



*Helping* **JUDGES**  
**JUDGES**

The Judicial Assistance Initiative:  
RESOURCES & EDUCATION

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# Judges Helping Judges

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ISBN – 10: 1-60442-731-0  
ISBN - 13: 978-1-60442-731-8  
Product Code: 3190038PDF



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AMERICAN BAR ASSOCIATION  
Commission on Lawyer Assistance Programs  
JUDGES HELPING JUDGES  
THE JUDICIAL ASSISTANCE INITIATIVE: RESOURCES & EDUCATION  
Judges' Volunteer Handbook

<b>MODULE 1 – OVERVIEW OF A JUDICIAL ASSISTANCE PROGRAM</b> .....	<b>1</b>
WHY A JUDICIAL ASSISTANCE PROGRAM? .....	1
PROPOSED JUDICIAL ASSISTANCE PROGRAM .....	2
PROPOSED MISSION STATEMENT FOR JUDICIAL ASSISTANCE .....	2
IMMUNITY AND CONFIDENTIALITY .....	3
WHY BECOME A TRAINED VOLUNTEER & INTERVENER? .....	4
PERSONAL CONSIDERATIONS FOR JUDICIAL ASSISTANCE VOLUNTEERS .....	5
POSSIBLE PROBLEMS FOR JUDICIAL ASSISTANCE VOLUNTEERS .....	6
JUDICIAL ASSISTANCE PROGRAM SERVICES .....	7
DOCUMENTATION .....	7
REFERRAL PROCESS .....	8
NOTES .....	9
<b>MODULE 2 – JUDICIAL ASSISTANCE/PEER ASSISTANCE</b> .....	<b>10</b>
PEER ASSISTANCE DEFINED .....	10
PEER ASSISTANCE POINTERS .....	11
LISTENING & RELATIONSHIP SKILLS .....	12
COMMUNICATIONS BARRIERS .....	13
NOTES .....	14
<b>MODULE 3 – ISSUES AFFECTING OTHERS</b> .....	<b>15</b>
FAMILY ISSUES .....	15
CO-WORKER ISSUES .....	16
ENABLING .....	18
ESTABLISHING LIMITS .....	20
RECOVERY PROCESS .....	22
EFFECTIVE RESPONSE TO FAMILY MEMBERS .....	23
NOTES .....	24
<b>MODULE 4 - ADDICTION</b> .....	<b>25</b>
DEFINITION OF ALCOHOLISM .....	25
CRITERIA FOR SUBSTANCE DEPENDENCE .....	26
OTHER DRUGS OF ADDICTION .....	27
COMPULSIVE BEHAVIOR .....	27
PROGRESSION IN USE .....	28
CAGE QUESTIONS: DO YOU HAVE A DRINKING PROBLEM? .....	28
DENIAL .....	29
NOTES .....	30
<b>MODULE 5 - INTERVENTION</b> .....	<b>31</b>
THEORY & OBJECTIVES .....	31
PROCESS OF PERSONAL CHANGE .....	31
TECHNIQUE & PRACTICE .....	32
PEER PROFESSIONAL APPROACH .....	34
TEAM STRUCTURE FOR JUDICIAL ASSISTANCE PROGRAM INTERVENTIONS .....	35
PREPARATION: INITIAL CONTACT & TEAM FORMATION .....	35
PLANNING MEETINGS .....	36
REHEARSAL .....	37
FINAL PREPARATIONS .....	38

THE INTERVENTION SESSION.....	39
GUIDELINES FOR INTERVENTION PARTICIPANTS.....	40
SAMPLE STATEMENTS FROM INTERVENTION PARTICIPANTS .....	41
SAMPLE LIMITS FROM INTERVENTION PARTICIPANTS .....	42
NOTES.....	42
<b>MODULE 6 – MENTAL HEALTH.....</b>	<b>43</b>
STRESS INDICATORS .....	43
STRESS.....	43
MOOD DISORDERS .....	44
CAUSES OF MOOD DISORDERS .....	46
LEVELS OF DEPRESSION .....	48
SUICIDAL THINKING .....	48
INTERVENTIONS IN MENTAL HEALTH.....	50
DEMENTIA .....	54
CO-OCCURRING DISORDERS .....	55
NOTES.....	56
<b>MODULE 7 – SUPPORT GROUPS, RESOURCES &amp; REFERENCES .....</b>	<b>57</b>
LOCATING TWELVE STEP GROUPS.....	57
SUPPORT GROUP PHONE NUMBERS .....	57
INTERNET RESOURCES.....	58
ADDICTION & RECOVERY REFERENCES.....	59
NOTES.....	60
<b>MODULE 8 – BEST PRACTICES IN COURT ADMINISTRATION TO ADDRESS THE PROBLEM OF IMPAIRED JUDGES .....</b>	<b>61</b>
INTRODUCTION.....	61
TRAINING AND EDUCATION.....	61
NEWLY ELECTED OR APPOINTED JUDGES .....	61
RESPONSIBILITIES OF JUDICIAL ADMINISTRATORS AND SUPERVISORS .....	62
SUPPORT FOR IMPAIRED JUDGES .....	62
PREVENTION STRATEGIES AND JUDICIAL WELLNESS .....	63
JUDICIAL DISCIPLINE .....	64
CONFIDENTIALITY.....	64
CONCLUSION .....	66
ABA - JUDICIAL ASSISTANCE INITIATIVE - JUDICIAL ADMINISTRATION WORKING GROUP.....	66
NOTES.....	66
<b>MODULE 9 – REFERENCE ARTICLES .....</b>	<b>67</b>
INTRODUCTION.....	67
WELLNESS.....	83
AREAS OF IMPACT ON JUDICIAL WELLNESS.....	95
ASSISTANCE – WHAT EXISTS.....	156
PERSONAL EXPERIENCE.....	204
<b>MODULE 10 – CASE CITATIONS ON JUDICIAL DISCIPLINE AND SANCTIONS .....</b>	<b>214</b>

ACKNOWLEDGMENTS

MODULE 1-7 – Adapted with permission from the Judges Volunteer handbook created by the Illinois lawyer and Judges Assistance Program.  
MODULE 8 -Submitted by the Judicial Administration Group of the Judicial Assistance Initiative of CoLAP. We acknowledge the significant suggestions of COSCA made at the February 15, 2009 meeting of the JAI which have been substantially incorporated in this draft. This re-draft, compiled by Gordon L. Doerfer as of May 13, 2009, has been submitted to the other members of the Judicial Administration Group and final revisions were made in August 2009.

*Special thanks to Bill Dressel, Gordon Doerfer and Hon. James Morrow for their work on the Education Articles and Best Practices; special thanks to Terry Harrell, Lila Judson and Hon. John Rowley for their work on the Best Practices Module.*

*A very special thanks to Noreen Braman of the New Jersey LAP for her work in editing and formatting the final copy.*

## MODULE 1 – OVERVIEW OF A JUDICIAL ASSISTANCE PROGRAM

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### WHY A JUDICIAL ASSISTANCE PROGRAM?

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

The American Bar Association estimates that fifteen to twenty percent of attorneys and judges suffer from addiction or mental illness. When these estimates are applied to Illinois lawyers in 2006, it means nearly 12,000 to 16,000 of that state's legal professionals are impaired by these problems.

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

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

Compulsive gambling problems are not frequent, but when they occur they are extremely serious and often involve financial, mental health, and legal consequences. A Judges' Assistance Program intervention model has been applied with good success in some jurisdictions and a Judges Assistance Program can refer problem gamblers to individual professionals and specialized treatment programs for assistance.

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

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

In the mid 1970's and early 1980's, the first lawyer assistance programs were created throughout the country to help legal professionals impaired by substance abuse. Lawyers and judges, particularly those who had struggled with their own addiction and found recovery, saw the impact of alcoholism in the legal community and wanted to help their colleagues. Thus began a powerful movement that has led to an important resource for those in the profession of law. Judges' Assistance Programs will certainly have a beneficial impact on these stress and emotional related issues in the judiciary.

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## PROPOSED JUDICIAL ASSISTANCE PROGRAM

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Like all members of the legal profession, judges sometimes face problems – stress, depression, balancing work and family, alcohol or drug abuse, and compulsive behaviors. But a judge’s problem is more likely to go unnoticed and untreated because of the very nature of the judge’s role in the legal system.

Judges work in isolation, often shielding their problems from colleagues and associates. They are frequently reluctant to seek help because of fear, denial, and embarrassment – even hopelessness. Above all, they are concerned about their problems becoming known and negatively impacting their status and reputation.

A Judicial Assistance Program can respond to judges who call for help with complete confidentiality and discretion. Services could include referral to professionals and treatment programs, peer support from judges who are JAP volunteers, and facilitated support groups.

Judges are often in the best position to see problems or impairment in their colleagues on the bench. Lawyers are reluctant to initiate judicial intervention for fear of retaliation by the impaired judge or alienation of other judges.

Judges can help other judges most effectively with the support of trained Judicial Assistance peer volunteer judges who understand the issues and are genuinely concerned about helping their judicial colleagues. When alcohol or drug dependency causes impairment, a peer intervention team of volunteer judges could meet with concerned individuals, educate them on the intervention process and effectively intervene on the impaired judge with the goal of getting the judge to treatment.

Intervention can interrupt the harmful, progressive, and destructive effects of chemical dependency. It is also highly effective with compulsive gambling. It is suggested that when an intervention on a judge is necessary, a volunteer team of three trained Judicial Assistance Volunteers should conduct the intervention with respect and concern.

Judges are in a unique position to recognize impairment not only in the lawyers who appear before them but also in their colleagues. Sharing your concerns with other judges about the behavior of another judge can help spot someone who needs help. Most warning signs, such as changes in personality and job performance, are key indicators that something is wrong.

A perceptive, understanding, but assertive judge can cut through the denial, enabling, and indifference and reach the impaired judge as no one else can. A Judicial Assistance Program would always be available to provide assistance when a judge expresses concern about an attorney or about another judge and ideally would work closely with the Lawyer Assistance Program.

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## PROPOSED MISSION STATEMENT FOR JUDICIAL ASSISTANCE

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A Judicial Assistance Program recognizes that addiction and mental health problems significantly impact a judge’s ability to function in a court setting and accept the responsibility to assist judges who suffer from such impairments. Its three-fold mission is:

- to protect litigants and lawyers from impaired judges,
- to help judges and their families get assistance for alcohol dependency, drug addiction, and mental health problems,

- to educate the legal community about these issues in the judiciary.

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## IMMUNITY AND CONFIDENTIALITY

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In most states the work of Lawyer Assistance Program (LAP) interveners and the actions of the individuals who come to a state or local LAP asking for help regarding a colleague, friend or loved one, are covered under state statutes or court rules relating to the confidentiality and privileged nature of reports or findings which are generated while assisting any individual seeking help from the program as well as proceedings and data relating to the course of an intervention. This results in all client interactions being held in the strictest confidence.

It is recommended that a Judicial Assistance Program either adopt similar provisions under the appropriate court rules or that legislation be propose and passed to protect the confidentiality of information gathered by the JAP during the course of its work in assisting affected judges or their families as well as provide immunity to those who participate in interventions.<sup>1</sup>

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### <sup>1</sup> A Sample Immunity Provision

ILCS EXCERPT REGARDING LAP IMMUNITY

#### **Alcoholism and Drug Reporter Immunity Act, 745 ILCS 35/4:**

§ 4. (a) Any trained intervener or fact-reporter who participates in an intervention shall not be liable in tort for any personal injuries caused by an act or omission in the course of an intervention unless the act or omission constitutes willful or wanton misconduct, and no such intervener or fact-reporter shall be liable for any cause of action in the nature of invasion of privacy, infliction of emotional distress, interference with family or business relationships, or defamation, unless that person acted with actual malice or willful intent to injure the subject of the intervention.

(b) No public or private organization or agency, or any officer, director, trustee, employee, consultant, or agent of any such agency, that sponsors, authorizes, supports, finances, or supervises the training of interveners or fact-reporters shall be liable for damages in any civil action based on the training of interveners, unless the allegedly wrongful act or omission constitutes willful or wanton misconduct. In addition, no such entity or person shall be liable for any cause of action in the nature of invasion of privacy, infliction of emotional distress, interference with family or business relationships, or defamation, unless that entity or person acted with actual malice or willful intent to injure the subject of the intervention.

(c) No person who instructs a course for interveners or fact-reporters shall be liable for damages in any civil action based on the acts or omissions of an intervener or fact-reporter who received instruction on interventions by that instructor, unless the instruction given by such instructor constitutes willful or wanton misconduct. In addition, no such instructor shall be liable for any cause of action in the nature of invasion of privacy, infliction of emotional distress, interference with family or business relationships, or defamation, unless that instructor acted with actual malice or willful intent to injure the subject of the intervention.

(d) Any fact-reporter who encourages an individual or an individual's family members to seek treatment or who, as part of the intervention process, makes a report in good faith to a trained intervener of any conduct that reasonably appears to indicate that an individual suffers from alcoholism or drug addiction shall have immunity from any liability, civil or criminal, or otherwise, that might result as a consequence of making such a report, unless the person making the report is subject to a privilege recognized by the law of this State. The good faith of any fact-reporter making such a report shall be a rebuttable presumption.

(e) All reports, findings, proceedings, and data relating to the course of any intervention, including the steps taken in preparation and implementation, are confidential and privileged and are not subject to discovery or disclosure nor are they admissible in any proceeding including, but not limited to, any civil, administrative, or criminal proceeding, and no person who participates in an intervention shall be permitted or required to testify in any proceeding as to any evidence or other matters produced, presented, or considered during an intervention. However, information, documents, or other records otherwise available from original sources are not to be construed as immune from discovery or use in a proceeding merely because they were presented during an intervention.

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Synopses of general provisions in such statutes are as follows:

- All reports, findings, proceedings, and data regarding interventions are confidential, privileged and not subject to discovery, and are inadmissible in any legal proceeding.<sup>2</sup>

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<sup>2 2</sup> A Sample of A Confidentiality Rule

Illinois Rules of Professional Conduct (Supreme Court Rules, Article VIII)  
Pertinent Excerpts:

Rule 1.6 Confidentiality of Information

- (a) Except when required under Rule 1.6(b) or permitted under Rule 1.6(c), a lawyer shall not, during or after termination of the professional relationship with a client, use or reveal a confidence or secret of the client known to the lawyer unless the client consents after disclosure.
- (b) A lawyer shall reveal information about a client to the extent it appears necessary to prevent the client from committing an act that would result in death or serious bodily harm.
- (c) A lawyer may use or reveal:
  - (1) confidences or secrets when permitted under these Rules or required by law or court order;
  - (2) the intention of a client to commit a crime in circumstances other than those enumerated in Rule 1.6(b);  
or
  - (3) confidences or secrets necessary to establish or collect the lawyer's fee or to defend the lawyer or the lawyer's employees or associates against an accusation of wrongful conduct.
- d) The relationship of trained intervener and a lawyer, judge, or law student who seeks or receives assistance through the Lawyers' Assistance Program, Inc., shall be the same as that of a lawyer and client for purposes of the application of Rule 8.1, Rule 8.3 and Rule 1.6.
- (e) Any information received by a lawyer in a formal proceeding before a trained intervener, or panel of interveners, of the Lawyers' Assistance Program, Inc., shall be deemed to have been received from a client for purposes of the application of Rules 1.6, 8.1 and 8.3.

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- Interveners who are members of any professional association that has established an assistance program to intervene in alcohol and drug-related problems, the instructors of those interveners, and the agencies of those instructors, have immunity from any tort liability that may arise from their acts or omissions relating to their interventions.
  - This immunity from tort liability applies only so long as such interveners or instructors do not act with "actual malice or willful intent to injure the subject of the intervention."
  - Persons who report facts to trained interveners, in good faith, have immunity from all liability, "civil or criminal or otherwise," relating to the course of an intervention. The good faith of any fact-reporter is a rebuttable presumption.
  - However, any information or record that is otherwise available from original sources does not become privileged merely because it has been presented in an intervention.

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## WHY BECOME A TRAINED VOLUNTEER & INTERVENER?

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Volunteers are the foundation of a Judicial Assistance Program. Although staff members are there to receive calls, meet with individuals who need assistance, and make referrals to



treatment professionals, it is the volunteers who provide direct peer support and may help carry out the interventions.

To assure all volunteers understand the JAP mission and philosophy and to provide them with up-to-date information on addiction and mental health among legal professionals, all JAP volunteers should be required to participate in JAP education and training. Any judge may attend a JAP education and training seminar to:

- Acquire a foundation of knowledge regarding the philosophy and theoretical concepts which form the basis for peer assistance and interventions; and
- Develop a capability for providing peer support to legal colleagues; and to learn how to participate in and make a contribution to the intervention process.

**Objectives of Training:** Through this education and training seminar, participants will learn to:

- Recognize symptoms of depression and maladaptive responses to stress;
- Recognize key symptoms of addiction and its effects on individuals, families and co-workers;
- Know the concepts of peer assistance and be able to provide support to colleagues impacted by depression and addiction; and
- Know the theory and concepts of intervention as a means of interrupting the illness of addiction, and be able to participate in a LAP intervention with experienced interveners.

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## PERSONAL CONSIDERATIONS FOR JUDICIAL ASSISTANCE VOLUNTEERS

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### **Benefits of Volunteering:**

- Judges may volunteer with JAP because they feel peer assistance is valuable and beneficial for the profession.
- It is personally rewarding to help others. Sharing hope and giving assistance also enhances one's own recovery experience from alcoholism, drug dependence, family dysfunction or mental illness.

### **Volunteers in 12-step recovery programs:**

- A Judicial Assistance Program will have volunteer opportunities for recovering judges to serve as either peer assistance volunteers or interveners, or both.

**Peer Assistance Volunteers:** Provide one-to-one support to colleagues who recognize they have a problem and would like to speak to a recovering attorney about recovery from addiction are receiving help for a mental health issue.

**Interveners:** Work in intervention teams to assist the colleagues, families and friends of troubled attorneys in conducting interventions to help those attorneys.

- JAP peer volunteers and many, but not all JAP interveners are in recovery from addiction themselves or have experienced mental health treatment. They may be personally involved in Alcoholics Anonymous, Al-Anon, Cocaine Anonymous, Overeaters Anonymous, Emotions Anonymous or another twelve-step program. This involvement provides an excellent foundation for understanding addiction and gives credibility to the hope offered the subject of an intervention that recovery is possible and can be successful.

A Judicial Assistance Program should require that at least one member of an intervention team be in recovery from the illness afflicting the subject.

- However, persons in recovery do need to be aware that intervention work is not the same as twelve-step work. Successful intervention work requires a clear conceptual understanding of what the intervention is designed to do: help the subject to admit a problem exists and to accept help.

#### **Volunteers Not Involved in Recovery:**

- Though not affected by any addictions themselves, those JAP volunteers who are not in recovery, but who have been trained, contribute services to JAP as trained interveners.
- Volunteers not involved in their own personal twelve-step recovery programs may have some initial difficulty understanding the power of denial and the dynamics of recovery. The best preparation for a person who has never been afflicted by the disease of addiction to alcohol or other drugs is to:

Read AA, Al-Anon and other twelve-step program literature; and  
Attend open meetings of twelve-step programs.

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### POSSIBLE PROBLEMS FOR JUDICIAL ASSISTANCE VOLUNTEERS

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**Potential Problems for Volunteers:** Volunteers should be aware of possible problem areas:

- Burn-out: Fatigue and/or disillusionment that can result from too much helping, or from having unrealistic expectations;
- De-focusing: Over-involvement in others' lives as a way of avoiding one's own issues;
- Feelings of failure: Misplaced self-criticism when an intervention does not succeed in getting a subject to immediately accept help, or when a peer counseling assignment does not work out as well as intended.

#### **Alleviation of Problems:**

- "Let Go" and practice healthy detachment as taught by Al-Anon.
- Practice respect for the dignity of each person, including you.
- Understand and accept that "success" is not the same as "winning."

The "success" of any volunteer work for JAP is never to be gauged by whether a particular peer consultation or group intervention results in the subject actually entering treatment and "getting sober," or otherwise learning to follow a way of life that will keep his or her malady in remission. JAP volunteer work is deemed to be a success whenever a subject has been shown, through the caring, personal concern of a JAP volunteer, that he or she is never alone in combating an illness. Even in the case where the subject of our efforts rejects JAP assistance outright, the most frequent result is that a "seed" of hope for recovery has been "planted," and that person may later seek help through JAP, or through some alternative resource.

Furthermore, the assistance JAP provides to the family members, friends and colleagues of an afflicted attorney is deemed to have been successful even if JAP's efforts have merely instilled some confidence in those concerned individuals that they have at least made their best efforts to do what they could to help the impaired judge.

On rare occasions, the subject of a planned intervention will decline to attend the intervention. Even in these infrequent instances, volunteer efforts are still considered to have had a significant measure of success. Valuable information will have been provided and support given to concerned individuals regarding the problem afflicting the judge. Recommendations will have been made as to their future course of action, and suggestions made to those concerned individuals that they seek help for themselves, by attending a group such as Al-Anon, if they themselves have been affected by co-dependency to the disease afflicting the judge. This approach has proven to have a beneficial impact on individuals.

