranged to meet with her.

"You can't imagine how sorry I've been all these years," Jim told her.

"I needed to hear that," Lucinda answered. "I'm glad you're still sober."

On September 1, 1996, the tenth anniversary of his sobriety, Jim was sworn in as president of the Riverside County Bar Association. His life is now full and contented. Still, the urge for a drink occasionally returns. "The hold that alcohol can get on you is terrible," Jim says. "I thank God every day that I'm sober."

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COLAP

Peer to Peer Information

1. Long explanatory version/Cover Page for Questionnaire

**ABA Commission on Lawyer Assistance Programs
Judicial Assistance Initiative
Peer to Peer
800-219-6474**

The ABA/COLAP Judicial Assistance Initiative has established a list of judges throughout North America who are willing to share their recovery experiences with their peers on the bench. These judges have volunteered to be a personal resource to other judges in their jurisdiction or throughout the US and Canada and share their experience, strength and hope around myriad recovery issues. A judge who is interested in being connected with a Peer to Peer Volunteer Judge can call the National Judges' Hotline (800-219-6474) created to facilitate this pairing. The Hotline is answered during normal business hours by the staff of the Texas Lawyers' Assistance Program in Austin, Texas. All information relating to the Peer to Peer program obtained by TLAP is protected under the statutory confidentiality protections of TLAP, the collected commitment of the members of the ABA Commission on Lawyer Assistance Programs and the personal commitment of the TLAP director, Ann D. Foster, JD, LPC-Intern, a recovering individual.

2. Short Version to be placed at bottom of Peer to Peer Questionnaire:

ALL INFORMATION REGARDING THE PEER TO PEER VOLUNTEER JUDGES' QUESTIONNAIRE WILL BE KEPT ENTIRELY CONFIDENTIAL AND DEPOSITED EXCLUSIVELY WITH THE TEXAS LAWYERS' ASSISTANCE PROGRAM AND ITS DIRECTOR, ANN D. FOSTER, JD. CONFIDENTIALITY IS PROVIDED BY THE TEXAS HEALTH & SAFETY CODE, CHAPTER 467.

Addiction and the Legal Profession

1. Addiction – General Discussion

Magnitude of the Problem

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

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

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

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

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

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

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

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

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

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

Addiction – Specifics within the Legal Profession

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

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

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

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

1.3 Substance Abuse, Addiction and the Workplace

As extensively outlined in Alcohol and the Workplace, an article by Karen Clopton in the July 2001 issue of the California Bar Journal, alcoholism is a covered disability under the *Americans with Disabilities Act (ADA)*, the *California Fair Employment and Housing Act (FEHA)*, and federally, under those governed by Sections 501, 503 and 504 of the *Rehabilitation Act* 29USCA §2612 (a)(1)(D). Under the *Family Medical Leave Act (FMLA)*, it is also deemed a serious health condition.

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

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

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

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

The Implications of the Disease

Personally: marriages, family life and other social relationships

suffer

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

productivity:

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

Symptoms of Dependency:

- 1) Tolerance, needing more of the substance to produce the desired effect;
- 2) A variety of withdrawal symptoms, which are treated with repeated use of the substance;
- 3) Increased use, drinking or using more than planned;
- 4) Craving, an overwhelming desire to use the substance;
- 5) Continued use in spite of problems;
- 6) Much time spent procuring, hiding and obsessing about getting or using the substance;
- 7) Repeated failed attempts to control use;
- 8) Isolation, loss of interest and abandonment of many social activities.

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

Symptoms of abuse:

- 1) Failure to fulfill home or workplace responsibilities.
- 2) Physically dangerous use, e.g., driving under the influence.
- 3) Legal problems;
- 4) Continued use in the face of legal and/or personal consequences.

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

Treatment and Assistance

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

Consultants throughout the state can bring a panel to a law firm, law school, corporation, the judiciary etc. It operates a 24hr/7day support hotline (800-222-0767).

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

Interventions, done with the guidance of a trained interventionist, can often be used to successfully persuade the substance abuser that he or she needs treatment.