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## JUDICIAL ASSISTANCE PROGRAM SERVICES

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Trained volunteers and staff members usually provide JAP services. Services could include:

- **Consultation:** Consultation should be provided to administrative and supervising judges, judicial organizations and associations, and judicial education institutes, regarding chemical dependency and mental health issues in the work place.
- **Information and Referral:** JAP should provide information to judges on issues of chemical dependency and mental health, which impact the judiciary. Referral options and recommendations are discussed with clients regarding appropriate treatment organizations, agencies and private practitioners.
- **Peer Assistance:** JAP volunteers can provide peer support to judges who identify a problem and request to meet with a colleague who has successfully managed a similar problem. Peer assistance is available to colleagues and family members, also. Most often the problem identified by the client is addiction, specifically alcoholism; however, peer assistance may address issues including mental health, gambling, etc. JAP attempts to match clients with trained volunteers who share similar demographic characteristics. Frequently a volunteer accompanies the individual to a 12-step meeting. Interventions: Intervention is a group process initiated by family, friends or colleagues with the objective of confronting a chemically dependent judge with the facts regarding his or her using behavior. An intervention is coordinated by a trained, experienced JAP volunteer intervener or a professional intervener. A JAP intervention usually includes three JAP interveners, at least one being a judge and at least one intervener that is in recovery. Interventions, which may take place in a judge's chambers, are well planned and rehearsed.
- **Education:** JAP may provide education to the judiciary on issues of addiction and mental health or such issues as stress related work problems and depression. Judicial Assistance volunteers may speak with new judges or at judicial conferences and judicial education seminars on the impact of chemical dependency in the judiciary and the services to address such issues, which are provided by JAP.

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## DOCUMENTATION

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### Record-Keeping:

- A Judicial Assistance Program should not keep long-term records on individuals. Anonymous demographic data is collected and provided to the administrative arm of the court.

- A Judicial Assistance Program's data collection should include information concerning every call which was received, which might include data about gender, age, particular problem or issue presented, judicial district and service provided

**JAP Database:** This list includes the names and addresses of all of JAP supporters, volunteers, treatment resources, members of the judiciary, and representatives of bar associations and legal organizations. This list should not be shared with any other organization.

**Volunteer List:** A list of JAP volunteers should be kept by the JAP office. This list is comprised of trained peer counselors and interveners including recovery status of each volunteer. This list is never shared with outside organizations, nor is it distributed within JAP with recovery status noted.

**Brochures and Advertisements:** Volunteers' and intervener's names and phone numbers may occasionally appear in JAP brochures and in JAP advertisements in legal publications, only with their specific permission. These volunteers and interveners may get calls directly for information — many people may feel more comfortable calling someone they know, someone who lives in their community, etc. When volunteers receive direct requests for assistance, it would be important to report these calls to the JAP office so the correct demographic information can be added to tabulated reports.

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## REFERRAL PROCESS

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**Sources of Judicial Assistance Program Cases:** Cases may come from two main sources:

**Peer assistance:** JAP's peer counseling matters will come to JAP directly from the individuals who have identified their own personal problems and are seeking assistance.

**Intervention:** Interventions come to JAP from colleagues, friends and family members who have become concerned about a judge's or a judge's family member's drinking, using or behavior problems.

### Internal Process:

**Office Calls:** The professional staff should respond to calls received by the JAP office or picked up from a JAP hotline.

**Assessment:** Staff members should conduct a telephone assessment identifying problems, existing sources of support, and resources available. If practical, staff members also meet personally with individuals for further assessment

**Consultation, Information and Referral:** Consultation and information is provided; referrals are made to appropriate agencies, self-help groups, practitioners, etc., including JAP volunteers for:

**Peer Assistance:** The JAP professional staff consults with an appropriate volunteer who is willing to accept the case. The judge-caller is never given a list of peer support volunteers or a specific peer volunteer's name without the volunteer's knowledge.

- The peer assistance volunteer telephones client. When leaving a message is necessary, the volunteer identifies him or herself as returning a call. Messages are not left identifying the volunteer with JAP without the judge's permission.

- The peer support volunteer consults with the JAP staff as appropriate, including these situations:
  - The judge is a danger to self or others — suicidal, homicidal;
  - The judge exhibits difficult or problematic behaviors;
- Further information and referral is required; or
- The need for an intervention develops.

**Intervention:** The JAP professional staff consults with an appropriate intervener who agrees to coordinate the intervention process. Interveners are matched for effectiveness and similar demographic characteristics as much as possible.

- Interveners follow the JAP intervention procedures.
- An effort should be made to have experienced interveners work with those who are less experienced in order to provide a learning environment for newer volunteers.
- **Progress Reports:** The leader of each intervention team should maintain regular contact with the JAP professional staff regarding any need for additional help, the progress of the intervention preparations, in general, and treatment referrals for the subject of the intervention.
- **Follow-up:** The JAP professional staff provides ongoing follow-up and support with judges and their families who have been the subjects of interventions. In addition, the members of every intervention team who are in recovery themselves are encouraged to make further contact with those subjects as they complete their courses of treatment. This recommendation should be implemented in the manner of an AA twelve-step call, as each recovering intervener deems appropriate given the particular needs and circumstances of a subject.
- **Direct Calls to JAP Volunteers:** All calls to interveners and peer counselors that come directly from judges seeking help should be reported to the JAP office.
  - Volunteers may handle these calls themselves, as appropriate, providing peer counseling or intervention services; or
  - The JAP professional staff should assign these matters to appropriate volunteers.
- **Crisis Calls:** Direct calls to JAP volunteers from judges in crisis should be referred to a JAP staff member during business hours and to a JAP hotline number during non-business hours. The hot-line number should be given on the JAP answering machine during non-business hours.

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NOTES

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## MODULE 2 – JUDICIAL ASSISTANCE/PEER ASSISTANCE

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### PEER ASSISTANCE DEFINED

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- Peer assistance is support given to a colleague from someone who has experienced a similar problem and managed it successfully. Peer assistance is appropriate when a person recognizes that he/she has a problem and asks for help.
- Peer assistants are not therapists or professional counselors. They are judges who share their personal recovery experience from addiction or successful mental health treatment and provide support for their peers to get help.
- Although Judicial Assistance Program “clients” may report a wide variety of problems, the most frequent request for peer assistance comes from a judge citing alcoholism or depression. Other problems cited include other drug addiction, gambling and stress.

**Relationship:** The relationship between the judge (“client”) and the (judge) volunteer will vary in intensity and duration. It may end after several telephone conversations or after attending one AA meeting together. In the case of addiction, it may be that the judge’s main concern is overcoming his or her fear in getting to those first meetings. In some instances the JAP volunteer may serve as a temporary AA sponsor. There may also be many peer assistance relationships that will mature into lasting friendships between the JAP volunteer and the judge who asked for help.

#### **Is peer assistance the same as AA Sponsorship?**

Peer assistance is the initial help needed for a person to take action in addressing a personal problem. The peer assistant shares personal experience that may be helpful to the person in taking that action. The process of sharing one’s problems with a peer is in itself very therapeutic. Peer assistance is monitored by the professional staff of the Judicial Assistance Program.

AA sponsorship is a personal decision done within the context of Alcoholics Anonymous. It could grow out of peer assistance, but this would be a completely separate decision later.

#### **Qualifications to be a Peer Assistant**

- Willingness to share your own experience as appropriate
- Willingness to set aside the time needed
- Stable in your own recovery for two years minimum
- Completion of Peer Assistance training through a Judicial Assistance Program
- Ability to listen and be empathic

**Process:**

- When a judge contacts JAP and requests help, the professional staff should assess the situation to see if the person may be appropriate for peer assistance.
- Peer assistants may be helpful in reentry issues for persons completing an intensive alcoholism/ drug rehabilitation program. This would not be in place of an AA sponsor but to assist the person in understanding some of the reentry issues involved in the legal profession.
- The caller is asked to agree to be contacted by a JAP volunteer.
- If the judge agrees, an initial match will be made between judge and peer assistant volunteer based on certain commonalities: gender, location, and other relevant characteristics.
- These shared characteristics will help the judge identify with — not distinguish him or herself from — the recovery experience shared by the volunteer.
- A volunteer is contacted and asked to consider his or her availability at this time and whether there may be any conflicts for the volunteer in this situation.
- The volunteer contacts the judge. If the volunteer gets a secretary or voicemail, the volunteer will either say he or she is “returning a call” or say he or she is from JAP — this will depend upon the judge’s indicated preference; and
- The judge and volunteer will plan when and where to meet, or they may agree to only speak over the telephone.

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**PEER ASSISTANCE POINTERS**

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**Guidelines for the Peer Assistant:**

- When contacting the person requesting help, be respectful and, above all, be honest;
- Tell the judge why you are contacting him or her, and that JAP has asked you to become involved to offer your help;
- Remind the judge of the privileged confidentiality of all JAP communications;
- Emphasize that your only purpose is to be of help, as the judge deems appropriate;
- Focus on what the judge would like to change;
- Share your own “experience, strength and hope;”
- Avoid discussion of diagnoses or clinical counseling issues;
- Offer a specific solution — such as accompanying the judge to a meeting — and help in carrying out that solution;

- Follow through in taking whatever action you may offer as soon as possible; and
- Keep JAP staff apprized of the outcome of your contact(s)/visit(s).
- The JAP staff can assist you at any time you feel there is a need for professional assessment or recommendations.
- Do not get involved in sexual relationships.
- Do not get involved in business relationships.
- If you feel your objectivity is lost, ask the JAP staff to get another person to join you or replace you.
  - If you over-identify with the person
  - If the situation becomes too emotionally intense

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## LISTENING & RELATIONSHIP SKILLS

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### Listening Skills:

1. Begin with an open, patient and caring attitude:
  - Establish rapport;
  - Be non-judgmental; and
  - Be calm and reassuring.
2. Pay careful attention to:
  - **What** is being said;
  - **How** it is being said; and
  - Body language.
3. Reflect back what you hear and see by restating and paraphrasing what was said to be sure you both clearly understand it. Maintain eye contact. Summarize the main themes and keep the focus on the client.

**Relationship Skills:** In establishing a rapport, it is important to practice:

- **Empathy:** Perceiving and identifying with the person's experiences and then communicating that perception back to that person;
- **Genuineness:** Matching your outer words and behavior with your inner feelings;
- **Respectfulness:** Communicating the belief that each person has the capacity and the responsibility to make choices;
- **Self-Disclosure:** Sharing your personal feelings, attitudes and experiences when such



disclosure is of therapeutic value for the person being helped;

- **Immediateness:** Dealing with interpersonal feelings as they are occurring;
- **Focus:** Keeping the discussion specific and personal rather than general and about others;
- **Reflection/Confrontation:** Help the person face discrepancies or inconsistencies in:
  - Verbalization and affect (*"I'm fine"* but the person doesn't look fine);
  - Verbalization and behavior (*"I'm not angry at my boss, but I've written threatening memos"*)

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## COMMUNICATIONS BARRIERS

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### Verbal Barriers to Communication:

- Moralizing;
- Advising or giving suggestions prematurely;
- Persuading using logical arguments, lecturing, instructing and arguing;
- Judging, diagnosing, making glib or dogmatic interpretations;
- Reassuring, sympathizing, consoling and excusing;
- Using sarcasm or humor that is distractive or makes light of the problem; and
- Threatening, warning and counter-attacking.

### Patterns of Responses that are Barriers to Communication:

- Using too many questions — closed vs. open questions
  - Closed questions can be answered "yes" or "no" and do not invite further disclosure of feelings and reactions. Example: "Were you angry when your wife told you she might leave?"
  - Open questions invite more discussion and shift focus from you to the person talking. Example: "How did you react when your wife told you she might leave?"
- Interrupting inappropriately or excessively;
- Dominating the interaction;
- Fostering a personal social interaction;
- Responding infrequently;
- Parroting or over-using certain phrases or clichés;
- Dwelling on the remote past; and
- Inappropriate self-disclosure.

### Role Playing Exercises:

- Reflective Listening
- Open questions
- Empathy
- Self-disclosure
- Timing

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NOTES

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## MODULE 3 – ISSUES AFFECTING OTHERS

### FAMILY ISSUES

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

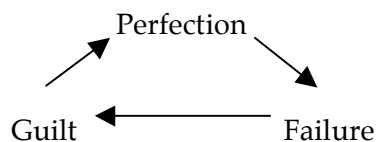
**Co-Dependence:** Families, co-workers and significant others in the addicted person's life develop many of the same symptoms from living with and reacting to chemical dependence. This syndrome is frequently labeled "co-dependence."

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

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

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

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



- **Out of Touch with Reality:** Family members believe their own rationalizations, and may have distorted perceptions of the addict's reality; and
- **Delusional Memory:** Family members become sincerely deceived as to reality.
- **Preoccupation/Obsession with the Alcoholic:** What is going on in the drinker's/user's life dominates the lives of the rest of the family.
- **Family Rules:** Don't talk, don't feel, don't trust are unspoken rules. Each person is isolated and unavailable to the others for emotional and spiritual support.

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## CO-WORKER ISSUES

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

### Co-Workers and Families:

#### Similarities of Feelings:

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

#### Similarities in Enabling Behavior:

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

#### Special Considerations for the Judicial Profession:

- **Professional Discipline:** Judges are held to a high degree of professional responsibility. Issues of substance abuse, depression and other mental impairments will increase the likelihood of a judicial misconduct complaint if not addressed quickly and effectively<sup>3</sup>

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<sup>3</sup> **The ABA Code of Judicial Conduct**

**CANON 1: A JUDGE SHALL UPHOLD AND PROMOTE THE INDEPENDENCE, INTEGRITY, AND IMPARTIALITY OF THE JUDICIARY, AND SHALL AVOID IMPROPRIETY AND THE APPEARANCE OF IMPROPRIETY.**

**RULE 1.2 *Promoting Confidence in the Judiciary:*** A judge shall act at all times in a manner that promotes public confidence in the independence, integrity, and impartiality of the judiciary, and shall avoid impropriety and the appearance of impropriety.

#### Comment

[1] Public confidence in the judiciary is eroded by improper conduct and conduct that creates the appearance of impropriety. This principle applies to both the professional and personal conduct of a judge.

[2] A judge should expect to be the subject of public scrutiny that might be viewed as burdensome if applied to other citizens, and must accept restrictions imposed by the Code.

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- **Loss of Public Trust:** Incompetent decisions in court cases damage the reputation of the justice system.<sup>4</sup>

<sup>4</sup> **CANON 2: A JUDGE SHALL PERFORM THE DUTIES OF JUDICIAL OFFICE IMPARTIALLY, COMPETENTLY, AND DILIGENTLY.**

RULE 2.14 *Disability and Impairment:* A judge having reasonable belief that the performance of a lawyer or another judge is impaired by drugs or alcohol, or by a mental, emotional, or physical condition, shall take appropriate action, which may include a confidential referral to a lawyer or judicial assistance program.

**COMMENT**

[1] "Appropriate action" means action intended and reasonably likely to help the judge or lawyer in question address the problem and prevent harm to the justice system. Depending upon the circumstances, appropriate action may include but is not limited to speaking directly to the impaired person, notifying an individual with supervisory responsibility over the impaired person, or making a referral to an assistance program.

[2] Taking or initiating corrective action by way of referral to an assistance program may satisfy a judge's responsibility under this Rule. Assistance programs have many approaches for offering help to impaired judges and lawyers, such as intervention, counseling, or referral to appropriate health care professionals. Depending upon the gravity of the conduct that has come to the judge's attention, however, the judge may be required to take other action, such as reporting the impaired judge or lawyer to the appropriate authority, agency, or body.

RULE 2.15 *Responding to Judicial and Lawyer Misconduct*

- (A) A judge having knowledge\* that another judge has committed a violation of this Code that raises a substantial question regarding the judge's honesty, trustworthiness, or fitness as a judge in other respects shall inform the appropriate authority.\*
- (B) A judge having knowledge that a lawyer has committed a violation of the Rules of Professional Conduct that raises a substantial question regarding the lawyer's honesty, trustworthiness, or fitness as a lawyer in other respects shall inform the appropriate authority.
- (C) A judge who receives information indicating a substantial likelihood that another judge has committed a violation this Code shall take appropriate action.
- (D) A judge who receives information indicating a substantial likelihood that a lawyer has committed a violation of the Rules of Professional Conduct shall take appropriate action.

**COMMENT**

[1] Taking action to address known misconduct is a judge's obligation. Paragraphs (A) and (B) impose an obligation on the judge to report to the appropriate disciplinary authority the known misconduct of another judge or a lawyer that raises a substantial question regarding the honesty, trustworthiness, or fitness of that judge or lawyer. Ignoring or denying known misconduct among one's judicial colleagues or member of the legal profession undermines a judge's responsibility to participate in efforts to ensure public respect for the justice system. This Rule limits the reporting obligation to those offenses that an independent judiciary must vigorously endeavor to prevent.

[2] A judge who does not have actual knowledge that another judge or a lawyer may have committed misconduct, but receives information dictating a substantial likelihood of such misconduct, is required to take appropriate action under paragraphs (C) and

(D). Appropriate action may include, but is not limited to, communicating directly with the judge who may have violated this Code, communicating with a supervising judge, or reporting the suspected violation to the appropriate authority or other agency or body. Similarly, actions to be taken in response to information indicating that a lawyer has committed a violation of the Rules of Professional

Conduct may include but are not limited to communicating directly with the lawyer who may have committed the violation, or reporting the suspected violation to the appropriate authority or other agency or body.

RULE 2.16 *Cooperation with Disciplinary Authorities*

- (A) A judge shall cooperate and be candid and honest with judicial and lawyer disciplinary agencies.

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(B) A judge shall not retaliate, directly or indirectly, against a person known\* or suspected to have assisted or cooperated with an investigation of a judge or a lawyer.

COMMENT

[1] Cooperation with investigations and proceedings of judicial and lawyer discipline agencies, as required in paragraph (A), instills confidence in judges' commitment to the integrity of the judicial system and the protection of the public.

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## ENABLING

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

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

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

behavior) to continue unabated.

**Locus of Control:** Enabling may be thought of as:

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

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

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

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

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

2. **Victims:** "Poor little me." Victims are people who tend to be passive as they:
  - Assume the user's responsibilities, thus enabling the drinking or drug use to continue without serious effects;
  - Accept the blame, accusations and often violence. They may believe they cause the drug/using. Anger and self-pity are common emotions;
  - Complain to others, seeking sympathy; and
  - Cooperate in silence about the drinking/using.
  
3. **Provokers:** "If you loved me, you'd change." Provokers' anger causes them to:
  - Try to force change, often by punishment and ridicule, that keep the user angry and on the defensive;
  - Try to control the drinking/using, people or situations in the user's life;
  - Feed back into the relationship fear, resentment, hurt feelings and bitterness.
  
4. **Adjusters:** "No problem, I can handle it." This is a common management response. Adjusters are fixers who:
  - Try to handle problems that occur for the users, assume responsibilities;
  - Try to make things work by reassignment of work, or relocation; and
  - Never confront the drinking/using itself as the problem.

**Examples of Enabling:**

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

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## ESTABLISHING LIMITS

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### **The Enabling Process:**

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

### **Detachment:**

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

### **Steps in Detachment:**

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

#### **1. Self-Responsibility (Self-Respect)**

- a. The beginning of detachment is developing an awareness of my own reactions, emotions and behavior. The problem behavior of the alcoholic cannot be used as an excuse for things I do that I don't respect in myself.
- b. Acceptance of personal responsibility to decide or choose my reactions rather than shifting responsibility for my own behavior to someone else.



- c. Example: *"I had become so attached (addicted) to my husband's drinking problem that my own life had become a reaction to his. I was not making decisions and choices. I explained my behavior as being caused by him and his problems. Detachment helped me to take responsibility for my own life. I realized I could no longer rely upon his problem as an excuse for my own unhealthy behavior."*
  - d. People need external support and guidance for this process to develop. Al-Anon meetings and literature are invaluable. The resistance to and fear of change will be intense and deep-seated. Catastrophes will be imagined. This process takes time and patience.
- 2. External or Relationship boundaries/limits:**
- a. Once individual boundaries have been established, and the person has established a new sense of self-respect and healthy autonomy, limits or boundaries regarding the addict can also be established.
  - b. Behavior that will not be tolerated from the addict.
  - c. Responses that will happen to continued unacceptable behaviors. These decisions, and the ability to implement them, can be a critical part of the intervention process.
  - d. The subject will test these new behaviors. Never encourage enablers to promise action that they are not able to carry out. Discourage idealistic or dramatic changes that you sense the family member or colleague will not be able to do.

**Understanding and Using Limits:**

- Many people who call for help are looking for techniques to change the problem person. Typically, they exhibit strong initial resistance to the idea that there is anything problematic about their own behavior. Family members, who probably feel very guilty about somehow "causing" the problem, will often resist the idea that there is something they can change about their own behavior that will improve the situation. They, as well as work colleagues, will often want to stay focused on the addict. They may find it threatening to look at their own reactions and choices as contributing to the problem.
- These people need to learn that there is a better, more effective way of responding to the addict's behavior. Changing their own responses will help them to feel better and thereby begin their own recovery. These changes also will have a positive impact on the problem person, but they are not focused on "fixing" the addict.
- Limit setting involves one in the process of recognizing that all people, including addicts, must be accountable for their own behavior, and that there is a limit to what anyone can or should do for another person.
- Effective limits are always natural and genuine; never artificial or manipulative. The persons involved must develop them individually.
- The volunteer can assist individuals in identifying what they need to change in

their behavior. They must understand how important it is to avoid bluffing or threatening any action they are not fully prepared to take. When the limits are tested the person must follow through or the cycle of alcoholic and co-dependent behavior will continue.

- **"Tough love"** is a phrase widely used to describe limit setting. Unfortunately it can also be an excuse for cold and uncaring behavior towards the alcoholic. It can also become a disguise for anger, punishment, and retaliation. The phrase really means making **tough** decisions about allowing the alcoholic to face the painful consequences of continued problem behavior, rather than continuing to enable by reacting in the old ways. The toughness, or firmness needs to be accompanied by love for the person. Often we best express our love and care for an individual when we are willing and able to make tough decisions.
- Articulating these decisions in a kind but firm way is the essential ingredient of a new freedom from being controlled by the situation. It is also a necessary foundation for participating in an intervention.

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

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## RECOVERY PROCESS

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

### **Alcoholic/Substance Abuser**

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

### **Family, Friends and Co-Workers**

- Intervention: Changes perception of illness and options.
- Detach: Stop enabling.

- Participates in treatment.
- Education: Symptoms and recovery.
- Acceptance: Increased self-esteem through self-responsible actions.
- New life: Planned growth through professional and self-help groups (Al-Anon, FA).

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## EFFECTIVE RESPONSE TO FAMILY MEMBERS

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**Responding to a Family's Needs:** Family members are on an emotional roller coaster. They are desperately trying to understand what is going wrong with their lives. Without realizing it, their preoccupation with their loved one's drinking/using has become the dominant thing in their lives. Most are convinced that there is something they could do that would change the situation. They usually do not realize that they have become the primary enablers that keep the cycle going. The following guidelines can help the volunteer intervener or peer assistance volunteer respond effectively.

- **Listen Carefully:** Family members need time to ventilate, to unload their frustration, anger, and fears. Ask "open" questions, such as, "Tell me what it's been like for you," rather than, "Did he come home late when he had promised to be on time?" Closed questions can be answered yes or no. Open questions invite elaboration and disclosure of how the person feels. Don't rush to get facts. They will come out naturally. Talking is the basis for building a relationship that can go deeper.
- **Don't Moralize, Lecture, Rescue, or Give Advice:** After good rapport has been established, it may be appropriate to share your own experience. Many family members will ask directly, "What would you do?" Don't jump at the chance, tempting as it may be. Help them clarify their choices. Many hope there are some "tricks" they haven't tried that can change the alcoholic.
- **Offer Hope and Support:** If you have Al-Anon or other similar experience, offer the hope that many others have been in similar situations and it can get better. Clarify that most of us in this situation are convinced that there is only one way for it to get better: that the alcoholic/user stop. Steer firmly in the direction that it is more realistic to start our change efforts with our own responses, so that we feel more positive about our own choices and actions.
- **Help the Family Member Explore Options:** Explain that there are no magic tricks or techniques that will change the drinking/using, but there are things they can do to stop the enabling. These positive changes will make them feel better about their own lives, and reduce the feelings of being trapped and victimized. Continue to stress the hope and support available through Al-Anon meetings and relationships.
- **Emphasize the Positive:** The most important step a family member can make

toward true freedom is to realize that choices are possible. Even if the drinker/user does not change, I can be different. Support the person in taking action. Congratulate the person for calling for help.

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NOTES

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## MODULE 4 - ADDICTION

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### DEFINITION OF ALCOHOLISM

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

Primary refers to the nature of alcoholism as a disease entity in addition to separate from other pathophysiologic states that may be associated with it. Primary suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state. Disease means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.

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

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

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

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

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

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

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## CRITERIA FOR SUBSTANCE DEPENDENCE

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

1. Tolerance, as defined by either of the following:
  - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - (b) markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following
  - (a) the characteristic withdrawal syndrome for the substance
  - (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended
4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

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

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## OTHER DRUGS OF ADDICTION

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

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

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## COMPULSIVE BEHAVIOR

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

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

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## PROGRESSION IN USE

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Most alcoholics show progression in use and its consequences:

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

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## CAGE QUESTIONS: DO YOU HAVE A DRINKING PROBLEM?

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### The CAGE Questions:

- Have you ever felt the need to **cut down** on your drinking (or drug use)?
- Have you ever been **annoyed** by criticism of your drinking (or drug use)?
- Have you ever felt **guilty** about your drinking (or drug use)?
- Have you ever had a morning **eye-opener** (used drugs/alcohol first thing in the morning to get started or to relieve withdrawal)?

**Interpretation:** The total number of “yes” answers indicates:

1. Possible alcohol or drug problem; discuss further with patient;
2. Probable alcohol or drug problem, diagnostic assessment necessary to confirm or rule out alcohol/drug abuse or dependence; and
- 3 - 4. Nearly diagnostic by itself.



## CAGE References:

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## DENIAL

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

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

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

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

### Addiction + Denial = Denial System:

- Gradual Progressive Onset: The denial mechanism allows the user, family, and coworkers to transform abnormal problem behavior into normal behavior;
- There is a chemical effect on the brain's ability to perceive accurately; and
- The sporadic or intermittent appearance of problem behavior tricks and deceives the user and others into thinking;

- It's not a disease;
- It's not permanent — it will go away by itself; and
- It's under willful control.

**Professionals and Denial:**

- High intelligence and verbal skills intensify a denial system:
- Usually control and manage others; and
- Work patterns and productivity not easily measured and monitored.

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

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

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NOTES

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## MODULE 5 - INTERVENTION

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### THEORY & OBJECTIVES

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**Definition:** An interpersonal group process in which a subject with serious personal problems connected with alcohol and/or other drug use is confronted with specific facts, as known by significant others, in a planned, objective manner. The process is developed out of concern and love for the person.

**Objectives:** The three principle objectives of an intervention are to:

**Surround the subject with reality to dismantle denial:**

- The process provides an emotionally powerful assault on the subject's denial system. The subject hears facts and feelings; and
- This “reality” is an organized presentation of first hand FACTS as experienced and known by the reporters. This destroys the subject's delusional perception of reality.

**Stop the enabling of the subject's behavior by family and colleagues:**

- The family and colleagues need education and support to identify and recognize their enabling behavior; and
- They need to develop a plan to replace the enabling behavior with reality-based, self-responsible action.
  - Develop and implement genuine limits; and
  - Begin to practice new behavior.

**Initiate change:**

- Reduce defensiveness and resistance to change by surrounding subject with:
  - Love and concern for the individual; and
  - Communication from team member who has “been there.”
- The team presents a clear, concrete plan of action to remedy the problem; and
- The family and colleagues experience the tremendous relief and self-esteem of being honest and action-oriented with the subject.

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### PROCESS OF PERSONAL CHANGE

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**Personal Change:** The process of making personal change is challenging when it involves problems that are perceived by the individual as a weakness or deficit. There is the natural reluctance to admit problems, compounded by a resistance to making changes. This resistance includes inertia, comfort with the known, learned helplessness, fear of looking bad, etc.

The only point in time where any personal change will occur comes at the intersection of two forces:

- The natural resistance to change; and
- The negative consequences of behavior.

**Purpose of Intervention:** Intervention is a process, either formal or informal, which helps the intersection of the two forces to occur sooner than would happen without any action on the part of significant others. Interventions have the effect of shortening the period of time necessary for individuals to reach a point where their natural resistance to change is at last exceeded by their reluctance to face the negative consequences of their behavior. As the pain resulting from their behavior is increased, their resistance to change that behavior is decreased. Intervention creates no new forces; but does capitalize on the existing dynamics. It clarifies and accelerates those dynamics to help the subject take the next step needed for change to occur.

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## TECHNIQUE & PRACTICE

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**Preparation:** Preparation is absolutely essential in order to handle effectively: volunteer;

- Emotions about the illness and associated behavior;
- Anger and counter-charges by the subject; and
- Emotions about the subject.

**Writing:** Writing is an important tool. It:

- Helps clarify perceptions and feelings;
- Stimulates memory of events and reactions;
- Becomes a foundation for what is said;
- Begins the process of objectifying; and
- Communicates the seriousness of the process.

**Set Limits and Consequences:** Participants must establish limits and consequences:

- The new boundaries and plans for action must be based in reality; and
- Threats or punishments that have been tried before unsuccessfully, or limits that are not sincere and genuine, are to be avoided.

**Rehearse the Intervention:** Interventions must be rehearsed to:

- Help participants become comfortable with both the procedure and the content; and
- Allow the team leadership to make assessments as to readiness.

**Concerns for Family Members:** To further help the participants, team members should:

- Evaluate the emotional readiness of each family member to avoid trying to push him or her beyond their emotional capabilities. For some family members, frustration and anger have often peaked in the aftermath of a particular incident, however, once the reality of the intervention process becomes clear, they lose their willingness to proceed;
- When appropriate, refer family members and/or colleagues to literature, Al-Anon, other 12-Step groups, professional counseling, or LAP/JAP assistance, if indicated.

**Never Rush an Intervention:**

- A poorly planned and executed intervention can be worse than none at all.
- Emergencies can be handled through other mechanisms, such as police, hospitals and treatment centers.

**Early “Informal” Interventions:**

- Subject sometimes “sense” the change in attitude (less restrictive, more decisive) in significant others, and seek help directly; and
- Healthy, assertive behavior by significant others may result in an “informal” intervention. If this happens, make a referral to an appropriate 12-Step group and a treatment center.

**Intervention Coordinators:** Interventions must have a **clearly defined leader** who decides:

- Who is to participate;
- What content is appropriate;
- The order of presentation;
- The ground rules;
- The physical arrangements; and
- The time and place.

**Behavior vs. Diagnosis:** Interventions focus on the need for action to address a problem. Diagnosis and treatment are the responsibilities of treatment professionals.

- The process should not stray into discussion regarding underlying causes or definitions of what defines “alcoholism” or “dependence.”
- The focus of the intervention process must stay in the facts of the problem behavior and the need for remedial action.

### **All Interventions Are “Successful”:**

- Most have the desired effect if well planned and executed;
- Even if the desired outcome is not immediate, it is a success if the significant others stop enabling and begin taking healthy steps toward their own recovery.

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## PEER PROFESSIONAL APPROACH

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### **Why Peer Assistance and Interventions Conducted by Professional Colleagues Succeed:**

- Professionals in need of help are better able to identify with, and listen to, individuals having their own educational background and coming from their own profession;
- Peers are better able to understand, and respond effectively to, the specific types of denial present in their own profession;
- Addictive illnesses have the same dynamics, regardless of occupation, but the form it takes will incorporate the culture of the profession, *e.g.*:
  - Judges
  - Lawyers
  - Clergy
  - Physicians
  - Nurses
  - Pharmacists
  - Business Executives
- Peers, especially those who have experienced the illness and a successful recovery, are in the best position to give hope to the:
  - Subject
  - Family
  - Co-Workers
- Peers are in the best position to help family and co-workers set realistic limits.
- Peers have a motivational advantage:
  - Help a peer save a career; and
  - Contribute to the well being of the profession.

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## TEAM STRUCTURE FOR JUDICIAL ASSISTANCE PROGRAM INTERVENTIONS

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**Intervention Teams:** Each team consists of three trained interveners. If possible, when the subject of an intervention is a judge, every effort is made to maximize the participation of judicial colleagues. At least one member of each team is a judge, and at least one is a person in recovery.

- All chosen for personal experience, background and willingness to take part in the project; and
- The recovering intervener will be expected to disclose his or her personal recovery experience.

**Coordinator:** Usually a judge is the Intervention Team Coordinator; however, a colleague with intervention experience or a Judicial Assistance Program Director may be a Coordinator.

- Teams develop rapport and comfort in working together;
- Teams come to an understanding of how they will work together and decide who has appropriate skills/experience for special situations.

### **Review of Team's Roles:**

- As interveners;
- As educators; and
- As a support system.

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## PREPARATION: INITIAL CONTACT & TEAM FORMATION

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### **Initial Contact:**

- **Call:** Received by one of the LAP/JAP offices, executive director, associate director, or clinical director in the LAP/JAP office, or a volunteer;
- **Initial Assessment:** The clinical director or the LAP volunteer conducts a telephone assessment identifying whether the situation is appropriate for an intervention, including:
  - An indication of an alcohol or substance abuse problem;
  - The "Central Figure" or "Subject" denies problem, refuses treatment; and
  - Family members and colleagues are identified who may be able to participate.
- **Outcome:** The initial assessment may not lead to an intervention. When an intervention is not appropriate, a peer assistance referral is available for the caller, which may lead to an intervention at a later date.

**Organizing the Team:** The clinical director and volunteer consult regarding team formation. Emphasis is placed on effectively meeting the needs of the situation, matching demographics of clients and team members as appropriate. An effort is made to have experienced interveners work with those who are less experienced, and with those who have not been a part of an intervention team. The team then:

- Convenes in person or by telephone and reviews pertinent information;
- Determines who shall be leader and allocates roles to other members;
- Gathers additional information from family and colleagues;
- Reviews findings and makes a decision whether to continue with the intervention process;
- Sets a date for a planning meeting — more than one planning meeting may be necessary; and
- Identifies appropriate treatment options by consulting with the clinical director and gathering information about insurance coverage and ability to pay for treatment costs.
- Determines which family member can be the contact person and supply information to the treatment facility? Who will be the financial guarantor? Who will check on bed availability?

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## PLANNING MEETINGS

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**Planning Meeting:** Note that there may be more than one planning meeting.

- Confidentiality must be protected throughout the process; clearly explain Rule 1.6 to all participants and reassure them that anything they say will be held in strict confidence;
- Meet with all the participating significant persons to explain the intervention concept and process;
- As to each participant, assess the particular need for further information and education regarding the disease of addiction to alcohol or drug(s);
- Have legal pads on hand; explain their use and the need for each individual to prepare in writing the facts they will present;
- Colleagues and family members frequently are reluctant to share their facts. They usually know more than they think they do. Help them discover what they know; and
- You may need to help them remember what they know and identify the events they should write.



### Family and Colleagues:

- Determine the strengths and weaknesses of each significant person. Identify those who are most appropriate to participate in the intervention. Identify who:
  - Has the ability to contribute;
  - Has the most influence;
  - Cannot control emotions; and
  - Really cares about the individual.
- Recommend professional help and self-help groups, if needed, to help them begin to plan and implement changes in their own behavior;
- Provide support and counsel them — emphasize the therapeutic value for them to say what they've seen happen in their lives;
- Prepare them for rejection — if the person says "no" what are alternative actions they will take for themselves;
- Explain the role of the recovering member of the team; and
- Summarize what has occurred in the planning meeting and plan the next step.

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### REHEARSAL

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#### The Rehearsal:

- **Order:** Decide who will lead off. Start with the person with the most influence and end with the second most influential;
- **Content:** Ask each person to give specific data about behavior problems they have encountered, especially those directly related to the use of alcohol/ drugs;
- **Focus:** The focus is on facts — avoid opinions and generalizations;
- **Facts Relevant to Subject:** Help them focus on incidents when the subject would feel hurt by his/her own behavior or when behavior is inappropriate;
- **Personal Experience:** All statements must describe a first person experience with dates, times, places and personal reactions. **Stress that statements of fact be written;**
- **Non-Judgmental:** Statements should be non-judgmental, but keep focus on the subject. Avoid derogatory terms: no put-downs or pejorative labels, e.g., bum, lousy rotten drunk, liar, you've never cared about us, he's an S.O.B. and always has been, etc.;
- **Concern:** Help each person to express real concern and care. A family member might say, "I really care about your welfare and I want you to join me in getting help;"

- **Objective:** Stress that participants should not personalize the reactions of the subject;
- **Personal Plans for Change:** Ask each person to identify and be prepared to state his or her own personal plans to change;
- **Confidentiality:** Again, stress confidentiality; and
- **Determine Timing:** The total intervention session should not last more than an hour — edit material as necessary.

### What's Next?

- Another meeting? Intervention next? Consider the timing of the subject's life.
- Do any of the participants need more help with their preparations?
- Does any participant need more time to prepare?
- Are more participants needed?
- Is any individual inappropriate to take part in the intervention?
- Is there a critical need to move quickly?

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## FINAL PREPARATIONS

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**Scheduling the Intervention Session:** Set a time and place for the session. Early in the morning (8:00 a.m.) is often the best time. A neutral, private setting is best. Have participants arranged transportation?

When selecting a date for the intervention, keep in mind that it is best to enter a treatment center early in the week when admissions are the smoothest – not on a Friday or Saturday when fewer staff members are present.

Are plans in place for an assessment? For treatment? Which participant will pack an overnight bag for the subject? Spouse? Family member? How will the individual get to treatment? Will someone travel with him/her?

**Seating at the Intervention:** Determine who will be present; plan their seating arrangement.

- A circular arrangement is best, so that all participants are able to see each other;
- Avoid too large of a room; it works best to have people seated near enough to each other that they are able to touch one another;
- Arrange the seating of the participants so that those who are to relate the information that is the most difficult to present are not seated immediately beside the subject; and
- Participants offering the most emotional support should be seated beside the subject.

**No New People at the Intervention:** Remember that only those at the rehearsal should be in the intervention. Never allow a newcomer to the intervention.

**Call the Subject:** The best person to do this is the Intervention team member to whom the Judge will most likely say “yes”.

- Inform him or her about the committee and the circumstances causing the call;
- Explain why the team wants to meet with him or her to "hear together how we and you see it." LAP/JAP does not practice surprise or "ambush" style of intervention;
- Inform him or her who will be attending the session — this is a judgment call since it may not be appropriate; and
- Reassure him or her of the confidentiality.

**Review:** Determine that all practical arrangements are complete:

- Arrangements for an assessment/evaluation, if that is the plan;
- Transportation, clothing packed, insurance checked;
- Coverage of professional responsibilities; and
- Coverage of personal obligations.

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## THE INTERVENTION SESSION

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### The Intervention Session:

- **Coordinator’s Role:** The coordinator of the team will set the stage, review the reasons for the meeting, and explain the role of the program and of the various persons present;
- **No Unexpected Participants:** Never allow an unexpected participant. If a participant brings one, ask the person to leave. The leader must stay in firm control;
- **Family and Colleagues:** If the group of participants includes family and partners or colleagues, it may help to separate the family from the professionals. Children and the spouse may be more comfortable without the partners present; likewise, the partners may feel better if the family is not in the room when they confront the person;
- **Confidentiality:** Remind all present of the confidentiality of the meeting;
- **Format:** Describe the format so everyone knows how the meeting will go and how long it might be. Plan the meeting to be an hour or less; and
- **Guidelines and Procedure:** Establish guidelines and procedures for the session:
  - Ask the subject to agree to listen to everyone. Explain that he or she will have a chance to talk, but only after all have spoken;

- Proceed with the intervention. Be ready to transport the person to treatment center for a professional assessment if he or she agrees to one;
- If the subject wants to “make a deal,” and it is the only option he or she will consider, make a “contract” resulting in positive action if the subject's plan fails;
- If the response is a flat “nothing doing,” accept that, but review for the subject what the consequences are likely to be, and keep the door open for a request for help. This is the point where the family and other participants should describe their limits and alternative plans;
- Failure? If the meeting falls apart completely, the leader should try to summarize, give reading material to the subject, and explain who may be called for help.

Note: Even an intervention that may seem to have failed, as when the subject declines to seek any immediate help, can often serve as the beginning for a gradual process of recovery. The members of the intervention team should be certain to let all participants know of this, and to give support and encouragement for the adoption of this attitude by every person involved.

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## GUIDELINES FOR INTERVENTION PARTICIPANTS

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**Goals:** The goals of the intervention are to have the subject:

- Hear and feel the reality of the facts being communicated;
- Accept the reality / facts to see the serious nature of the problem; and
- Receive hope and encouragement to accept the need for help.

**Guidelines:** The following guidelines may be useful for persons taking part in an intervention. Whenever possible the information should be first person. Avoid reporting what you have heard from someone else.

- Tell \_\_\_\_\_ of your deep care and concern — that you are here because of it;
- List in writing specific incidents connected with alcohol and drug use (dates, times, places) where \_\_\_\_\_'s behavior caused you concern; describe current behavior and conditions that continue to cause concern;
- Connect the problem incidents with drinking and using. The subject will probably try to talk about times when alcohol/ drugs were not a problem, or blame others for the drinking and using;
- Present these facts in a matter-of-fact way. Let the tone come from the facts;
- Tell how you felt as a result of \_\_\_\_\_'s behavior, i.e., sad, hurt, angry, concerned for spouse, family, colleague, and clients, etc.;

- Avoid opinions and generalizations. You are not in a position to make a diagnosis or identify causes. Do not use derogatory names or sarcastic put-downs. Stick to the facts; and
- Identify actual consequences/limits and plans for alternative behavior that are realistic and healthy for you. State clearly that you are ready, willing and able to follow through with these plans.

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## SAMPLE STATEMENTS FROM INTERVENTION PARTICIPANTS

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**Personal Statements:** Each person's statement should begin and end with something like:

- "I'm here because I love (care about) you. I'd like you to get help for yourself."
- "Dad, last Friday you were drinking and driving; you were arrested and charged with a DUI. I'm scared for you that you will get hurt, or hurt someone else."
- "Joe, last Wednesday I dragged you out of Jack's Bar, drove you home and helped your wife get you to bed. I was upset with you and angry because it was the fifth time in two months."
- "Mom, Tuesday morning you and I were in the bathroom at 7:00 A.M. I saw you take five Valium. Your hands were shaking; your face was pale; you looked sick and scared. I'm worried about you and I want you to get help."
- "Dad, you finished a six-pack of beer before 8:00 every night last week. Then you passed out each time. I'm angry that I never get to do anything with you any more."

**Third Party Statements:** Reports of another may be repeated, if they could be documented and you are not compromising another person's privacy:

- "Your boss called me last Friday. He said that you've been absent or late to work much more frequently lately, and that there was an odor of alcohol on your breath after lunch every day last week. I was embarrassed, and I'm afraid you're going to lose your job."
- "Yesterday our bank statement came in the mail and I found checks made out to the liquor store for a case of whiskey each week this past month. I'm angry that so much money is being spent on whiskey, and I'm scared that drinking has such a hold on you."
- "When I had my physical last month, our doctor asked how you're doing with not drinking. When I asked what he meant, he told me your last check-up indicated you're developing cirrhosis, but you told him you had quit drinking. Darling, I'm embarrassed that I didn't even know about this, and I'm worried about you."