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

accompany addiction are more easily penetrated.

The Lawyer Assistance Program

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

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

Conclusion

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

SOME SIGNS and SYMPTOMS of CHEMICAL DEPENDENCY
 (with thanks to Florida Lawyers Assistance, Inc.)

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

**DOS and DON'TS:
FOR THE FAMILIES, FRIENDS AND CO-WORKERS
OF ALCOHOLICS AND OTHER DRUG-DEPENDENT PEOPLE**

- DO** talk to someone who understands the disease of alcoholism and other drug addictions.
 - DO** learn the facts about chemical dependency.
 - DO** develop an attitude to match the facts.
 - DO** go to Al-Anon and/or seek professional help.
 - DO** learn about yourself, your needs, desires, reactions and behavior patterns.
 - DO** maintain a healthy and consistent atmosphere in your home or workplace as much as possible.
 - DO** take care of your needs and let the addicted person take care of his/her needs.
 - DO** share your knowledge with others.
 - DO** be committed to your own growth, health and life goals -- be constructively selfish.
- *****
- DON'T** preach and lecture to the person addicted to alcohol or other drugs.
 - DON'T** make excuses for the chemically dependent person.
 - DON'T** rescue -- let them clear up his or her own mistakes and assume the responsibility for the consequences of his or her drinking behavior.
 - DON'T** make threats you won't carry out.
 - DON'T** believe that you are the cause of the other person's alcoholism or drug dependency.
 - DON'T** suffer for the chemically dependent person.
 - DON'T** protect the chemically dependent person from alcohol or drinking situations whether he or she is drinking or in a program of recovery.

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

A SELF TEST

Use this questionnaire to assess alcohol and/or chemical dependency problems.

1. Are my associates, clients, or support personnel alleging that my alcohol/drug use is interfering with my work?
2. Do I plan my office routine around my alcohol/drug use?
3. Am I fooling myself into believing that drinking at business lunches is really necessary?
4. Do I ever feel I need alcohol/drugs to face certain situations?
5. Do I frequently use alcohol/drugs alone?
6. Because of my alcohol/drug use, have I ever had a loss of memory when I was apparently conscious and functioning?
7. Has my ambition or efficiency decreased since I began to drink or use drugs?
8. Do I ever use alcohol/drugs before meetings or court appearances to calm my nerves, gain courage, or improve performance?
9. Do I want, or take, alcohol/drugs first thing in the morning?
10. Have I missed or adjourned closings, court appearances, or other appointments because of my alcohol/drug use?
11. Due to my use of alcohol/drugs, have I ever felt any of the following: fear, remorse, guilt, loneliness, depression, severe anxiety, or a feeling of impending doom?
12. Is alcohol/drug use making me careless of my family's welfare or of other personal responsibilities?
13. Does my alcohol/drug use lead me to questionable environments or acquaintances?
14. Have I neglected food, hygiene, health care?
15. Have I ever neglected my office administration or misused funds because of my alcohol/drug use?
16. Am I becoming increasingly reluctant to face my clients or colleagues in order to hide my alcohol/drug use?
17. Have I ever had the shakes, the sweats, or hallucinations as the result of my alcohol/drug use?
18. Do I lie to hide the amount I am drinking or using drugs?
19. Could disturbed or fitful sleeping be the result of my alcohol/drug use?
20. Have I avoided important social, occupational, or recreational activities as a result of my alcohol/drug use?

If you have answered **YES** to more than one of the above questions, it is time to seek help. You do not have to manage it alone. Don't put off calling while you are trying to decide whether things are bad enough. You do not have to lose your license, reputation, or family before reaching out for assistance.

How Can a Firm or Corporation Deal With the Issue of A Partner or Employee who is abusing Substances?

Promptly—addiction is a disease that gets worse, never better. It is Important for the firm as well as the individual involved To break through DENIAL and address the problem.

Firmly---- Set boundaries, conditions for the individual in the workplace. INTERVENTION??? The addict senses when and where there Is wiggle room, and often will not get help without an ultimatum. They may be in their own denial.