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## SAMPLE LIMITS FROM INTERVENTION PARTICIPANTS

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Intervention participants should be prepared to “set limits” as to what they will, or will not, do should the subject of the intervention refuse to accept help. Examples of such “limits” are:

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

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## NOTES

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MODULE 6 – **MENTAL HEALTH**

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**STRESS INDICATORS**

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

<p><b>Physical Symptoms:</b></p> <ul style="list-style-type: none"><li>• Pounding heart;</li><li>• Tightened stomach;</li><li>• Neck and back pain;</li><li>• Headaches;</li><li>• Mouth and throat dryness;</li><li>• Insomnia;</li><li>• Disruption of digestion.</li></ul> <p><b>Behavioral Symptoms:</b></p> <ul style="list-style-type: none"><li>• Inability to sit still and concentrate;</li><li>• Self medicating: increased smoking, drinking, use of drugs;</li><li>• Loss or increase in appetite;</li><li>• Prone to accidents;</li><li>• Isolation.</li></ul>	<p><b>Personality Changes:</b></p> <ul style="list-style-type: none"><li>• Emotional tension and alertness;</li><li>• General irritability;</li><li>• Listlessness;</li><li>• Depression;</li><li>• Hyper-excitation;</li><li>• Diminished self-esteem.</li></ul> <p><b>Impact on Professional Performance:</b></p> <ul style="list-style-type: none"><li>• Procrastination;</li><li>• File stagnation: cases and projects are not moving forward;</li><li>• Failure to respond to phone messages;</li><li>• Making excuses;</li><li>• Lowered productivity.</li></ul>
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**STRESS**

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

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

2. Don't give in to guilt.
  - Don't let others impose it on you.
  - Don't impose guilt on yourself.
  - If you regret actions, fix them or learn from them; don't make same mistake again.
3. Develop strategies.
  - Maintain control during stressful situations by developing either an action strategy if you can identify a solution or a coping strategy if you can't.
4. Learn to accept and adapt to change.
  - Look for the opportunities, hidden or obvious, that result from change.
  - Take a leadership approach to your life.
  - Use your strategies to keep moving.
5. Change the way you look at stress.
  - Stress isn't an external force being imposed on you. It is your personal reaction to situations.
  - Try to look at stressful situations from a new angle. Look for choices and alternatives.
  - Avoid letting your fears take over.
  - Try to see the problem-solving process as a challenge, not a burden.
6. Develop a support system.
  - Have friends, co-workers, family members or counselors act as a sounding board.
7. Learn to accept the things you can't change.
  - Learn to accept a difficult situation without seeing it or yourself as hopeless.
  - Accept that life has its ups and downs. Look to the future when things will improve.
  - Don't try to suppress your feelings. Acknowledge them and get support if necessary.
  - Keep busy. Having too much free time allows you to dwell on your negative feelings.
  - Pamper yourself. Find time to recharge your emotional battery.
8. Develop your personal anti-stress regimen.
  - A program of diet, relaxation and exercise helps reduce or eliminate stress. Use techniques that conveniently fit your personal preferences and lifestyle.
9. Don't take it personally. Much of others' negative behavior is caused by the stress they experience and isn't directed toward you personally. If you "catch" their stress, you participate in a stress cycle.
10. Believe in yourself. Trust your inner strength to see you through adversity. Cultivate your sense of self-confidence.

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## MOOD DISORDERS

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



The most prevalent mood disorders are:

- Major Depression
- Dysthymia
- Bipolar Disorder
- Cyclothymia

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

### **Major Depression**

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

#### **Symptoms of major depression:**

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

#### **Symptoms of depression in the workplace:**

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

### **Dysthymia**

Dysthymia is a less severe type of depression that involves long-term (two years or more), chronic symptoms. It is not disabling but keeps one from functioning at an optimal level or from feeling good. It may be associated with episodes of major depression. Symptoms are the same as for depression except that there are no thoughts of death or suicide and no manic episodes. Dysthymia affects about 6% of adults during their lifetimes. These people typically regard their chronic low mood as normal. Because they suffer quietly and are not severely disabled, such individuals often don't come to light until a major depressive episode supervenes.

## **Bipolar Disorder**

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

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

### **Symptoms of Mania include:**

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

## **Cyclothymia**

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

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## **CAUSES OF MOOD DISORDERS**

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There are many causes of depression. These include:

- *Inherited vulnerability.* 80-90% of those with Bipolar Disorder have a relative with some form of depression. Researchers have identified several genes involved in bipolar depression, and they are looking for genes linked to other types of depression.
- *Biological factors.* Bipolar Disorder is often triggered by a disturbance in neurotransmitters that regulate mood and activity. An imbalance in the amount or activity of these neurotransmitters can cause major disturbances in thought, emotion, and behavior.
- *Environmental triggers.* Stressful life events, particularly a loss or threatened loss, can trigger depression; e.g., death of a loved one, divorce, breakup of an important relationship, loss of job, financial problems, loss of health or independence.
- *Medications.* Long-term use of certain medications may cause symptoms of depression. These include the beta-blocker Inderal, some blood pressure drugs and some drugs used to treat arthritis and Parkinson's disease.
- *Illnesses.* People with chronic illnesses such as heart disease, stroke, diabetes, cancer, and Alzheimer's disease are at high risk for developing

depression. About a fourth of stroke survivors, more than a third of Parkinson's sufferers, and a quarter of those with Alzheimer's experience major depressive disorder.

- *Personality.* Certain traits such as having low self-esteem and being overly dependent, self-critical, pessimistic, easily overwhelmed by stress can make one vulnerable to depression.
- *Alcohol, nicotine and drug abuse.* Previously experts thought that people with depression used alcohol, nicotine, and mood-altering drugs as a way to ease depression; but new studies indicate that these may actually contribute to depression and anxiety disorders. About 30% of people with major depressive disorder and 60% of those with bipolar disorder abuse alcohol and drugs. A family history of alcoholism also increases the risk of bipolar disorder. Also, people with a depressive disorder are twice as likely as those without depression to be addicted to nicotine.
- *Diet.* Deficiencies in folate and vitamin B-2 may cause symptoms of depression and a poorer response to antidepressant medications.
- *Post-partum depression.* Hormonal changes can trigger an episode of bipolar disorder in women who are genetically vulnerable.
- *Other mental disorders.* Depression can accompany many mental disorders.

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## LEVELS OF DEPRESSION

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### Healthy ("Normal") Depression

Based on real life experience.

Able to function (feels bad, less effective).

Appropriate feelings from current experience.

Feeling of temporary helplessness; not suicidal.

Withdrawal for hours or 1-2 days.

Feeling hurt, but hopeful of healing.

Feeling bad about self, but self-blame comes and goes.

Productive: --> wisdom, creativity, and maturity.

### Unhealthy ("Disabling") Depression

Based on distortion: denial of real experience or overwhelming, negative experience.

Unable to function at work, in relationships, physically, etc.

Distorted reaction to current or past trauma. Experiences past or present loss as permanent or greater than reality.

Feeling of hopelessness, despair; suicidal thoughts.

Emotionally unresponsive for days, weeks, months.

Feeling of being defective and damaged beyond repair.

Chronic low self-esteem, perhaps self-hatred.

Unproductive: --> paralysis, physical and mental deterioration, illness, even death.

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## SUICIDAL THINKING

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

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

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

Michael Faenza, NMHA President and CEO noted that:

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

Who is the "typical" suicidal person? According to the Suicide Information Center in San Diego, most suicidal people (perhaps 95%) do not want to die. They are seeking relief or escape from an intolerable situation. The person usually wants help but has

difficulty asking, doesn't know where to get help, doesn't know what s/he specifically wants others to do to help. Descriptors of the typical suicidal person are Hopeless, Helpless, and Hapless.

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

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

### **Suicide Rates**

Rates increase steadily with age. In the United States, the annual average is 12 suicides per 100,000 people.

Among adolescents, suicide now is the 3rd leading cause of death in the US. From 1980 to 1997, the rates for ages 15-19 increased 11%; the rates for ages 10-14 increased 109%.

In mid-life, people may experience loss of spouse or parents; children leaving; serious illness.

Elderly people commonly experience life-altering changes such as the loss of loved ones, decline in health, loss of independence. The largest relative increase in suicide rate from 1980-1997 occurred among those ages 80-84.

### **"Hardcore" Suicidal People**

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

**No suicide talk should be dismissed or treated lightly!**

### **Warning Signs**

Verbal threats such as "You'd be better off without me" or "Maybe I won't be around."

Expressions of hopelessness and/or helplessness

Previous suicide attempts

Daring or risk-taking behavior

Personality change (withdrawal, aggression, moodiness)

Depression

Giving away prized possessions

Lack of interest in the future

Organizing case files

Cleaning house and office

Assessing the Degree of Suicidality

Ascertain whether the person has suicidal thoughts, a plan, and access to the plan requirements.

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

**DO:**

Trust your instincts and believe that the person may attempt suicide.  
Talk with the person about your concerns, and show that you care and want to help.  
Remember that the most important thing is to listen.  
Get professional help, even if the person resists.  
Do not leave the person alone; offer to go with the person to get help.  
Do not swear to secrecy.  
Do not act shocked or judge the person.  
Do not counsel the person.

**Mood Disorder Treatment Strategies**

Evaluation. The first step is always a complete diagnostic evaluation by a licensed professional. With accurate diagnosis, a proper treatment plan can be recommended.

Medication Psychotherapy Combination. For mild to moderate depression, medication or psychotherapy alone may be successful. When severe, a combination of medication and therapy is more effective.

Electroconvulsive Therapy or shock treatment is used when medication and therapy prove ineffective. It is highly effective for severe depressive episodes. Risks of memory problems and physical harm have been reduced with modern techniques.

**Mood Lifters**

Act rather than react to bad feelings and problems.  
Substitute positive thinking for negative thoughts.  
Contact someone close.  
Be supportive of others who need help.  
Exercise regularly.

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**INTERVENTIONS IN MENTAL HEALTH**

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

The conceptualization and articulation of this practice is credited to Vernon Johnson, (author of the book, *I'll Quit Tomorrow*), an Episcopal priest in MN who helped many alcoholics into recovery through a process he called “intervention.” He practiced this by teaching family members and friends that there was something they could do to prod a troubled individual into getting help. The conventional wisdom at the time (during the 50's & 60's) was that AA and treatment could be very effective in many cases, but you had to wait for the alcoholic to “hit bottom” and ask for help. The thinking of the time was that until the alcoholic hit bottom, external attempts to create positive change were mostly a waste of time, and often actually seemed to exacerbate the problem. It was also noted that family members typically responded with guilt and anger in their attempts to control or fix the alcoholic, so they actually got worse as they tried many different attempts to intervene on the problem. The standard advice to the family was to “Take care of yourself; there's nothing you can do to stop alcoholics until they want help.”

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

Volunteer groups such as LAP have adopted the classical intervention method by professional training of peer volunteers who follow an established format to accomplish remedial action for an identified problem. The leader is a veteran with experience, usually a judge, who guides the team through the fact finding, the practice sessions, and finally the intervention session.

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

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

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

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

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

2. **Call the JAP office** with your concern. Depending on the situation, a peer counselor may be helpful, or a modified intervention may be planned.
  - a. Mental illnesses do not have the same kind of denial system inherent in addictive illnesses. Denial is usually not as entrenched or systematic.
  - b. The intervention process with mental illness is more individualized depending on how aware the person is about having a problem.
  - c. The focus of the intervention is getting professional help for an assessment and treatment plan.
  - d. People with mental illness often struggle with fear both about what's happening to them and also what getting help may involve. A peer counselor may be helpful in reducing the fear.
3. **Focus on the problem behavior.** You do not need to be an expert on mental illness and attempt to diagnose the problem. You do not need to decide how the disorder is to be treated. But you can share your care and concern. The focus is always on: "Something has changed, and I want to help you get some help."
4. **Professional resources are key.**
  - a. A professional therapist and psychiatrist are used as consultants.
  - b. A peer assistant can be of great support in reducing the feelings of:
    - (1) "I'm alone."
    - (2) "I know there's something wrong, but I don't know what to do."
    - (3) "There's no hope."
    - (4) "I'm afraid of seeing a doctor."
    - (5) "I don't want to take pills."
    - (6) "I'll snap out of this myself."
  - c. The first level of intervention is an assessment by a therapist or psychiatrist.
5. **Intervention Process**
  - a. Fact gathering – Is intervention needed?
  - b. Consultation with JAP office and professional resources
  - c. Meeting the person
    - (1) Usually in a non-threatening setting with supportive approach
    - (2) Expressions of confidentiality care and concern
    - (3) Action plan



## **Anxiety Disorders**

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

### **Panic Disorder**

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

### **Obsessive-Compulsive Disorder (OCD)**

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

### **Post-Traumatic Stress Disorder (PTSD)**

PTSD is an extremely debilitating condition that can occur after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Trigger events can include violent personal assaults (rape, mugging), natural or human-caused disasters, accidents, and military combat. Symptoms include repeated re-experiencing of the ordeal in the form of flashbacks, memories, nightmares, and frightening thoughts, especially when exposed to reminders; emotional numbness and sleep disturbance; depression, anxiety, irritability or outbursts of anger; feelings of intense guilt; avoidance of any thoughts or reminders of the ordeal. It affects at least 3.6% of US adults during a given year.

PTSD develops at any age, including childhood. About 30% of people who have spent time in war zones experience PTSD. Sexual assault is more likely to lead to PTSD than other traumatic events. This is explained in part because survivors are more likely to have been injured, to perceive the event as life threatening, to blame the event on someone else, and to have experienced multiple traumatic events. Recent research has found that debriefing people very soon after a catastrophic event may reduce some of the symptoms; also that people with PTSD tend to have abnormal levels of key hormones involved in response to stress.

## **Social Phobia**

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

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

## **Generalized Anxiety Disorder (GAD)**

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

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

## **Treatment of Anxiety Disorders**

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

### **In a Word**

When working with someone in distress, always:

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

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## **DEMENTIA**

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

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

### **Symptoms of Dementia**

- Erosion of recent and remote memory (amnesia)
- Impairment of one or more of the following functions:

- Language: misuse of words or inability to remember and use words correctly (aphasia)
- Motor activity: inability to perform motor activities even though physical ability remains intact (apraxia)
- Recognition: inability to recognize objects even though sensory function is intact (agnosia)
- Executive function: inability to plan, organize, think abstractly

### Causes

- More than 50 conditions are associated with dementia, including
- Degenerative neurological disorders (e.g., Alzheimer's disease)
- Vascular disorders (e.g., multi-infarct disease)
- Inherited disorders (e.g., Huntington's disease)
- Infectious diseases (e.g., HIV/AIDS)
- Some are irreversible. Alzheimer's disease causes 50-70% of all cases of dementia.
- Those that can be reversible include:
  - Alcoholism, chronic drug use
  - Viral, bacterial, fungal infection including Meningitis, Encephalitis, Neurosyphilis dementia
  - Structural abnormalities (operable benign brain tumors, chronic subdural hematoma)
  - Metabolic disorders such as hypothyroidism, hypoglycemia, hypercalcemia, liver disease

### Differential Diagnosis

- Delirium is a temporary but acute mental confusion due to heart or lung disease, infection, poor nutrition, hormone disorder, *and reaction to medication*. Emergency treatment is vital. Pseudodementia is a type of severe depression with cognitive changes that resemble dementia. It occurs mostly in elderly people and may exist with dementia. The depression is treatable.
- Diagnosis of dementia involves a complete medical and neuropsychological evaluation, a complete history, and brain scan (e.g., CT, MRI, PET, SPECT) to rule out treatable causes. A definitive diagnosis requires an autopsy.

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## CO-OCCURRING DISORDERS

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

According to the report 33.2 million adults age 18 or older had a serious mental illness or a substance abuse disorder in 2002. Of those adults, 40.4% (13.4 million) had a serious mental illness; 47.4% (15.7 million) had a substance use disorder; and 12.2% (4.0 million)

had both serious mental illness and a substance use disorder. The data also indicate that while 47.9% of adults with both a serious mental illness and a substance use disorder received some type of treatment, only 11.8 % received both mental health and addiction treatment disorders.

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

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

*The report can be accessed at [www.oas.samhsa.gov](http://www.oas.samhsa.gov). Source: SAMHSA, “Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders,” July 2004*

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## MODULE 7 – SUPPORT GROUPS, RESOURCES & REFERENCES

### LOCATING TWELVE STEP GROUPS

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Most states have hundreds of support groups for compulsive disorders, with thousands of meetings.

- **Contacting Support Groups:** Volunteers should become familiar with 12-step recovery groups. Most 12-step recovery programs have groups that conduct “open” meetings at which all interested persons, even those without the illness, are welcome. Open meetings are held so that anyone who wishes to may learn more about the illness, the 12-step group, and the program of recovery.
- **Alcoholics Anonymous, Al-Anon, Alateen:** Most cities have telephone listings for these groups. Simply call the area office for information on open meetings. If no number is listed in your area, call the nearest larger city, or the numbers listed on the following pages.
- **Telephone Listings:** The following pages list the national contact numbers and web sites of relevant self help groups.
- **Locating an AA Meeting in a Remote Area:** AA meetings have now become very widely recognized and available. In major metropolitan areas, the times and locations for AA meetings can be obtained by calling the local telephone number for Alcoholics Anonymous that is usually listed in most telephone directories. After business hours, when the AA information line may be closed, or in more remote areas, where a number for AA may not be listed in the telephone directory at all, the times and locations of AA meetings can sometimes be learned by contacting a local hospital, police station, church or synagogue. In some reported cases, perhaps interesting to note but really not too surprising when one thinks about it, the times and locations of AA meetings in rural areas have even been obtained by asking a local bartender!

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### SUPPORT GROUP PHONE NUMBERS

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<b>Alcohol and/or Drugs</b>	<b>National #</b>
Alcoholics Anonymous	212-870-3400
Al-Anon and Alateen	800-344-2666
Adult Child - of Alcoholics	562-595-7831
Cocaine Anonymous	800-347-8998
Co-Dependants Anon -	602-277-7991
Dual Recovery Anon -	913-991-2703 / 2706 / 2704
Families Anonymous	310-313-5800

Narcotics Anonymous	818-773-9999
Nar-Anon	800-477-6291
Nicotine Anonymous	877-879-6422
Rational Recovery	530-621-2667, 530-621-4374

<b>Behavioral Problems</b>	<b>National #</b>
Anorexia Nervosa	847-831-3438
Debtors Anonymous	212-642-8220
Emotions Anonymous	651-647-9712
Gambling Helpline	800-567-8238
Gamblers Anonymous	213-386-8789
Gam-Anon (for families)	718-352-1671
Overeaters Anonymous	505-891-2664
Sex and Love Addicts Anonymous	781-255-8825

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## INTERNET RESOURCES

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**Alcohol, Drug Addiction and Mental Health Resources on the Internet:** Internet web sites are a valuable source of information concerning addiction and mental health. Take some time to explore the sites listed below and find many others.

### **Web Addresses for Peer Support Groups:**

Alcoholics Anonymous	<a href="http://www.alcoholics-anonymous.org">www.alcoholics-anonymous.org</a>
Al-Anon and Alateen	<a href="http://www.al-anon-alateen.org">www.al-anon-alateen.org</a>
Cocaine Anonymous	<a href="http://www.ca.org">www.ca.org</a>
Dual Recovery Anonymous	<a href="http://draonline.org">http://draonline.org</a>
Gamblers Anonymous	<a href="http://www.gamblersanonymous.org">www.gamblersanonymous.org</a>
Gam-Anon	<a href="http://www.gam-anon.org">www.gam-anon.org</a>
Narcotics Anonymous	<a href="http://www.na.org">www.na.org</a>
Overeaters Anonymous	<a href="http://www.oa.org">www.oa.org</a>

### Other Pertinent Web Sites:

ABA Commission on Lawyer Assistance Programs	<a href="http://www.abalegalservices.org/colap">www.abalegalservices.org/colap</a>
Depression and Bipolar Support Alliance	<a href="http://www.dbsalliance.org">www.dbsalliance.org</a>
Depression Anonymous	<a href="http://www.depressionanonymous.org">www.depressionanonymous.org</a>
Lawyers Assistance Program, Inc. (Illinois)	<a href="http://www.illinoislap.org">www.illinoislap.org</a>
Lawyers With Depression	<a href="http://www.lawyerswithdepression.com">www.lawyerswithdepression.com</a>
National Center on Addiction and Substance Abuse	<a href="http://www.casacolumbia.org">www.casacolumbia.org</a>
National Clearinghouse for Alcohol and Drug Information	<a href="http://www.health.org">www.health.org</a>
National Council on Alcohol and Drug Dependence	<a href="http://www.ncadd.org">www.ncadd.org</a>
National Institute on Drug Abuse	<a href="http://www.nida.nih.gov">www.nida.nih.gov</a>
National Institute of Mental Health	<a href="http://www.nimh.nih.gov">www.nimh.nih.gov</a>
National Mental Health Association	<a href="http://www.nmha.org">www.nmha.org</a>
National Mental Health Information Center	<a href="http://www.mentalhealth.org">www.mentalhealth.org</a>
Recovery, Inc.	<a href="http://www.recovery-inc.org">www.recovery-inc.org</a>
Substance Abuse and Mental Health Services Administration	<a href="http://www.samhsa.gov">www.samhsa.gov</a>
Web of Addictions	<a href="http://www.well.com/user/woa">www.well.com/user/woa</a>

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### ADDICTION & RECOVERY REFERENCES

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The most important literature resources for a newcomer to the field of alcoholism and addiction are the books and pamphlets of Alcoholics Anonymous and Al-Anon:

- Alcoholics Anonymous, commonly referred to as the “Big Book,” the best resource.
- Twelve Steps and Twelve Traditions, commonly referred to as the “12&12,” explains the 12 Steps and 12 Traditions of Alcoholics Anonymous.
- AA Comes of Age, describes the historical development of AA.
- Pass It On, AA’s official biography of AA co-founder, Bill Wilson.
- Dr. Bob and the Good Old-Timers, AA’s biography of AA co-founder, Dr. Robert Smith.

- Al-Anon Faces Alcoholism, (2<sup>nd</sup> Edition), the “Big Book” of Al-Anon.

Many authors have written books, articles and pamphlets on addiction and recovery. Some of the classics in the field are:

- Keller, John, Alcoholics and Their Families, (Harper). *Keller is a Lutheran Pastor who specializes in the treatment of addiction and working with families. Section 10, “The Family,” is helpful in understanding and accepting family dynamics with this disease.*
- Keller, John, Let Go, Let God, (Augsburg Fortress). *Development of the theme of surrender and its application to recovery and daily living.*
- Keller, John, Drinking Problem?, (Augsburg Fortress). *A pocket book which helps the reader determine the difference between problem drinking and alcoholism; an excellent introduction for those struggling with the definition of alcoholism or addiction.*
- Johnson, Vernon, I’ll Quit Tomorrow, (Harper). *Vern Johnson is one of the pioneers in the field of understanding the nature of addiction. He developed the intervention model upon which most interventions are based.*
- Kurtz, Ernest, Spirituality of Imperfection, (Bantam). *Develops the spirituality of AA in its application to daily life.*
- May, Gerald, Addiction and Grace, (Harper). *May is a psychiatrist who writes from the Christian perspective on the dynamics of addiction. This book is an excellent portrayal of classic spirituality and its relation to the addictive process.*
- Carroll, Don, J.D., A Lawyer’s Guide to Healing, (Hazelden). *Carroll is the Director of the North Carolina Lawyer Assistance Program and has helped hundreds of colleagues overcome addiction and depression. The book discusses how addiction affects lawyers and how they can reclaim their professional lives.*
- Coffey, F. Gregory & Kessler, Maureen, The Reflective Counselor, Daily Meditations for Lawyers, (NBN), short meditations to help the busy and stress-out lawyer.
- Maddi, Salvatore and Khoshaba, Deborah, Resilience At Work: How to Succeed No Matter What Life Throws At You. *Learn how to build your resiliency factors and understanding the importance of the “3 C’s” – Commitment, Challenge and Control in successfully managing stress.*
- Real, Terrence, I Don’t Want to Talk About It, Overcoming the Secret Legacy of Male Depression. *Offers important insights to men suffering from depression and also guidance to those who are trying to help them.*

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## MODULE 8 – **BEST PRACTICES IN COURT ADMINISTRATION TO ADDRESS THE PROBLEM OF IMPAIRED JUDGES**

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### INTRODUCTION

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Judges impaired by alcoholism, other drug abuse, or mental health disorders have a detrimental impact not only on the affected judge and his or her staff and family, but also on the judicial system as a whole. These issues may lead to disciplinary proceedings against the judge with outcomes that include removal from the bench. The Best Practices outlined here are intended to help judges deal with these issues by providing a framework for supportive oversight and intervention with both the administrative arm of the court as well as judicial disciplinary organizations. If effectively addressed, judges can receive the assistance they need, avoiding disciplinary entanglements, and remaining productive in their public service.

These proposed Best Practices can be adopted or modified by a court system to fit local structure and organization. These practices can be put in place by a court system at a variety of levels, depending on how the courts are administered and organized in a given jurisdiction.

### TRAINING AND EDUCATION

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#### **Topics and Audiences**

A court system should provide universal training for judges and staff in stress management, recognition of signs and symptoms of impairment, and wellness. Substantial attention should be given to this topic.

### NEWLY ELECTED OR APPOINTED JUDGES

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Special attention should be given to training new judges as they face the often-dramatic change of transitioning from the life of a lawyer to the life of a judge.

#### **Teaching Techniques**

Frequent reminders are needed to keep this issue at the forefront. In order to insure that these issues are given attention, materials, such as pamphlets, handbooks, newsletters, DVDs and interactive learning-websites, should be available and distributed on a regular basis. Most importantly, judges and judicial staff should be invited to regularly discuss these topics together and with their peers.

#### **Family members**

Outreach to family members should be included in a comprehensive educational plan. Instruction should include information on the signs and symptoms of impairment and effective stress management. Again, family members should be encouraged to talk about their experiences living with the judge and their observations of the judge's success in managing work stress.

#### **Knowledge of Judicial Assistance Resources**

Judges, staff, and the families of judges should have easy access to contact information for the appropriate judicial assistance program if there is a program serving the

jurisdiction. A basic description of the process associated with referral to the judicial assistance program must be readily available.

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## RESPONSIBILITIES OF JUDICIAL ADMINISTRATORS AND SUPERVISORS

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### **Performance Reviews**

Administrative judges with supervisory responsibilities should conduct periodic performance reviews of judges over whom they have supervisory responsibilities. These internal performance evaluation systems should be designed to identify problem areas for judges for the purpose of providing additional support where appropriate. Performance problems such as delays in processing documents, conducting hearings, poor record keeping, and other problems which may indicate problems with stress management and/or impairment should not be ignored.

When such problems are identified, the evaluator should be forthright with the judges about troubling conduct and symptoms that may indicate stress or alcohol and/or drug abuse. When there is substantial evidence of problematic conduct or symptoms of abuse, administrative judges should not hesitate to make inquiries of colleagues and staff in order to avert potential problems. Referrals for appropriate evaluations can clarify what difficulties the judge is experiencing and provide a direction for future action.

### **Administrative Protocols**

Court systems need a clear, written protocol for responding to credible reports of judicial impairment. Issues that must be addressed include the confidentiality of such reports including who will be notified of the report, a protocol for requiring appropriate assessments including an identified source of payment for the same, and a plan for covering the caseload of a judge who is temporarily unavailable to continue their duties. Clear distinctions must be made between reports of problematic behavior and reports of possible ethics violations. Most jurisdictions require the filing of an ethics violation with the appropriate disciplinary authorities. The Best Practices for the disciplinary response is described below.

### **Procedure for Lawyer's Complaints**

Lawyers are often in a position to note changes in the behavior of a judge or other signs of impairment or distress. Lawyers are understandably reluctant to make formal complaints about judges they appear in front of absent clear evidence of unethical misconduct. Nonetheless, it is important to create an atmosphere that encourages lawyers to report concerns that do not rise to the level of misconduct. Components of this atmosphere must include a clearly designated person whose responsibility is to receive such concerns, a guarantee of confidentiality, and protection against retaliation.

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## SUPPORT FOR IMPAIRED JUDGES

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### **Judicial Assistance Programs (JAP)/Lawyer Assistance Programs (LAP)**

It is imperative that the assistance programs within the jurisdiction are involved in cases involving alcoholism, other drug abuse, or mental health disorders. Besides their expertise in these areas, assistance programs typically rely on peer support. Judges who have experience with the problem facing the impaired judge can provide invaluable experience, strength, and hope during a very difficult period. In this regard, it is important to remember that judges who enter treatment need substantial support upon their return to the community to maintain their stability.

### **Employee Assistance Programs**

Jurisdictions without either a JAP or a LAP generally rely on an Employee Assistance Program (EAP) in cases of this kind. It is recommended that EAP's providing assistance to judges have a working relationship with individuals or organizations that can provide peer support for judges.

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## **PREVENTION STRATEGIES AND JUDICIAL WELLNESS**

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### **Caseload Review**

Many judges handle high volume caseloads and/or highly emotional cases (i.e., violent crimes, difficult divorce proceedings, etc.). Both the lack of control over the types of cases a judge hears and the volume of cases for which a judge is responsible are significant factors contributing to stress. Ongoing monitoring of a judge's performance under such caseloads can help prevent burnout and other stress related problems. Periodic rotation of the types of cases a judge handles should be considered where possible.

### **Work Flexibility**

Mechanisms to adjust and accommodate calendars affected by unexpected personal or family obligations or responsibilities should be developed.

### **Leave of Absence or Study Leave**

Upon appropriate request, judges should be granted a leave of absence or a study leave after a defined length of service.

### **Mutual Support**

Court systems should confront the isolation inherent in serving as a judge. The separation from attorney colleagues required by the job frequently represents a major disruption in social support for a new judge. Judges often experience isolation from their colleagues as well because of their heavy caseloads and their differing assignments. Effective strategies to combat isolation include creating judge only break room/meal rooms within buildings housing multiple judges, regularly bringing judges with similar responsibilities together for continuing education and a free exchange of ideas, and organizing social events where judges can spend "down time" with their peers.

### **Support during high profile cases**

Judges are occasionally the subject of criticism or scrutiny, e.g., during high profile cases. Ethical considerations generally prevent a judge from responding directly when unfair or false comments are made about the judge. Utilization of a public information office that can provide appropriate information to the public and refute false or exaggerated claims can provide significant relief to a judge. Other strategies may include utilizing lawyers from bar associations to help the public understand difficult or controversial legal issues that might lead to unjust criticisms of a judge if left unexplained.

### **Retirement and aging issues**

Judges face the challenges of aging just like everyone else. However, the length of their term and the goal of completing the same may complicate their situation. It is important for judicial supervisors to monitor the health and performance of judges as they age. The effects of aging are sometimes misinterpreted as signs of impairment and vice versa. Retirement systems for judges should be designed to encourage judges to retire before they are overtaken with age related impairments. The guidelines in the Federal circuits

for a chief judge who must certify the fitness of senior status judges may be useful to consider.

### **Ongoing Wellness Education**

Wellness programs like that of the 9<sup>th</sup> circuit should be explored to head off problems before they spin out of control.<sup>5</sup>

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<sup>5</sup> For aspects of wellness programs: See Zimmeman article in vol. 90 no.1 Judicature (2006) at pp. 13-15

Judges may suffer vicarious trauma, burnout, high stress, etc. solely because of the nature of the cases they hear. Effective educational programs that candidly discuss these issues and provide judges with an opportunity to talk freely about their experiences are essential.

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## JUDICIAL DISCIPLINE

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### **Court administrators' responsibilities**

Court administrators should be able to interact with judicial disciplinary systems in appropriate cases. Disciplinary cases involving judges should be jointly screened by disciplinary authorities and wellness programs or JAP/LAPs to identify appropriate cases for diversion into therapeutic remedies.

### **Professional Evaluations**

Judicial Discipline bodies need to be educated on when it is advisable to seek an assessment for dependence or stress related problems to assist in determining the factors related to judicial misconduct and/or appropriate responses to misconduct.

### **Disciplinary Options**

There must be an array of options available to the body deciding judicial discipline. Procedures like deferred prosecution, suspended sanctions, and diversion should be utilized where appropriate.

### **Monitoring**

When a disciplinary sanction such as diversion is imposed on a judge by a judicial disciplinary agency, court administrative structures should be used to monitor the overall progress and compliance by the judge. Day-to-day monitoring may best be contracted out to qualified professionals.

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## CONFIDENTIALITY

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### **Cases of Misconduct**

Judges, lawyers, and judicial staff who report concerns about misconduct by judges must be granted complete confidentiality to encourage appropriate review of serious matters. Judges who are the subject of misconduct complaints are guaranteed different levels of confidentiality by statute or court rule within their jurisdiction. However, even in states where judicial complaints are made public, judges are entitled to confidentiality regarding all medical/mental health/substance abuse evaluations and treatment. Reports to the supervising judges should generally be restricted to information about general compliance with recommended treatment.

**Voluntary Cases**

Judges who privately seek help from a JAP, LAP, or EAP must be guaranteed complete confidentiality as long as they have not committed acts of professional misconduct and have not been directed to seek an evaluation by a supervising judge. No information regarding the judge's case should be available to anyone in the court system absent the express consent of the judge seeking treatment.

**Court Rules and Statutes**

The parameters of confidentiality must be clearly established for all cases. The best practice in this regard is passage of statutes that guarantee appropriate protections.

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## CONCLUSION

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Court administrators and judicial supervisors have the responsibility to support judges in their roles as public servants and to protect the integrity of the institution. However, this responsibility is often poorly defined and court systems lack coordinated approaches to identify judges who are not performing well due to alcoholism, other drug abuse, or mental health problems. The Best Practices outlined here are designed to suggest a global approach to this challenge. It is our belief that implementation of these practices will help administrators and supervisors provide meaningful support to judges and prevent some impairment problems. In more serious cases, earlier identification of judges in distress can prevent judicial misconduct and save lives. Surely it is worth the effort to not only ensure the absolute best outcomes in the administration of justice but also to provide the mechanisms to assist judges in addressing serious issues of health and wellness.

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## NOTES

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## MODULE 9 – REFERENCE ARTICLES

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### INTRODUCTION

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The three introductory articles provide an overview which is best summarized in the first article, an editorial from **JUDICATURE**:

*“It is time to recognize that judges face the same challenges to their physical, mental, and emotional health as do other members of society, and that their unique position in society renders the provision of assistance in meeting those challenges as critically important.”*

The second article *Helping Judges in Distress* similarly notes that *Judges are subject to a wide range of physical and emotional problems and stresses but often don't get the help they need*. The article goes on to describe the range of problems from health and medical, mental health, substance abuse and addiction, career and organizational stressors, marital and family issues, aging and retirement, judicial culture and self identity. This article also touches on the subject of the second category “Wellness”. The third article *Growing Old is Not for the Faint Hearted* similarly is applicable to the judicial officer and includes a partial list of risk factors for substance abuse, depression, and warning signs as we grow older.

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### EDITORIAL: A FRESH LOOK AT JUDICIAL IMPAIRMENT

It is time to recognize that judges face the same challenges to their physical, mental, and emotional health as do other members of society, and that their unique position in society renders the provision of assistance in meeting those challenges critically important.

The problems of impairment due to alcoholism, other addictions, depression or other mental health issues and of declining mental acuity due to age afflict people in all segments of society, including the judiciary. The administrative, social and political structure, within which judges operate, however, can make it difficult to recognize and deal effectively with these problems. Public confidence in the judiciary is seriously undermined when these issues are ignored. Rather than wait until a judge's DWI arrest or bizarre behavior makes the news, courts should have in place resources that make it as simple as possible for judges to obtain help. Policies and practices should afford sympathetic support to a judge with an addiction or disability as long as the judge, too, acknowledges the necessity of finding a remedy. Judicial collegiality needs to be redefined so that looking the other way to avoid embarrassment or confrontation is no longer acceptable, and intervention is expected and encouraged. Education about the availability of programs and information about other wellness issues needs to be provided in new judge education and regularly reiterated at judicial meetings in substantive sessions rather than just a five-minute reminder. Handbooks, websites, and newsletters can keep the issue from being pushed to the bottom of the agenda until the next headline. There should also be outreach to family members who may be struggling with how to obtain help for their judicial relative. Judges with supervisory authority should receive intensive training about how to intervene after receiving complaints about a judge's behavior. Staff and attorneys need to be encouraged to bring their concerns to the appropriate authorities while a confidential solution is still possible rather than to cover up a judge's behavior until there is a public scandal.

The presence of an assistance program does not eliminate the possibility of judicial discipline as the incentive that may finally force judges to commit to treatment and as the vehicle for a judge to make amends by restoring public confidence. Appropriate confidentiality rules and procedures for the conduct commissions and assistance programs will foster a cooperative relationship between the two groups that will both assist judges and protect the public.

Several times in the last few decades, courts across the country have admitted they had a problem – the appearance of gender or racial bias, for example – and applied themselves to solving it through study, education, and sustained policy and procedural change. Recent innovations to meet the challenges raised by the increasing number of pro se litigants also demonstrate the ability of courts to successfully tackle a dilemma once they choose to confront it. As suggested by Isaiah Zimmerman in his article in this issue, the courts need to work for a culture change in which personal problems that affect judicial duties can be seen not just as potential disciplinary issues but as opportunities to get out in front and intervene before serious damage is done. Such a culture change will also remove any stigma attached to disability retirement. Courts need to ensure that all judges and their families have access to understandable information about disability and retirement benefits and that those benefits are sufficient to allow judges to plan for and consider either partial or full retirement if the effects of aging or bad health make full service no longer the best choice for both the judge and the court.

While the precise features of a wellness initiative will no doubt vary from jurisdiction to jurisdiction, the United States Court of Appeals for the Ninth Circuit has created the template for some of the work that needs to be done, creating a working group to study the relationship between health and judicial performance, to consider formal and informal methods of dealing with judicial disabilities, and to make recommendations for changes and new programs. As described in the article in this issue by Richard Carlton, “Addressing disability and promoting wellness in the federal courts,” the Ninth Circuit then implemented many of the recommendations and continues to make the topic of judicial wellness a priority. Oddly, apparently no other federal or state court has so far followed the Ninth Circuit’s lead even though the working group report was completed in 2000. It is time for other federal and state courts to begin to follow that example. The kind of sustained, comprehensive commitment necessary to lend a consistent, effective helping hand requires leadership from the top, the chief justices and justices of the state supreme courts, the chief judges of the federal circuits and districts, and federal judicial councils. There are many challenges facing the judiciary, making it tempting to place the uncomfortable, awkward issue of judicial impairment low on the list of priorities. However, to meet the other challenges, all judges need to be acting at their fullest capacity and with the confidence that there are resources available if they need them. Any public confidence lost by the image of impaired judges will be restored by the judiciary’s public commitment to fairly and effectively address the problem and provide assistance that will help judges perform their responsibilities. A working group on impaired judges, established by AJS in 2004, will continue to address these issues.

**JUDICATURE** Volume 90, Number 1 July-August 2006



## HELPING JUDGES IN DISTRESS

*by Isaiah M. Zimmerman*

Judges come from the ranks of lawyers, and lawyers, as a group, are reliably estimated to include a steady minority of 15 to 18 percent<sup>1</sup> who suffer from problems with substance abuse and related disorders. Programs designed to help lawyers in distress have been established throughout the United States, as well as in Canada, Ireland, and the United Kingdom. These programs have a fine record of outreach and help, and are now an accepted part of intra-professional responsibility. However, the sections of these programs that are also meant to help judges have not attracted the level of requests for service that would be reasonable to expect. What are the reasons for the low use of these widely available services, and what can be done about it?

My own experience as a clinical psychologist, in a metropolitan area adjacent to four states, who has seen a significant number of judges over the past 30 years confirms that judges do indeed seek help with a whole variety of personal and family problems. But they do so outside the available bar programs. When asked why, they cite the need for strict privacy and confidentiality. They are willing to pay a premium in fees, and to not utilize their health insurance coverage. Can there be a broader and less expensive way for judges to get help when they need it?

### **Range of problems**

Let us review the situations in which most judges privately seek help.

### **Health and medical.**

Medical and surgical care often involves dealing with the disruption of family routines and responsibilities. The illness of children, spouses, and aging parents can entail arranging for home care, clinic visits, physical therapy appointments, and other collateral arrangements. Whether under a direct or master calendar, most judges have to work out backup for an already overloaded docket. Welfare clients sometimes have the help of medical social workers—judges do not. Between the presiding judge, calendar clerk, and court administrator, something is usually arranged. But the emotional toll on the judge and family is rarely addressed.<sup>2</sup> Most judges live in dread of these situations, because, ultimately, the caseload balloons and must be handled by extended hours on the bench and work at home. A chronic, long-term illness in the family places the judge in an indefinitely prolonged caregiver role. For all of the foregoing, the services of a health counselor or social worker would be most appropriate.

### **Mental health.**

Judges are subject to a normal spectrum of psychological issues, including depression, anxiety, and mid-life crises. These can underlie a reduction in productivity, tardiness in opinion writing, clashes within the judicial administration and hierarchy, and intemperate and inappropriate behavior on or off the bench. Psychiatric treatment still carries stigma in our society. Despite a more widespread acceptance of mental health diagnosis and treatment, psychiatric care is still not reimbursed on a par with medical and surgical care. CEOs, high officials, political leaders, and judges shun the suggestion of possible mental illness, diminished capacity of judgment, and the charge of malingering to evade misconduct charges. As a result, judges either put off seeking treatment until symptoms can no longer be denied, or obtain medication from their general practitioner. When they do seek psychological care, they employ safeguards such as seeing a practitioner out of their area, requesting telephone sessions, and asking

the psychiatrist to schedule them away from the session of any local lawyer or newscaster.

All this freights their psychotherapy with unfortunate burdens, and some quit counseling before they should. Group psychotherapy, a very effective modality of care, is virtually closed to them, as well as to other public figures, since confidentiality cannot be assured, and membership in a group cannot be totally selective. Group therapy for couples, another effective mode of marital help, is likewise unavailable to judges for the same reasons.

### **Substance abuse and addiction.**

Though a subset of psychiatric conditions, the prevalence and publicized nature of addictions in the legal professions warrant a separate listing. However, this is often referred to as a "dual-diagnostic"<sup>3</sup> area because concomitant psychological and medical conditions are usually involved. Alcohol abuse and addiction is the most frequent category. It can profoundly affect temperament and behavior on and off the bench, the quality of collegial relations, and caseload productivity. It can also affect staff morale and efficiency. Clerks and staff often cover for a judge who has such a problem. This creates enormous stress for everyone.