Openly----With discretion, of course, and respecting privacy and Employment law issues, but do need feed paranoia. Focus directly on how the substance abuse affects work quality and performance. Be specific. Share with others on a “need to know” basis.

Employment Law Issues turn on the status of the relationship, whether employee or partner. Some criteria:

Power to hire/fire

Right to supervise

If an employee, issues of Discrimination (ADA, Family Medical Leave Act (if more than 50 employees), Privacy of medical records, Defamation arise.

One is required to respect confidentiality, and make accommodation, and not discriminate.

If a partner, issues of Fiduciary Duty apply.

Establish and maintain institutional standards so that behavioral and performance problems are identified at an early opportunity.

Identify specific performance or behavioral problems such as erratic work hours, substandard performance, observations of intoxication or impairment, unacceptable or unprofessional behavior.

Confront the lawyer with factual information and observations, and provide an opportunity for explanation or a request for assistance.

If appropriate, request an evaluation by a healthcare professional to determine whether there is a medical problem and, if so, what course of treatment is recommended.

Impose appropriate requirements, including a "last chance" or "return to work" agreement.

LAST CHANCE AGREEMENTS

In business, employers generally require employees returning from treatment to execute a "last chance agreement" or "return to work agreement." These agreements can be a constructive part of recovery. They provide job-related motivation and outline job-related responsibilities, which relate to treatment and recovery. Although they vary from workplace to workplace, most include the following elements:

- Verification that the employee is participating in a treatment program (be careful not to require too much information);
- A commitment to remain drug and alcohol² free;
- An acknowledgement that the lawyer is committed to adhere to requisite standard of behavior;
- Drug or alcohol testing if appropriate (be careful to avoid random alcohol testing for employees);
- A commitment to participate fully in recommended aftercare, 12-step meetings, or other therapy recommended by treatment counselors;
- An acknowledgement that a violation of the agreement, or its incorporated standards, will result in immediate termination; and
- Authorization to talk to treatment counselors to obtain information about compliance with treatment requirements, aftercare conditions, and to get advice about the return to work, all limited to a need to know basis and carefully drafted to protect medical privacy.

"Last chance" or "return to work" agreements are appropriate for the lawyer too; however the type of agreement might vary with the lawyer's status. Partners and shareholders who have ownership interests may work under agreements that spell out rights and responsibilities that leave little room for a mandatory extra agreement such as a last chance agreement. That may leave the firm with little leverage beyond a motion to expel the lawyer or break up the firm. But don't overlook the value of negotiation too. You may be able to work out a perfectly satisfactory return to work agreement, which protects organizational interests and, in exchange, offers practice-related assistance upon return.

² Before requiring a commitment to remain alcohol free, check with developing interpretations of the Americans with Disabilities Act. While current use of illegal drugs is not protected under the law, alcoholism is as long as it does not have a negative effect on the business operations. That may lead to a tension between the need to abstain from alcohol for purposes of treatment and recovery, and the employer's insufficient interest in monitoring off-the-job drinking habits. We don't yet know

SAMPLE: TREATMENT AND RETURN TO WORK AGREEMENT

By signing this agreement I accept and agree to the following terms and conditions which will govern my continued employment with and my return to work with [firm].

I. TREATMENT

1. I acknowledge that my work performance and/or behavior have resulted in the need for intervention and have provided a basis for the termination of my employment (or: define nature of relationship) with the firm. As a consequence, and in order to avoid the termination of my employment (expulsion from the firm), I voluntarily accept the terms of this agreement.

2. I agree to submit to an immediate evaluation by a health care professional of the firm's selection.

3. I will follow all treatment recommendations of that professional including without limitation entry into a residential treatment program.

4. I understand that I am responsible for all costs associated with the treatment program to the extent they are not covered by insurance.

5. I will authorize regular progress reports to be made to the firm during treatment (tailor to specific consent).

II. RETURN TO WORK

1. Upon completion of the recommended treatment program I understand that the firm will return me to employment.

2. Upon my return, I will review all aftercare requirements and recommendations with my supervisor (on a need to know basis).