When media attention focuses on a judge in such circumstances, harsh reactions issue from legislators and op-ed writers, with negative reflections on the entire court and judiciary. Clearly this problem area has wide repercussions of public shaming.<sup>4</sup> The treatment of alcohol disorders requires a combination of in-patient care, medication, individual and group psychotherapy, family counseling, and long-term group follow-up. These are the most important factors in preventing relapse. Where judges are concerned, group treatment for alcohol disorder with lawyers or a mixed population is not an option, except in the rarest of cases where hardy souls have "gone public" and braved public humiliation or recall.

### **Career and organizational stressors.**

In mid-career, a number of judges experience a kind of pause. They know their options to re-enter law practice, government service, or academic life are waning. They have fully experienced the rewards as well as the vicissitudes of the judicial career. It is time to review: should they continue and seek another term, whether it be by appointment, election, or retention? They also ask themselves "What have I achieved? Was the financial and family sacrifice all worth it? Will it get any better in the second half of my career?"

In states where election is highly politicized and considerable campaign funds must be raised, this is not a trivial halfway point. Campaigning for a judgeship imposes extremely paradoxical judicial demands. Funds usually come from large law firms or affluent solo practitioners and political parties. Though judges are shielded by a campaign committee from the identity of donors, they generally know who they are. Judges also are pressured to present themselves, their records, and their positions on major local issues in a way that telegraphs their ideological tilt. The family often is drawn into multiple evening and weekend appearances, and the judge may acquire substantial debt. Having treated judges in the throes of an election and its aftermath (successful or not), I have witnessed what can be described as a post-traumatic stress reaction that extends to the family. Will that judge consult a local therapist? Of course not.

Another area in which judges occasionally seek help is organizational and collegial conflict. This is an intensely private area of concern. The issues range from pure personality clashes with a colleague or appellate panel, to power struggles with the administrative office or the presiding judge. Gossip may appear in local bar publications, and can be quite nasty. To obtain assistance and calm guidance in these circumstances is invaluable, and discretion is absolutely essential.

### **Marital and family issues.**

When a judge experiences marital and family conflicts, the size of his or her community matters. In smaller and rural communities, judges have little or no privacy outside of their homes. A judge in a one-judge court is especially vulnerable.<sup>5</sup> In larger or metropolitan jurisdictions, the media are interested in publicizing what may be occurring in the life of the judge and the court. In a divorce proceeding, judges, in my experience, tend to appease the spouse in contested custody and financial matters to minimize public scrutiny. These are severe stresses on the equanimity and working ability of the judge and his or her staff. The hidden posttraumatic consequences may continue for a considerable period.

The children of judges face challenges at school and on the playground that are remarkably similar to those of the offspring of the clergy. Often these children are held to a higher standard by teachers and coaches. Peer pressure may involve them in delinquent behavior. In the rebellious teenage years, a judge's child may engage in problem behavior to embarrass the parents. Disputes with neighbors can be compromised. A judge may choose not to sue or dispute a problem with a neighbor over a property line or with a local contractor. The role of the family is linked to the judge's public image, especially in electoral office states. Recall that in those areas, judges often campaign with their families by their sides. Though they may deny it publicly, judges tend to feel vulnerable in publicized disputes.

The life of the unmarried judge is another area that sometimes can benefit from counseling. The single woman on the bench is often an object of outright curiosity and chatter. Who does she date? If she doesn't date, is she gay or are there other issues? Many single judges choose to socialize in some distant county or to maintain a second home where they can be more relaxed. At their primary residence, they may create a high social wall around themselves. These are matters that even collegial friendship does not easily admit to discussion, so outside supportiveness can be appropriate and sustaining.

### **Aging and retirement.**

Most federal and state judiciaries offer pre-retirement orientation concerning benefits, health insurance, and the options for senior status and part-time judicial duties, as well as the new field of "private judging" and mediation. A number of programs include information for spouses, as well as a briefing on the personal emotional transition from active, full-time judging to retired or substitute status. For the majority, these presentations are adequate and suffice.

For a number of judges, however, this presents a serious tipping point in self-image and public esteem. Though it may be scoffed at and treated as unimportant, most deeply enjoy and covet their esteemed title of judge or justice as well as their standing in the community. Into retirement their title stays with them and remains cherished. That is quite understandable. In our society, the equivalent nomination continues past retirement from public office when we address individuals as "Governor" or "Mr. or

Madam Secretary," or "Senator," over a lifetime. Taken all together, it is extremely helpful for a retiring judge to discuss this freely and to integrate it in the transition process.

The dynamics of retirement (or entry to a new occupation) in general are well understood now. However, the specific needs of judges are not understood. The common reaction is that this appears to reflect an inflated ego as well as a certain shallowness. Because of the centrality to self esteem of the customary use of these appellations, this issue is definitely not trivial to the retiree.

Interestingly, judges collude in maintaining an image that evokes ambivalent reactions. Most of what has been advanced above can elicit public reactions of "Poor baby! The judge needs so much support and soothing! All on a high salary, great benefits, prestige and power . . . what on earth can he need help for? Ridiculous!" As a result of society's mixed image, assistance for judges does not gather sympathy from the press, legislators, or even the majority of lawyers.

Aging presents a new set of issues. Due to the gravity and responsibility of their work, mandatory retirement terms are in place in most jurisdictions, except in the federal courts. When a sitting judge on active service begins to exhibit signs of cognitive or physical decline, it is quickly noted and guardedly discussed within the court family and bar. At the same time, ranks close around the judge, and there arises a great disinclination to question the judge's capabilities. It is easier to help judges in senior status, as most face periodic re-certification. However, an older full-time judge may suffer for a considerable period and operate marginally and in denial before help arrives. The federal circuits have issued guidelines for chief district and bankruptcy judges who may face this matter. A wellness-based judge-to-judge assistance program might help the spouse or family of the judge in question to obtain discreet medical and psychological guidance to deal with the massive denial and indignation often involved. The properly oriented presiding or chief judge can develop procedures for a graceful and dignified departure by a marginally functioning older judge.

### **Judicial culture and self-identity**

Working as a psychotherapist and advisor to administrative law, state, and federal judges for many years has impressed upon me how insular the world of the judiciary really is, and how little is known about its inner culture and life circumstances. I have been impressed by how little accurate information the public and bar has about what it is like to be a judge. Fictional accounts about judges abound, but very little is to be found about the realities of judicial life. As a result, judges are distanced from the very group from which they originate.

Further, there is a widespread duality in how judges and the judicial system are perceived. On the one hand, great respect is shown to judges, and many lawyers aspire to that status despite obvious hurdles and costs. At the same time, the lawyer-judge relationship is ambivalent and burdened by formality and the strictures of the ethical code. Thus, even long-standing friends can feel a subtle inhibition in their relationship.

Figures of power and importance often inspire both envy and criticism. The media are quick to report questionable behavior or decisions. Practicing lawyers keenly observe and comment on all aspects of court life and share their opinions of sitting judges.

A profound change occurs as a lawyer becomes a judge.<sup>6</sup> He or she gradually loses the empathy and collegiality of most lawyers. While the judicial career is deeply satisfying

and rewarding, it also includes the accumulation of feelings of guardedness, isolation, and vulnerability, all of which are kept hidden behind the public persona.

Therefore, when placed in a mixed treatment or recovery group, judges, for both objective and subjective reasons, feel too vulnerable to participate. If questioned, they are not likely to offer reasons beyond the obvious: their political vulnerability and right to privacy. Rarely will a judge even agree to be interviewed for such a treatment referral. The reaction brings on the fear of loss of privacy and the specter of shame, of being found unworthy of the title and office, and of public humiliation. As a result, most judges in medical, emotional, family, or career difficulties soldier on without help, turn to other judges for advice, or seek help totally outside the system.

Being a judge at any level of court is totally unlike serving in other roles, with the possible exception of holding high public office. In this comparison, there are also significant differences. High officials can strike back in word and print if attacked. Judges normally do not. Others can endlessly explain and justify their actions and decisions. Judges do not. Others can socialize and behave with greater latitude. Most judges gradually experience an irreducible isolation and restriction in their public speech and behavior. This also extends to their families to some degree.

Where judges do share the life of other high officials is in their extensive visibility, as well as in the unrealistically high expectations placed on their performance. As official problem solvers and models of wisdom, they are presumed to have little need of therapy or other help, because they are expected to self-correct if troubled or overburdened.

It is not surprising that we seldom hear high officials or judges disclose that they are in any form of treatment or care, other than for totally non-perjorative medical conditions. Both groups scrupulously avoid any sign of impairment of judgment or capability.

#### **Widening assistance**

Existing lawyer and judge assistance programs are staffed by able and dedicated professionals and volunteers (see "Judges in lawyers' assistance programs, page 20). Their reported results are impressive. The ideas advanced in this article are offered to increase assistance to judges and to encourage use of bar programs designed for judges. The following suggestions seek to improve the existing situation, taking into account specific facts of judicial culture and identity.

#### **Sustained culture shift by leaders.**

A profound culture shift has to be gradually installed and promoted by the leaders—the chief justices, the chief federal circuit judges, state judicial councils, and chief judges at all levels of court. The goal would be to establish a "Wellness Initiative," a gradual and sustained culture change in the way assistance to judges is viewed and delivered. The key message would be to assure that all judges and their close family members can get assistance for a wide range of problems in total confidentiality. This policy would be rooted in a positive wellness model that promotes preventive practices for health, positive collegiality, and early provision of help in a program specifically designed for the judicial ethos.

#### **Confidentiality assured by court rules.**

The highest authority of each court system should establish by rule that all transactions and records pertaining to a judge's referral, treatment, and follow up are considered confidential. When a health delivery system is under contract to provide evaluation and

referral for treatment it would also be covered by that rule, in addition to the usual medical and psychological safeguards of confidentiality and privilege.

#### **Recovery counseling and group treatment.**

Contracts with health provider networks should stipulate that care would be exercised not to place a judicial officer in a treatment or recovery or counseling group composed of mixed public, non-judge members. The judge would be included in a mixed group only after being advised that this is the treatment of choice and that confidentiality in such a group is voluntary and unenforceable. The important point here is that under current mental health practice, substance abuse and recovery require group counseling,<sup>7</sup> group education, and orientation. Group methods are excellent and valid treatment modalities<sup>8</sup> but the fact remains that high officials and judges overwhelmingly elect not to participate. They choose individual care even though in many cases it may be slower, less effective, and less supportive.

There is nothing novel in proposing that “judge only” programs may work best in our society. Throughout the country and in Europe, groups exist composed exclusively for medical doctors with alcohol or alcoholism problems, for members of the clergy, or for mental health professionals.<sup>9</sup> All of these address a focal issue such as addiction and are led by either members of that profession, or counselors who are knowledgeable about that group and its culture.<sup>10</sup> Thus, modules of care solely for judges would encourage their voluntary participation, and offer the necessary understanding and privacy.

#### **Liaison with conduct commissions.**

Allegations of judicial misconduct and ethical breaches should routinely be screened by a joint liaison group including Wellness Initiative committee members. Experience with complex cases can be shared with anonymity and built up as a resource bank. Panels responsible for dealing with misconduct allegations, and the chief judges who deal with colleagues with problems, have much to learn from each other. This would be a challenging intersection of the disciplinary and health responsibilities of judicial administration. The purpose would be to assist a judge as early as possible in a potentially destructive situation, and steer him or her to appropriate care. Such joint committees should have sufficient tenure to benefit from their case-by-case experience and resolution. In many cases, knowing that impartial counseling help is available may motivate a judge to cooperate more actively in the resolution of his or her difficulties.

#### **System-wide orientation and education.**

The Wellness Initiative would establish and administer an annual program (for continuing legal education credit) on the full range of help available to judges and their families. DVDs and pamphlets would be provided outlining assistance that is available and how to obtain it. Vignettes would be presented as examples of help with, for instance, common family, medical, career, and aging issues. New judges would receive a full orientation by lecture and by talks with their chief and mentor judges. An annual report would describe the activities of the Wellness Initiative and provide objective data on patterns of use and suggestions for improvement. A panel of outside consultants representing the various areas would be helpful. A wellness website with information and links to resources should also be established and frequently updated.

#### **Training and orientation of chief and presiding judges.**

Each chief judge should attend an intensive brief course on “People Management.” This would include such topics as morale maintenance for court and chambers staff and positive collegial relations on a trial or appellate court. Practice sessions would

demonstrate how to evaluate reports of a possibly troubled judge and how to select alternative ways to offer help.

### **Volunteers.**

Because the appointment and tenure of chief judges varies widely among the states, experienced and temperamentally suited judges should be invited to become a corps of volunteers. They can help the chief judge when called upon and also participate in circuit-wide or state-wide education programs. Every instance of actual help provided should be studied (with appropriate anonymity) to build a knowledge base that will promote the Wellness Initiative's quality goals. A judge in difficulty does not automatically require a referral to the Employee Assistance Program network. Many can be helped by several private talks with an experienced and well-prepared colleague. Therefore, the Wellness Initiative would include the screening, selection, and training of volunteer judges who are motivated and temperamentally suited to be short-term counselors within each court.

The Lawyers Helping Lawyers programs use such volunteers from the bar very successfully and can also be a resource. They have assembled a core of recovering lawyers and judges who can be paired with a new entrant to the program to provide guidance on an ongoing basis.

In my own work with court systems and new judge orientation, I have encouraged judges to acquire one or two "buddy judges" with whom they maintain a mutually helpful collegial dialogue and relationship. These can occur within a particular court or across jurisdictions. A buddy judge may keep up a friendly periodic contact by email or telephone with a judge in another state or circuit. The key elements of such an important relationship require that both members of the duo (1) not have a competitive personality tendency, (2) fully respect confidentiality, (3) be reasonably available to communicate even across time zones, and (4) be a patient listener. Many such productive buddy judge relationships are best formed when new judges attend "Baby Judge" courses.

### **Referral networks.**

A system embracing a wide range of issues, and serving a prestigious and sensitive clientele, must be open and flexible.<sup>11</sup> It must be assumed that some judges will continue to search out helpers and treatment facilities in the open market of private practitioners or from religious and voluntary groups. The Wellness Initiative will add a court-wide set of oriented and prepared helpers who are judges or retired judges, and know the culture and the world of the courts. Not only will a judge have a qualified chief or presiding judge to turn to, but also a volunteer judge/counselor, or an existing group of judges he or she can join to discuss problems. The training of mentor judges would include sensitivity to problems that may arise in a new judge's career. Another part of the available network would be several telephone hotlines where a judge can ask anonymously about an ethical dilemma, a personal problem, or any other issue. All volunteer judges participating in the Wellness Initiative would thus be learning by experience and transmuting it into a database of help options.

### **Publicity and public relations.**

For today's media, with its focus on sensationalism, the courts are a frequent and easy target. A judge's behavior during a trial or conflicts with the bar can easily attract partially informed comment and speculation. A program such as the Wellness Initiative could easily be portrayed by critics as "coddling" judges, giving them preferential health benefits, offering excuses to be off the bench, or allowing errant judges to escape censure

or removal. Opponents in elections can also use some of the issues to “smear” a sitting judge. Thus, the program must be set up and guided with the advice of the court’s chief press or public relations person. In some jurisdictions it might be best to launch a wellness program gradually, without fanfare or even assigning a name to it.

### **Funding.**

As regards to funding, such a program should not impose significant additional costs because it would operate within the existing employee assistance program referral contracts and bar programs and use continuing judicial education programs for its promotion and training. In some cases, grant money could be available from foundations that support health initiatives and judicial administration.

What is crucial in launching and sustaining such an initiative is the leadership at the top and a cadre of motivated judges. Together they can design a program most appropriate to their state or circuit and serve as key supporters and stake-holders as it unfolds.

### **Summary**

To improve the use of health and collateral services by judges and their families, certain key elements should be considered in the spirit of a Wellness Initiative.

1. The range of services should be quite broad, and include mental health treatment and education, as well as help with stress management, substance abuse and addiction, family relations, physical fitness, career satisfaction, aging, and retirement, among others.
2. Due to the strictures of the judicial role and function in society, great care should be employed in the way that assistance is provided, taking into particular account the need for sensitivity, confidentiality, and privacy.
3. In accord with current best practices in the health sector, the approach best described as positive wellness should be employed. Outreach, supportiveness, and good organizational morale should characterize the network of services offered.

Judges work at the convergence of powerful demands, quite unlike those that confront other high officials. Heavy dockets, restrictions on their public speech and behavior, intense media exposure, wide public ignorance of the role of the courts, and the relative isolation of the judicial position all contribute to their unique personal and occupational stresses. The current body of knowledge and practice in positive health maintenance and psychology can inform and help judges. A Wellness Initiative program would contribute immeasurably to the quality of life of judges, their families, and coworkers.

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**JUDICATURE** Volume 90, Number 1 July-August 2006

## **GROWING OLD IS NOT FOR THE FAINTHEARTED**

*By Kenneth J. Hagreen and Cindy S. Reigle*

As we age, we lose our youthful vitality, including eyesight, hearing, stamina, and mobility. Our memories fade and our critical thinking skills slow down. Most of us will suffer from at least one major illness, and many of us will endure several chronic conditions. We will be treated by multiple doctors, be prescribed multiple medications, and take numerous over-the-counter medications in the never-ending search to feel and function better.

In addition to these bodily breakdowns, we must adjust to ever-increasing personal losses. Loved ones and friends become ill, are incapacitated, and die. Each loss will take its toll. The buildup of losses through the years can trigger severe emotional discomfort. Some of us are better able to accept and adapt to life on life's terms. But all of us are vulnerable to extended periods of bereavement, anxiety, or depression when too many losses accumulate. Many of us will use alcohol and other drugs to help ease the emotional pain.

### **Unintentional Alcohol Abuse**

As we become older, alcohol use may unintentionally become alcohol abuse. Unknowingly, we inflict additional harm upon ourselves if we continue to drink as we did when younger. By age 50, we experience a decrease in gastric alcohol dehydrogenase enzyme, a decrease in body water, and an increase in fat cells combined with a decrease in lean cells. The net result of these physiological changes is that a little alcohol now goes a long way. Amounts we used to drink with no ill effect may now cause intoxication or other complications. By age 65, it is generally recommended that a man should limit himself to one drink per day and a woman to even less.

### **Accidental Prescription Drug Misuse**

The use of sleep aids or tranquilizers creates another high-risk situation. Often a primary-care physician will prescribe these drugs to help us cope with insomnia, grief, or anxiety. This approach treats only the symptoms and not the cause. If they are to be used, these medications should be taken only for short periods of time and with carefully monitoring by the prescribing physician. Some sleep aids and nearly all tranquilizers carry a high risk for abuse and dependency. Inadequate instructions on the proper method of taking these medications, coupled with a poor memory often made worse by illness or fatigue, make the elderly vulnerable to unintentional misuse. When combined with alcohol and other medications, the interaction can be devastating and sometimes deadly. Anyone with a personal history of substance abuse or chemical dependency should avoid these medications. Before using sleep aids or tranquilizers, ask your physician if there are "safer" alternatives to help you sleep or relax.

### **Adverse Drug Reactions**

In addition to substance abuse and dependency, we must be aware of drug reactions. What do we mean by "adverse reactions"? For this discussion we are referring to a false appearance of dementia or depression — cognitive impairment, confusion, forgetfulness, indecision, anxiety, worry, irritability, a quick temper, and either an over- or under-reaction to serious events. "Younger" adults are all too quick to shrug off these symptoms merely as signs of "getting old." Their thoughts turn to finding facilities that

can provide proper care for the “senile” rather than finding a specialist to evaluate the older adult for a possible adverse reaction to the many medications he or she is taking. Such interactions may be further complicated by the use of alcohol.

### **Preventing Adverse Drug Reactions**

When you are prescribed new medications of any type, insist that your physician review all prescription and over-the-counter medications that you are taking. Potential adverse reactions or interference with the efficacy of your various medications should be carefully explained to you. If your physician refuses to conduct this review with you, find a physician who is willing to help you understand the effects of these drugs. The benefits of taking these medications should clearly outweigh the risks of an adverse reaction. If you must take these medications despite the risks, you will at least be informed and aware of what to look for should your medications cause you problems.

When taking multiple medications, it is easy to forget which pills to take, how many to take, or when or if you took them. The risk of inadvertent misuse resulting in adverse reactions to the medication is very high for the elderly. The consequences can be devastating. A written schedule and clear instructions can reduce the chances of accidental drug misuse. Some older adults, however, may require monitoring to ensure medication compliance.

### **Recognizing That a Problem Exists**

We need to catch ourselves whenever we automatically assign a diagnosis that someone is simply “getting old” and that there is nothing we can do to help. That is just not true. In many cases we *can* help, and it is relatively easy to do. Take a moment to read the risk factors that foretell a possible problem. Now look at the warning signs specific to older lawyers who are still practicing law. If your colleague has experienced a few of the risk factors or displays a few of the warning signs, there is cause for concern. What do you do if you think your older colleague is impaired?

### **Reaching Out**

First, assess their risk of harm to themselves or others. When in doubt, take immediate action—call an ambulance or your community crisis intervention center if you think your colleague is in immediate danger.

For the most part, however, we are talking about a colleague whose functioning is worsening but not life threatening *at this time*. Keep in mind that continued, albeit unintentional, misuse of drugs and alcohol will sooner or later become life threatening.

Become informed and get the best advice available on how to approach your colleague. Contact your state’s lawyer assistance program and ask for help. Do they have qualified clinical staff that can assist? If not, can they refer you to a specialist? Do any of their volunteers have experience with these kinds of situations? Can they recommend literature or websites?

You may or may not choose to involve family members or other colleagues at this time. Sometimes they are embarrassed or fearful. They may want to protect their friend or relative by denying or minimizing any problems. However, if they are concerned, willing and able to help, and discreet, keep them informed and use them as needed.

A private meeting with the “impaired” attorney may be best. Start off with general conversation. Then share something personal about your health, and work on winning confidence and trust. Blend in questions about his or her overall health, health-related behaviors, use of medications, and consumption of alcohol.

Here is where you may encounter the older lawyer’s coping mechanisms (which become stronger as we get older). Expect the lawyer to minimize or deny problems as well as misreport any emotional dis-comfort in terms of physical pain. Older lawyers generally fear losing their independence and feelings of self-worth, symbolized by their law practice. They may cling to their practice well beyond their ability to serve clients competently. Their practice becomes their only proof that their lives still have value. Understand that they will utilize very strong denial and coping mechanisms to protect their practice.

Try to elicit something they are concerned about. Listen patiently. Acknowledge and validate their concerns and complaints. Build upon their concerns in an effort to convince them to see their primary care physician. If they reveal nothing, tell them that you have noticed some problems and are concerned with how they are doing. Cite specific examples. Don’t come across as judgmental. Watch your tone of voice and body language, and make eye contact. Your primary goal is to show them that you sincerely care and are worried about them. Be careful not to give a “diagnosis.” Stick to the facts. Avoid terms that carry a stigma — alcoholic, drunk, drug abuser, addict. Put the focus on helping them to feel better and function better. Be patient and gentle. More than one meeting may be needed before they confide in you.

### **Enlisting Professional Assistance**

You have now started the process of making them aware that they have some health-related problems that can be treated to help them feel and function better. If they acknowledge that they can use some help, either you or their family should assist them in scheduling and keeping an appointment with their personal physician. Call the doctor in advance and present your concerns about possible adverse reactions to their use of alcohol and medications. The doctor may not be able to respond because of privacy laws, but he or she will likely listen to your concerns and address these issues when meeting with your older colleague. Hopefully there is a bond of trust between the physician and patient that will come into play if the physician recommends a second opinion and refers the patient to a specialist.

Either you or another concerned person should take all medications (prescription and over-the-counter drugs) to the doctor’s appointment and provide them to the physician. Obtain required authorizations for you or the family to stay informed and involved.

Keep in mind that the physician may likely not be a specialist in substance abuse and dependency. If this is the case, encourage him or her to refer the patient to a health-care professional who is knowledgeable in both aging and addiction. This expert can diagnose the problem and make appropriate treatment recommendations.

Diagnosing an alcohol or drug problem in the elderly can be tricky because of failing memory owing to the aging process or as a result of alcohol or drug misuse. Sometimes family members or friends can fill in the missing details. But if your colleague lives alone, even those closest to the person may not be able to provide complete and accurate information.

## **Hospitalization and Treatment**

If an adverse alcohol/drug reaction is suspected, the question is whether or not hospitalization is required while the senior is taken off the drugs (“detoxification”) and a new medication regimen implemented. Detoxification is medically riskier for older adults, especially when multiple chronic illnesses exist. A hospital setting is recommended when concerns for medical safety and removal from access to alcohol or mood-altering medications exist.

The need for extended alcohol/drug treatment must be addressed. Those who do not require hospitalization and have strong social support systems may be able to remain at home and attend outpatient services. Others may need the safety and reinforcement that comes with an inpatient stay at a traditional rehabilitation facility. Those who are frail, suicidal, or medically unstable should be placed in a medically managed and monitored intensive care facility. All treatment settings should incorporate age-specific group treatment; be supportive and nonconfrontational; aim to build or rebuild the patient’s self-esteem; place an emphasis on coping with depression, loneliness, and loss; use a pace and content of treatment that is appropriate for the elderly; have staff that are experienced in working with and are supportive of the elderly; and arrange appropriate aftercare for the patient upon the return home.

## **Help for the Recalcitrant Colleague**

But what do you do if after your private meeting your older colleague rebuffs your expressions of concern, denies having any problems, and tells you to mind your own business? Walking away is not an option. Your friend’s life may be in jeopardy. The quality of his or her life is already being harmed. It is time to recontact your state lawyer assistance program and request additional help. Bring in a professional who can help determine the best approach to motivate your colleague to change his or her attitude and behavior—behavior that is contributing to physical, mental, and emotional decline. Some circumstances may call for an “intervention”—a carefully planned and orchestrated meeting of a few concerned parties and the impaired lawyer. Interventions seek to stop friends and family from “enabling” the inappropriate behavior to continue. They also seek to help the impaired individual see the reality of their situation (“piercing the denial”) and agree to be evaluated by a qualified healthcare professional.

The intervention may lead to hospitalization and treatment if the person’s behavior, including misuse of alcohol and medications, places him or her at high risk of harm. In less severe cases, an intervention may be the first of several “motivational counseling” sessions. This approach acknowledges differences in each person’s readiness to address problem behaviors. Responsibility for change is placed on the individual. Although this is a slower approach, it can result in sincere, long-term, healthy changes.

## **You Can Make a Difference**

There is no silver bullet. Bar associations must establish programs on identifying and assisting the impaired, older lawyer. The bar should be prepared to appoint a conservator and, in some cases, close the practice. These are not the type of projects with which the average member of the bar wants to be involved. But this is a problem that is unlikely to go away. Baby boomers used or abused alcohol, prescription medications, and illicit drugs unlike any generation before; the prevalence of older lawyers in distress will dramatically increase during the next 25 years. We need to start preparing for this now.

You can make a difference. Create a committee of older lawyers, a judge, your state lawyer assistance program, and local health-care providers who specialize in aging, depression, and substance abuse. Establish a plan and procedure for helping elderly, impaired lawyers before they get into serious trouble with their clients and their health. Educate the bench and bar on how to identify an attorney in distress. Teach them how to reach out and help their impaired colleague. Help them to help others and in doing so allow them to experience the joy of having helped saved a lawyer's life.

#### **RISK FACTORS FOR SUBSTANCE ABUSE OR DEPRESSION**

- More than one drink a day (for people over 65 years of age).
- Prior history of alcohol or drug abuse or addiction.
- Coexisting psychiatric illness.
- Starting new medications or changing medications.
- Taking multiple medications (prescription or over-the-counter).
- Use of multiple physicians and/or pharmacies.
- Illness, injury, or a major traumatic event.
- Loss of vision, hearing, or mobility.
- Divorce or death of spouse.
- Retirement (voluntary or mandatory).
- Change in living circumstances (reduced social life or community support; increased social/drinking life).

#### **WARNING SIGNS FOR OLDER LAWYERS**

- Complaints about medications not working.
- Confusion, forgetfulness, indecisiveness.
- Anxiety, worry, fretting.
- Irritability or quick temper
- Over-reaction to events.
- Under-reaction to events.
- Poor hygiene.
- Clothes that are unclean or in disrepair.
- Insomnia or daytime sleeping pattern.
- Reduced physical activity.
- Unsteady gait, poor balance, tremors.
- Weight loss, skipping meals, forgetting to eat.
- Illness, injury, accidents.
- Being unprepared for meetings.
- Being financially irresponsible (bouncing checks, violating escrow accounts).
- Failure to complete work, missing deadlines.
- Failure to return calls or correspondence.
- Memory lapses.
- Decline in quality of work.

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## WELLNESS

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The Ninth Circuit has developed an outstanding *Wellness Issues - A Guide for the Chief Judges of the Ninth Circuit Courts* which provides a framework courts can use for offering assistance (*This guide, in its entirety, is attached to the end of this document.*) *Dealing with Professional Stress*: gives insights as judges discuss some of the major judicial stressors and suggestions for coping. *Preventing Burnout – Live Well, Laugh Often* discusses preventing burn-out and lists a number of very helpful quick-tips. The *Stress-Hardiness* article addresses a group of traits that allow lawyers and judges to thrive under extreme hardship: *challenge, commitment, control and connection/social support.*

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### DEALING WITH PROFESSIONAL STRESS: INSIGHTS FOR JUDGES

by Isaiah M. Zimmerman, Ph.D.

The judiciary is a numerically small group, subsisting on a modest budget, isolated, and shrouded in mystique. Some of the major stresses that affect judges include the following:

*An Abrupt Transition from Attorney to Judge.* With minimal preparation, a lawyer moves from active advocacy role to the more contemplative role of arbiter and judge. The euphoria and speed of the transition mask the shock of assuming the new role and learning the technical and procedural requirements. Later, most judges forget the trauma of being catapulted to the bench and facing a deluge of cases.

*Social Isolation, Image, and Status.* The judge and his family often find that they are gradually less involved in informal social life. The judge learns to observe the ethical strictures about the appearance of impartiality and withdraws from many political and business associations. As his status increases, an invisible wall forms, separating the judge and his family from friends and former colleagues. After that, a heavy workload ensues and the judge truly has little time for social life. The same taunts and pressures experienced by the children of clergy are often visited upon the children of judges. They become the targets of peers who wish to push them into a conflict between normal reflexes and the artificial and subtle constraints borne by a "judge's kid." The family of the judge is also exposed to periodic threatening and obscene phone calls. The judge himself is subject to physical assaults in and out of the courtroom. Public comments and complaints, as well as attacks by the press and television, are inflicted on the judge. The judge and his family typically offer no response or defense to such attacks.

*Bureaucracy.* Unless he has previously worked in the government, the new judge is not prepared for participation in a large bureaucracy with its multiple requirements for records, statistics, schedules, and approvals. Established administrative fiefdoms control and limit a great deal of what a judge can do, and what support he can elicit. Secretarial services, parking spaces, janitorial services, and prisoner transportation - all may be beyond his jurisdiction. The grind of these forces gradually subdues the eager, idealistic new judge. Individualized justice may yield to processing endless, faceless hordes of litigants and defendants. Due to the steep hierarchy of the levels of court, career progression, for most, is severely limited. Many judges end up feeling dead-ended.

*No Control over Caseload.* In an unceasing stream, the cases keep coming at the trial judge. He may call a recess, have lunch, hold a motions hearing - and in the meantime the paper and caseload creeps up and up. Established rotations in many states shift judges

between civil, criminal, and domestic courts. Unrelieved criminal or domestic cases can particularly burn out many judges unsuited by temperament to this type of work. In contrast to the reality of clogged dockets and judges' long hours, the public's image is that of a well-paid person who enjoys a leisurely schedule!

*Insufficient Critique.* Trial judges are never observed by their presiding judge" or colleagues except possibly in the context of a continuing judicial education course. They do not have the benefit of a constructive, impartial evaluation of their conduct of cases, behavior on the bench, handling of juries, and the atmosphere of their courtroom. The press, the court staff, and the members of the bar do not provide sufficient feedbacks. Judicial performance evaluation, when carefully designed, can be helpful. Without collegial critique, judges can be unaware of poor habits of communication, brusqueness of manner, or excessive aloofness. Judge-to-judge live observation and comment (without impinging upon decision-making) seems highly desirable. Appellate judges are fortunate in this regard. They are less isolated from colleagues and can legitimately offer comments upon each other's written work.

*Coping with Judicial Stress* In addition to the accepted utility of regular exercise, adequate nutrition, rest, and recreation, judges can manage stress more effectively by considering Some of the following suggestions.

1. More extensive initial preparation and training should be conducted before a judge embarks on full-time trial work. Such orientation should include stress management training, the voluntary use of a senior "mentor" judge, and guidance for the new judge's family. Observing an experienced sitting judge from the public's vantage point, and following him for two weeks in chambers and other official activities could be very helpful to a new judge, Realistic orientation to the structures and limits imposed by the court bureaucracy would also be worthwhile.
2. The cultivation of more judge-to-judge support can be achieved by extending the mentor judge network to include periodic meetings where personal reactions, naive questions, doubts, and worries could be expressed without self-consciousness. Such meetings should avoid domination by judges who project the image of being tough, omniscient, or brutally efficient.
3. Chief or presiding judges should be chosen on the basis of their talent and interest in people and systems management, and not by seniority. Chiefs should be supported and rewarded by additional training in judicial management. Since they are always part of an administrative team, it would be best for a new chief to be sent for management training with his Court administrator, to enhance their further cooperation.
4. Career judges should be required to take a sabbatical about every seven years. This, optimally, should not be another judicial course but an opportunity for any intellectual, artistic, or academic pursuit chosen by the judge.
5. A continuing public education program on the role of the courts and the functions of the judge would be beneficial. Several surveys have revealed how uninformed much of the public is about the judicial branch of government. Active participation by judges in such a program would have the additional effect of reducing their isolation.



6. Joint court-media committees could increase the understanding between the courts and the media. A norm of behavior should be established in the judiciary that each time a judge is attacked by the press, he should be contacted and offered support regardless of the merits of his alleged behavior.
7. Judges within two years of retirement should routinely be given an orientation about options open to them after retirement. This should not be a dry review of conditions and benefits but an engaging collegial process. They could be offered, on a voluntary basis, contact with an "exit-mentor" judge to discuss their plans and feelings. Many senior judges desire to continue serving in some capacity. Some could be utilized as part-time mentors of new judges; others could contribute to research.

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## **PREVENTING BURNOUT LIVE WELL, LAUGH OFTEN**

*By Adrian Hill*

The practice of law is a labyrinth of discomforts. As lawyers, we deal with people in trouble with the police, the tax collector, employers, employees, customers, suppliers, partners, and family. We work with interpersonal conflict in circumstances that invite moral discomfort. Our profession is aggressive, adversarial, competitive. We criticize our own without hesitation or mercy.

Our careers are made up of winning and losing, and our practice avoids or destroys opportunities for collegial support. Those of us in the non-adversarial areas of the law find ourselves swimming and sinking in a sea of mind-numbing paperwork and soul-destroying detail. Insight, creativity, resourcefulness, and instinct may find an outlet in our hobbies but rarely in our practice of law.

Many of us choose to work as sole practitioners or in very small offices. Even in large firms, isolation and alienation are common.

The challenge of meeting ever-higher public expectations and standards of performance while facing ever-lower public respect and understanding leaves us alone and resentful.

We learn to exhibit a professional demeanor and to hide our own alarm, fear, disgust, abhorrence, confusion, and boredom. We develop a tough exterior. We learn to expect little support from our colleagues. We learn to work with other lawyers as professionals and not as people. It is no surprise that many lawyers find themselves alienated and alone.

Lawyers and judges are notorious for working excessive hours throughout their professional lives. The process starts with young lawyers who feel they must excel just to keep up. Workweeks of 50, 60, 70, even 80 and 90 hours have become the accepted norm in some firms. Lawyers are actually boastful of the crushing schedules they keep, while secretly dreaming of another life.

We agree that our profession is becoming increasingly stressful owing to competition, specialization, and complexity. Lawyers are trained to develop a facade of imperviousness and implacability to personal problems. Some would suggest that lawyers are allowed to continue this steady progression of self-destructive conduct without interruption or intervention by their colleagues. Lawyers are rarely under the close supervision that is routine in other jobs.

### **Burnout and Workaholism**

Burnout is a type of depression characterized by fatigue, apathy, declining productivity and effectiveness, and negative feelings about work, career, and life. It often is accompanied by illness, increased substance abuse, and personal relationship difficulties. Burnout is often diagnosed as chronic fatigue syndrome or clinical depression.

Many lawyers suffering burnout admit to excessive hours over long periods, with little or no vacation. High levels of stress and job pressures are common factors, as well. For

these lawyers, the treadmill eventually loses meaning. They experience a loss of control and personal power over workloads and deadlines.

So, what tools help us enjoy our law practice and avoid burnout?

## **Having Fun**

**Laughter.** The first trick to a happy life is to laugh a lot. Laughing reduces stress, improves your immune system, and reduces anxiety and tension in your body. People will like you more. People will trust you more. People will want to be with you, and the people who want to be with you are the sort of people you would like to be with.

**Exercise.** Keep active and make sure you get exercise every day. It doesn't have to be anything dramatic: You can take a 10-, 20-, or 30-minute walk everyday, often with little change in the rest of your life. Let me give you an example. I have bicycled to work since 1963, and it rarely takes any longer than driving or using public transit. I do it all year round. It wakes me up in the morning and calms me down at the end of a difficult day. It gives me an hour's exercise, and this is a great base for a healthy life.

Whatever it is — biking, swimming, walking, gymnastics, competitive sports, gardening — do something every day. I mention gardening because, for me, gardening is an investigation into the very workings of the center of the universe. Get some exercise every day, and try to get strenuous exercise three times a week.

**Sleep.** Most men and women require seven to eight hours of sleep every night, but few of us make this a priority. You will find yourself fresher and more vigorous if you get a proper night's sleep. If you have trouble sleeping, just relax, lie quietly, and think nice thoughts. Force yourself to stop thinking about work or difficult personal issues. It takes practice, but you can do it. Avoid foods or drinks that will keep you awake.

**Sex.** It is no secret that sex is fun, exciting, fulfilling, relaxing — and it burns calories. Bottom line: Having sex with someone you love is healthy.

**Sunshine.** We need sun on our bodies for physical health. A little sun every day or so restores vitamin D and brings a whole army of health benefits. "A little sun" means about 20 minutes of direct sun contact or longer using sun protection. We all have to be aware of the dangers of over-exposure to the sun. As a cyclist, sailor, and canoeist, I have to take special precautions with my nose, the back of my hands, and the top of my knees—all areas exposed during these activities. I use a hat, clothing, and sunscreen to cover them. The best sun block is often an old white shirt from work. Hats are probably the most effective and underused form of sun protection. Seventy percent of skin cancers can be avoided by wearing a hat.

**Doing what you like.** What is it you really like in life? Reading? Music? A weekly bird-watching trek through a park? Canoe trips? Pickup baseball? Whatever it is, make sure you do it. If possible, do more of it. Keep your mind open. Be willing to learn new things about your likes and maybe even explore new activities. If you have an interest in something, read about it and learn about it. Remember to use your imagination and to use your mind. Both are like muscles: You need to exercise them.

**Friends and keeping in touch.** Remember to keep close with the people who are close to you. I keep a dozen postcards in my travel bag. When I am in a waiting room, sitting outside a courtroom, or if I have a few minutes to wait, I will write short notes to friends, just to keep in touch. Similarly, when I am out walking, I will use my cell phone to call people who might not otherwise hear from me. You can really brighten the day of an older relative, a next-door neighbor, or a friend with a very short phone call. It will brighten your day as well.

Every day of the week, make sure you talk to a friend. If the day is almost over and your schedule hasn't given you the opportunity to do so, get out your personal address book and look for someone who would like to hear from you. Send an e-mail, postcard, or short note. We cannot choose our families, but we can choose our friends—and these often make the best families. You have to invest in them, and that investment will pay off for the rest of your life.

**Dogs and other furry friends.** In my experience, the greatest source of unconditional, unlimited, perfect love and acceptance is to have a relationship with a dog. Who else will get so excited every time they see you? Who else will forget that you were cranky this morning and overlook the fact that you are exhausted tonight? Who else will want to go for a walk or have a cuddle? Who else will be happy with the dinner you serve? Dogs are wonderful. One of my dogs saved my life. One of my childhood pets saved my mother's life. My best friend would have died of a heart attack but for his team of dogs. My dogs enrich my life, each and every day.

If you can't fit a pet into your busy schedule, try to borrow one! Many of my friends have a surrogate relationship with my dogs and visit them often. If dogs are not your favorite, live with a cat, or a bird, or any other pet to add joy to your life.

**Helping others.** One of the best ways to build value in our lives is to find a way to give to others in our community. There is an old saying that we get to keep the happiness we have by giving it away. There are so many opportunities to help others; you can choose something that works for you. Let me share a secret: Helping others can replenish your energy, focus, and serenity. I sometimes go to a community group and pour coffee, set up chairs, and wash dishes. People love to see a big-city lawyer wash dishes! No matter how tired I am when I start, I always feel refreshed and invigorated by helping others. It's magical. By the time I get back home, I feel like a new man. Give it a try. The tough part is getting out the door.

**Keeping active.** Life is to be lived — this is not a dress rehearsal. Don't confuse having a career with having a life.

**Relationships.** Invest in, renew, and maintain your connection with your significant other. Remember the magic when you were first dating? Recapture it.

Schedule a weekly date with your spouse every week or several times a month for theater, dinner, sports, or just a walk. Be sure it's something you both enjoy and value. Find out what works in your relationship and try to do it. My wife loves it when I leave her a short note. Just a few words and she is cheered all day. Some people suggest the ten-second kiss, an open mind, or lifetime curiosity about your spouse. Others suggest that we stop listening like lawyers or forgo constructive criticism or ignore annoying habits in our spouse.

**Being grateful.** On a daily basis, remind yourself of the things you have to be grateful for. An attitude of gratitude can make a huge difference in your day and the way you treat those around you. Learn to want what you have, rather than having what you want.

## **Food and Diet**

Everyone knows that we should follow the National Food Guide and eat a balanced diet of food that is low in calories, rich in nutrients, and high in fiber. Still, many of us find ourselves eating fast food, often fried and high in fat and sugar, rather than the fruits, vegetables, and grains we need every day.

Below are some constructive ideas to help busy legal practitioners eat healthier and live longer. These ideas come from lawyers working in the trenches. Remember, the goal is progress, not perfection.

**Breakfast.** Have breakfast every day. My breakfast always includes protein (low-fat yogurt or cottage cheese) and mega-fiber (unsweetened cereal). Last year, I ended my 20-year romance with raisin bran when I learned that it has more sugar than any other cereal, including the sweetest children's brands. If you are one of those people who has trouble eating in the morning, find something you can handle and get into the habit every day. The important thing is to eat something to get your day started.

**Lunch.** Salads are a great choice for lunch. Ask for the salad dressing on the side and dip your fork into the salad dressing instead of drenching your salad with it. Don't forget protein in the form of white cheese, nuts, or meat. Most work days, I have a Greek salad with small strips of roast chicken on top. It's inexpensive and delicious. Better yet, bring your lunch on some days and then go for a walk with a colleague or take your cell phone and call your spouse, your mother, or an elderly neighbor.