3. I understand and acknowledge that my return to work will be conditioned upon my strict compliance with the following:

(a) Strict compliance with the treatment recommendations made by the treatment professionals with whom I have been working. Upon completion of my treatment program, a summary of those recommendations will be prepared and attached as Exhibit A to this agreement, and I will re-execute it at that time (tailor consistent with medical authorization);

(b) Complete abstention from all mood-altering substances except in strict accordance with the written authorization of a licensed physician who has been advised in advance of my treatment for substance abuse and who has reviewed any such prescription in advance with my substance abuse counselors (tailor to address off-duty alcohol use);

(c) Regular attendance at required or recommended 12-step programs.

4. For a period of two years from the date of my return to work, I agree to submit to testing to detect the presence or use of drugs (or alcohol if appropriate), on any basis including random or unannounced, and at the times and on the terms that are communicated to me by [insert authorized person or entity]. I understand that at the conclusion of the two-year period the company, in its sole discretion, may extend the period during which I will submit to drug testing for an additional year. (use caution in defining alcohol testing to avoid ADA problems)

5. I understand and acknowledge that I continue to be bound by and must adhere to all standards of professionalism, behavior and performance that are required of attorneys with the firm as they may exist from time to time, including but not limited to those set out in the firm's policy and procedure manual.

6. This agreement does not guarantee my employment or compensation for any period of time, nor does it in any way alter my status [as an at will employee]. I understand and acknowledge that strict adherence to these terms and conditions are a requirement of my continued employment with the firm and that any violation of the terms of this agreement (including its incorporated standards) will result in my immediate termination.

By my signature below I confirm that I have reviewed and considered these terms and accept them voluntarily as a constructive part of my recovery. I also acknowledge that these terms are being provided to me as an alternate to the termination of my employment. I understand that I may withdraw my consent at any time during the term of this agreement, but acknowledge that withdrawing my consent is a voluntary termination of my employment (consent to my expulsion from the firm).

Signature # 1 (at the time of intervention):

Signature # 2 (upon return to work, and incorporating aftercare recommendations)

Depression: The Parable of the Boiling Frog

By Doreen A. Diego

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

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

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

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

Major Depressive Disorder

In the United States, major depressive disorder is reported to affect nearly 14.8 million adults every year. Although this illness can develop at any age and affect both men and women, the median age at onset is 32 years old, and the

Doreen A. Diego is a case manager for the Lawyer Assistance Program of the State Bar of California. She may be reached at doreen.diego@calbar.ca.gov.

disease is more prevalent in women than in men. According to the National Institute of Mental Health, a person must exhibit five (or more) of the following symptoms during the same two-week period to qualify as having major depressive disorder (and the combination of symptoms must include one of the first two categories below):

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

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

Dysthymic Disorder

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

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

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

Froggy Went A Courtin'

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

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

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

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

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

Similarly, their personal lives are a shambles. Their relationships are either severed or dormant, and their family and intimate partnerships are typically no longer satisfying. If they have been fortunate enough to remain married or in a stable relationship, rarely do they find the kind of

fulfillment they wish for in their homes, marriages, and especially in their sex lives. They may argue with those near and dear, or they may have taken a virtual oath of silence, avoidance, or non-confrontation.

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

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

So Get Jumping!

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

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

Defense Strategies: Good in Court, Bad in Recovery

By Doreen A. Diego

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

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

Redefining Recovery

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

Lawyers may enter the recovery process for any number of reasons. For some it is addiction, for others it may be depression, anxiety, grief and loss, or a recurrent pattern of poor relational functioning with spouses, children,

Doreen A. Diego, MA, MFTI, is a case manager for the Lawyer Assistance Program of the State Bar of California. She may be reached at doreen.diego@calbar.ca.gov.

family, friends, or co-workers. Regardless, lawyers must become more aware of the various defense mechanisms that can operate in and through them, understand why they are formed, and see how they can negatively impact and sabotage the recovery process.

Understanding Defense Mechanisms

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

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

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

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

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

Unfortunately, this is not always the case.

Identifying Defense Mechanisms

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

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

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

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

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

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

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

Victimization is another favorite strategy of lawyers in recovery programs. Being the victim can have a very pow-

erful effect on how people approach you. Unlike the intimidator who uses behaviors to push people away, the victim uses behaviors to pull people closer. They elicit the sympathy and compassion of others, but not in a healthy direction that addresses their recovery.

Conquering Defense Mechanisms

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

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

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

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

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

RESOURCES

American Bar Association

http://www.americanbar.org/groups/lawyer_assistance.html for lawyer assistance resources and information across the country. National resources are listed at: <http://apps.americanbar.org/legalservices/colap/laplincs.html>
Numerous articles are linked at: <http://apps.americanbar.org/legalservices/colap/resourcelib.html>

Past issues of GP Solo, a publication of the ABA General Practice, Small Firm and Solo Division, include four theme issues "Bumps in the Road." Many topics related to addiction, mental illness, stress and others are available. Back issues may be viewed at:

http://www.americanbar.org/content/newsletter/publications/gp_solo_magazine_hope/gp_solo_magazine_index.html

Lawyers Assistance Programs

Lawyer Assistance Programs are available nationwide. Some are independent, some are under the auspices of the court and some are part of the bar association. They are listed at:

http://www.americanbar.org/groups/lawyer_assistance.html

The Other Bar (California)

1-800-222-0767 - www.otherbar.org; confidential@otherbar.org

The Other Bar is a network of recovering lawyers and judges throughout the state, dedicated to assisting others within the profession who are suffering from alcohol and substance misuse problems. They are a private, non-profit corporation founded on the principle of anonymity and provide services in strict confidentiality. The program is voluntary and open to all California lawyers, judges and law students.

American Psychological Association - www.apa.org

Numerous resources on many mental health and wellness topics. For specific information about depression visit, <http://www.apa.org/pi/aging/depression.html>

U.S. Department of Health and Human Services and Substance Abuse and Mental Health Services Administration (SAMHSA) clearinghouse for alcohol and drug information

<http://www.samhsa.gov>

This organization has a great deal of information for individuals seeking help, professionals in the helping professions and researchers. Their publications include *Substance Use Among Hispanic Adults* at <http://www.oas.samhsa.gov/2k10/HispanicAdults.html>

National Alliance on Mental Illness - www.nami.org

NAMI has information on wide variety of mental illnesses including ADHD, Bipolar Disorder, Personality Disorders, Depression, Eating Disorders, OCD, PTSD and others. There are also national and local support resources.

National Institute of Mental Health - <http://www.nimh.nih.gov/health/topics/index.shtml>

Information regarding various mental health issues, including anxiety disorders and depression.

Recovery Month - <http://www.recoverymonth.gov/>

This annual event is held every September. It features events and resources for those with substance abuse use issues and those who are about them.

National Institute on Drug Abuse - <http://drugabuse.gov/nidahome.html>

This division of the National Institutes of Health provides information on the science of drug and alcohol addiction. There are links to a wide variety of substances. An excellent pamphlet, *The Science of Addiction*, is available by mail as a PDF, in English or Spanish.

12 Step Support Meetings

<http://www overeaters.org/>; www.eatingdisordersanonymous.org

<http://www.caofmn.com/>

<http://www.sexaa.org/mlist18.htm>

<http://www.gamblersanonymous.org/>

<http://www.al-anon-alateen-msp.org/>

American Psychiatric Foundation - www.psychfoundation.org

Committed to operating programs and funding initiatives that promote awareness of mental illnesses, the effectiveness of treatment, and the importance of early intervention.

Depression and Bipolar Support Alliance - www.ndmda.org

A patient-directed organization whose purpose is to educate patients, families, and the public concerning the nature of depressive illness.

HealthyMinds.org - www.healthyminds.org

Created by the American Psychiatric Association, the site provides information on psychiatric disorders such as depression and provides help locating a psychiatrist in your local area.

Mental Health America - www.nmha.org

An association that works with over 340 affiliates to promote mental health through advocacy, education, research, and services.