**Dinner.** Eat before you are actually starving. Try not to overeat and remember to avoid caffeine and other stimulants from early afternoon onward.

**Protein.** I find that I need to eat protein throughout the day. For years, I thought it was normal to feel light-headed, spacey, and frantic as the workday progressed. Now I know I was mildly hypoglycemic. The simple cure is protein. Surprisingly, it doesn't have to be very much, but it does have to be every three to four hours. When my work schedule interferes, I will grab four or five plain almonds from a jar in my desk drawer. On the go, a small tub of yogurt is more than enough.

**Vitamins.** Make sure that you have a diet that includes all the necessary nutrients, vitamins, and minerals. Some nutrition experts swear that vitamin supplements are a waste of money. Others claim they are salvation itself. Personally, I have no idea who is correct. I compromise and use low-cost generic store brands for the basics—a good American compromise.

## **Health Issues**

**Weight.** Try and keep a constant and desirable weight. There are index scales available that allow you to check your body mass index (weight to height ratio). Forget the fad

diets and miracle weight-loss programs. If your weight is too high, develop better eating habits. Moderate your diet until you achieve a healthy and desirable weight.

**Aspirin.** It is helpful for men over 40 and for women over 50 to take aspirin. We need only about a quarter of a regular-strength tablet. I cut generic aspirin into four parts and take a quarter at a time, but you can now buy 80 mg tablets for this very use. Some folks prefer coated aspirin, which is easier on the stomach.

**Cholesterol.** Check your levels every year. Unfortunately, many people check their cholesterol only after a heart attack. This is a little late. Sometimes, the first symptom of heart trouble is a fatal heart attack. Fatal means dead. Enough said.

**Menopause.** Every woman should check hormone levels every year or two. Most women expect to go into menopause in their middle 50s, but some women start menopause in their early 30s. Get the best professional advice about hormone replacement therapy and keep on top of the literature. Talk to your friends who are older or who have personal experience.

**Alcohol.** Drink alcohol in moderation. One or two drinks a day (standard quantity) are absolutely fine for most people. In later life, alcohol consumption should be reduced, as aging reduces the body's ability to metabolize alcohol safely. Many doctors say that a glass or two of red wine a day actually improves health. For people who can drink safely, this may well be true. Those of us at risk for alcohol abuse or addiction should be very, very careful. This includes those of us with a family history of alcohol or drug abuse or addiction. If you have a problem, contact your lawyer assistance program (LAP).

**Prescription drugs.** Drugs play a major role in medical treatment and health, including preventing and curbing disease, relieving pain, controlling psychological problems, and speeding recovery from illness and surgery. But they also play a devastating role in the lives of many who become dependent on or addicted to them. Popular myths suggest that people become addicted because of personality problems or that only young people have problems with drugs or only illegal drugs are addictive or dangerous. In fact, the majority of lawyers with drug addiction or dependency use legal prescription drugs. The elderly may be the fastest-growing population to become addicted or drug dependent. If you need help, information, or recovery services, contact your LAP.

**Moderation.** Work and play in moderation. Don't burn yourself out in any area of your life. Consume in moderation: meats, fats, sugar, coffee, chocolate, alcohol. Participate in moderation: running, weight training, aerobics.

**Smoking.** If you smoke, quit. If you don't smoke, never start. Mark Twain once said, "To cease smoking is the easiest thing I ever did. I ought to know because I've done it a thousand times." Personally, I finally quit more than 20 years ago, but I still get cravings. Smoking dependency or addiction is no joke. It is just about the most damaging thing we can legally do to our bodies. When you are ready to quit, get help and stick with it.

### **Managing Your Business and Your Personal Finances**

Finances. You can avoid tremendous stress and day-to-day trouble by living within your means. Money worries are the biggest stress in marriage and certainly in professional practices as well. Far too many of us live beyond our means by borrowing on credit

cards, lines of credit, and term loans. Be sensible about your finances and about managing your business.

Networking. Every business day of the week, make sure you contact two people who could give you work or help your practice or your career. Keep a note in your business diary or appointment book of the people you contact. Keep the calls short. You will be surprised how much work you can pick up simply by keeping your contacts active.

Workload. Don't take on work you can't or shouldn't handle if you don't have the necessary expertise or experience or energy or time; if the fee will be so low that it isn't worthwhile; if you have a personality clash with the client or the project; or if you just don't like this client.

**Quick tips:**

- When all hell is breaking loose, pause and identify your true priorities.
- Anticipate problems and prevent them from happening.
- When problems do occur, jump on them as soon as possible.
- Break down big tasks into smaller parts and get started.
- Resist the temptation to do everything yourself.
- If you just can't decide if it is a good idea, you have already decided that it just isn't worth it.
- When taking on new staff, follow your gut instinct. If it "feels" wrong, it will turn out badly for you and your practice.
- And perhaps most important of all: Dump the 5 percent of your clients who are the source of 95 percent of your problems!

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GPSolo Magazine - October / November 2004

## **STRESS-HARDINESS: THE PATH TO RESILIENCE FOR LAWYERS**

*By Nancy Stek, Assistant Director  
New Jersey Lawyers Assistance Program*

Lawyers belong to a profession that is highly stressful. Studies confirm we have higher rates of depression, anxiety-related disorders and addiction than the general population. Recognizing and building our “resilience” or “stress-hardiness” provides needed protective factors that enhance legal careers despite high levels of stress and strain. Continually working against deadlines in highly charged, adversarial and competitive settings exacts a very high price, unless a lawyer ranks high in hardiness traits.

### **HARDINESS AND RESILIENCE**

What are the attitudes and skills that comprise hardiness and resilience? More importantly, how can they be acquired? Dr. Martin Seligman, the founding father of Positive Psychology, has recently identified a set of human strengths acting as buffers against extreme stress, adversity and psychological illness. According to Seligman, these traits include courage, optimism, interpersonal skill, work ethic, hope, honesty, responsibility and perseverance. His work also identified several buffering traits that protect against stress and adversity. These traits fit well into a framework developed by Dr. Salvatore Maddi known as “Hardiness.”

Lawyers benefit from Dr. Maddi’s research and work with corporate executives. Over a twelve-year period, Dr. Maddi and his team of researchers worked with 400 employees before, during, and after the greatest divestiture in history: the break up of AT&T. The results of this landmark study showed almost 2/3 of the people had significant health/wellness breakdowns. Problems included heart attacks, strokes, obesity, poor performance, demotions, depression, anxiety states, burnout, substance abuse and divorce.

However, one result from the study was remarkable: 1/3 of the employees not only survived the upheaval but thrived in spite of it. This opened the door to 25 years of additional studies about hardiness, continuing to validate the original findings. Those who thrived had in common three key beliefs that helped them to turn adversity to advantage. These beliefs, according to the researchers, “appear to interact together to synergistically motivate coping behaviors that help one to manage change.” These three characteristics came to be described as “Hardiness.” Hundreds of research studies conducted since Dr. Maddi’s original work in the 1980’s consistently confirming the unique stress buffering nature of the characteristics referred to as “the 3 C’s.”

### **CHALLENGE**

The first characteristic of people maintaining health in the face of change and high levels of stress has to do with the “challenging” way they approach life. Those looking at life as a challenge tend to welcome new situations as opportunities. They learn, grow, and develop rather than reacting to new prospects as threats. They believe they can grow from positive life experiences as well as negative ones and they readily accept the idea that change is a positive and normal characteristic of life. This optimistic, challenging attitude about self, the world, and the interaction between the two allowed employees in



the study to stay motivated. They engaged in peak performance, leadership, and health enhancing thoughts and behaviors. The “glass half-full” as opposed to “half-empty” characterizes this kind of attitudinal shift. This shift also encompasses risk-taking, adapting easily to change, and looking at life and its adversity with a “give it your best shot” attitude.

## **COMMITMENT**

“Commitment” is the second characteristic that the ‘hardy’ group shared. Being committed to finding meaningful purpose in life set these individuals apart from the 2/3 who had wellness breakdowns. People who are high on commitment are fully involved in what they are doing. This sense of commitment allows people to feel important and worthwhile enough to engage fully in work tasks despite stressful changes that may be taking place. They give activities their best, not their perfect, effort and have a curiosity about what they are doing instead of a feeling of detachment or isolation. Involving oneself in experiences in committed, meaningful ways is the second essential anchor in this “hardy” triad.

## **CONTROL**

The last characteristic is “Control.” Control motivated the thrive group to find ways to influence the outcome of stressful changes, rather than lapse into helplessness and passivity. The element of control has been studied extensively in the field of psychology. Studies look at the extent to which we believe that the outcomes of our actions are contingent on what we do (internal control orientation) or on events outside our personal control (external control orientation). Those who experience unhealthy emotional states and engage in harmful behaviors have an “external locus of control.” Individuals with an ‘internal locus of control’ would rate high on this hardiness element and tend to perceive themselves as “in charge” and “responsible” for the outcomes of their lives. They tend not to be “blamers” and “complainers” and feel in control of their destiny and direction in life. These people develop a strong sense of self-efficacy instead of feelings of powerlessness. They have a realistic perspective on changing the things they can and accepting the things they cannot.

## **CONNECTION OR SOCIAL SUPPORT**

In addition to the three C’s, challenge, commitment, and control, a fourth “C” surfaced in Maddi’s work. “Connection,” has proven to be a crucial factor in individuals who bounce back and resist stress. Research exploring how and why people get well in therapy points strongly to the connection between the client and therapist. Mutual-aid or self-help groups owe their success, in part, to the power of belonging and connectedness provided by being a member of a community. In the original study, employees who thrived possessed a specific pattern of giving and getting social and personal assistance and encouragement both to and from their work community. According to the research, social support contributes strongly to the strengthening of their attitudes and coping skills. Creating and maintaining a supportive, caring and encouraging environment goes a long way to enhancing and strengthening personal hardiness. Additionally, social support from individuals outside of work is just as important in fostering and building hardiness. Having close family ties, friendships and other avenues for social support (religious / spiritual, community based clubs / interest groups) is shown in several studies as adding or supplementing what is missing or available in the work community.

## **STRESS AND HARDINESS IN THE PRACTICE OF LAW**

Two main factors contribute to the legal profession experiencing higher rates of stress-related problems: the nature of the practice of law and the characteristics of those who are drawn to it. Most people who pursue law school are high achievers, intelligent, hard workers who have fared well academically. Law schools are full of people who are used to excelling and being at the top. Competing with other high achievers doesn't allow for the same level of accomplishment. Not always finishing first may lead to diminished self-esteem and questions of self-worth. For some attorneys, reasons for pursuing a law career may eventually be inconsistent with their goals and clash with their sense of self. Others may be suited for neither the more exacting aspects of the practice of law nor the more monotonous ones. They may discover that they do not have the passion for the work or may lack the skills necessary to survive in our highly competitive profession.

The practice of law often creates a highly stressful, demanding work environment. The stress and demands persist for seemingly countless hours and endless days. As a result, lawyers have less time to spend on their own physical, mental, and emotional needs. There are innumerable and conflicting deadlines, many of which may be out of the lawyer's control. Attorneys are often obliged to serve several masters: clients, judges and partners, each demanding priority. Additionally, there are individuals in a lawyer's personal life also demanding attention, compounding the stress. The legal system is an adversarial process and therefore is not always a good fit for the personality styles and emotional needs of many dedicated attorneys. The practice has become more focused on winning or losing, not how the game is played. Many lawyers find it difficult to reconcile these conflicting goals and values. Finally, lawyers are sought out and expected to handle complex, difficult and painful matters. Vicarious trauma or the "cost of caring" as identified by Dr. Charles Figley in *Compassion Fatigue* (1995), results from working with difficult and traumatized clients and negatively impacts the attorney's ability to perform and cope. Continually working in such highly charged settings exacts a very high price.

## **THE HARDINESS PATH TO RESILIENCE**

Much learned from the hardiness research fits the legal profession. The researchers identified a group of traits that allow lawyers to thrive under extreme hardship. Through special training researchers helped individuals develop key attitudes and resources for transforming change to opportunity. Participants decreased in signs of strain such as anxiety, depression, distrust, and blood pressure while increasing in job satisfaction, morale, and Commitment, Control, and Challenge. Applying the 3 C's to the practice of law while creating social support leads to stress-hardiness: thriving in adversity, seeing the glass half-full and taking an active role in the direction of one's life and practice. Building stress-hardiness is the path to becoming a resilient lawyer.

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## AREAS OF IMPACT ON JUDICIAL WELLNESS

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The vicarious trauma article discusses the need for greater awareness among judges on this subject which can result in judicial burn-out. The *Attorney Interrupted* article uses an incident in the life of an attorney combating depression, but is similarly applicable to judges handling the resultant stresses. The *Compassion Fatigue* article is in the same vein as the *Vicarious Trauma* article. The *Dangerous Link* article describes the connection between office chaos, stress, depression and substance abuse, followed by articles on *Isolation, Gambling, Internet Addiction, ADHD, and Denial*.

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### **Vicarious Trauma in Judges The Personal Challenge of Dispensing Justice**

*Peter G. Jaffe, Claire V. Crooks, Billie Lee Dunford-Jackson and Hon. Michael Town*

Becoming a judge is considered the pinnacle of professional achievement in the field of law. Literally and symbolically, judges are the face of justice in many areas of their communities. Judges must model fairness, impartiality, patience, dignity, and courtesy to all with whom they come in contact, in contrast to the often rough-and-tumble environment that constitutes the courtroom. Matters of domestic violence, murder, rape, child neglect and abuse, divorce and child custody, mental illness, sentencing, and more play out daily, while the media, families of the parties, victims, and others often observe and comment. The combination of factual circumstances and emotions that is displayed, together with the sheer volume of cases, would test any judge's patience.

As modern-day judges take the bench, we need to ask what skills, values, and attitudes they need to bring with them and to develop as they continue their careers. How can they balance the need to be human and engaged in their work with the need to maintain professional distance? Is their role that much different from that of an emergency room physician, clergy person, mental health professional, or social worker? And what models and techniques exist to guide judges in addressing the stresses and pressures of daily emotion-laden cases? A better appreciation of all of these dynamics helps inform the judiciary to remain as effective as possible in the face of these stressors. At the extreme, these stressors, together with the traumatic nature of the material that judges have to consider, can result in vicarious trauma.

### **What Is Vicarious Trauma?**

Vicarious trauma (VT) refers to the experience a helping professional undergoes in developing personal trauma symptoms as a result of working with victims of trauma. VT is a very personal response to the work such helping professionals do. VT is sometimes used interchangeably with terms such as compassion fatigue, secondary trauma, or insidious trauma. This phenomenon is most often related to the experience of being exposed to stories of cruel and inhumane acts perpetrated by and toward people in our society.<sup>1</sup> The symptoms of VT parallel those of posttraumatic stress disorder (PTSD) and can be similarly clustered into the areas of reexperiencing, avoiding and numbing, and persistently arousing.<sup>2</sup> The fundamental difference between VT and PTSD relates to the nature of the stressor. Figley distinguishes these as primary stressors (experiencing a serious threat to self or sudden destruction of one's environs) and secondary stressors (experiencing a serious threat to a traumatized person or sudden destruction of a traumatized person or sudden destruction of a traumatized person's environs). Empathy has been identified as one of the mechanisms of transfer between primary and secondary trauma. Thus, the empathy that is so critical to working with traumatized people also increases the likelihood of vicarious traumatization.

VT has been identified as a potential occupational hazard for numerous professionals who confront trauma, violence, and personal injury. Although most of the research and literature has been geared toward police, therapists, shelter workers, and emergency relief workers, recent efforts have expanded the concept to recognize the risk of VT to those in other roles. Saakvitne and Pearlman offer a list of twenty-one professions that are affected by VT and have expanded the traditional group to include others such as foster parents and prison staff.<sup>3</sup> Although judges are also on that list, there has been little public recognition of VT among the judiciary until recently. Psychologist Isaiah Zimmerman conducted interviews with fifty-six Canadian judges and presented his findings at the Canadian Bar Association Annual Meeting in August 2002. His stories of the "torment" judges experience in dealing with cases of sexual abuse, child maltreatment and domestic violence captured the attention of the public at large.<sup>4</sup>

This article was written to extend this preliminary effort by Dr. Zimmerman and to serve as a springboard for future research and discussion in this area. We also recognize that there are many well-adjusted judges who truly enjoy their work and look forward to long and satisfying careers. The extent to which respondents in the Zimmerman study are representative of the general population of judges is unclear. Research in this area needs to be informed by judges who have developed successful coping strategies, as well as by those judges who have been more adversely affected. An important conceptual distinction must be made between *burnout* and *vicarious trauma*. The construct of burnout has been the focus of far more theoretical and empirical study than VT.<sup>5</sup> Maslach developed the most widely used definition of burnout: "A pattern of emotional overload and subsequent emotional exhaustion is at the heart of the burnout syndrome. A person gets overly involved emotionally, overextends himself or herself, and feels overwhelmed by the emotional demands imposed by other people."<sup>6</sup>

Farber offers a slightly different definition that posits burnout as a syndrome that stems from a perceived discrepancy between an individual's effort in his or her work and the reward received for that work.<sup>7</sup> Both of those definitions suggest that burnout can be a chronic, negative emotional experience, but one that lacks the intensity and trauma-related symptoms of VT. Thus, although burnout is neither necessary nor sufficient to produce VT symptoms, it can be a contributing or exacerbating factor. Burnout results in a vulnerability to VT, whereby the individual may not have the personal resources to combat the impact of VT effectively. Although stress may be normal and even motivational, excessive stress leading to burnout would likely magnify the impact of VT.

Three overlapping spheres of experience are thought to influence a person's vulnerability to VT: individual, organizational, and life-situation.<sup>8</sup> The likelihood of experiencing VT is as assumed to vary for individuals and their circumstances. For example, a judge dealing with domestic violence in a child custody hearing would more likely experience VT if he or she had grown up with domestic violence, experienced a recent or particularly difficult divorce, or had a heavy docket of emotional cases with little support from peers. Conversely, some judges may be better equipped to deal with difficult cases by virtue of their own positive life experiences with family, school, and work, while others who have been overly sheltered may be quite ill prepared.

VT is especially relevant for judges given the changing nature of the cases in family, criminal, and civil dockets. Today we certainly hear more about and see more difficult cases that reference child abuse and domestic violence. There is also a clear trend toward unified or coordinated family courts and dedicated specialty courts such as drug courts, domestic violence courts, problem-solving courts, and community courts. The necessary corollary for judges in these courts is a steady diet of highly emotional cases. Judges'

dockets have changed dramatically in a short period of time and will continue to change as society tries to hold itself accountable for families, children, and communities in distress by placing more and more responsibility on the judiciary.

In some respects, the delay in recognizing judges' vulnerability to VT may stem from several apparent contradictions. On one hand, judges may not be considered "frontline" workers in the same sense as child protection and shelter staff; on the other hand, judges are increasingly exposed to graphic medical evidence, tapes of 911 calls, photographs and videotapes of injuries, and victim-impact statements of surviving family members. Although judges are widely seen to occupy a place of privilege, the "privilege" of adjudication is often accompanied by isolation. In addition, there are many unique aspects to the judicial role that further complicate the process. For example, judges are required to maintain neutrality in the face of apparent tragedies and are expected to perform their duties impartially, without being swayed by emotion. Judges are expected to keep their own counsel in the interests of confidentiality and due process. As a result, they are largely excluded from the critical debriefing process that is in place for many other frontline professionals. A number of recent initiatives have emerged to remedy this gap, including judicial mentoring programs and judicial teams that encourage collegial collaboration and debriefing.

The legal training that provides a foundation for judges' careers emphasizes a variety of experience, including trial preparation and advocacy, settlement and mediation, legal and factual analysis, working with expert witnesses, and legal research. Professionals in other sectors that deal with violence, such as social workers, may be better trained to disclose their own thoughts and feelings, and to process the emotional impact of their work, to their colleagues. Clearly, the judicial role is one that shares many characteristics with other professions that are recognized to create risk for VT, but judging 'carries its own unique risk factors.

### **The Study**

The current study was conducted as a preliminary investigation into the types of VT symptoms that judges experience over time. Because of the dearth of research in this field, the initial research questions were:

1. What are the rates and types of VT symptoms experienced by judges?
2. Are there relationships between VT experiences and judge characteristics such as age, experience, and gender?
3. What do judges suggest as effective coping and prevention strategies to deal with VT?

### **Participants**

A total of 105 judges were involved in the study (54.3 percent male, 45.7 percent female). The average age of the judges was fifty-one years ( $SD = 8.1$  years), with male judges significantly older than female judges,  $F(1, 103) = 12.69, P < .01$ . The average experience of the judges was ten years ( $SD = 6.7$  years), with male judges serving longer on the bench than female judges,  $F(1, 103) = 5.77, P < .05$ . With respect to type of court, 81 percent did some criminal court work, 54 percent indicated domestic relations/ civil court work, and 30 percent presided in juvenile court. (Percentages exceed 100 percent as a result of overlapping assignments.)

### **Materials and Procedures**

Participants were judges attending one of four workshops. Three were entitled "Enhancing Judicial Skills in Domestic Violence Cases" and were organized by the

National Council of Juvenile and Family Court Judges and the Family Violence Prevention Fund. The fourth covered the topic of domestic violence and was hosted by the American Judges Association. These conferences were held in Seattle, San Diego, Santa Fe, and Maui. These judges represented a cross section of urban and rural centers across the United States; different levels of courts; and a range of criminal, civil, and specialized courts.

Judges were invited to complete a survey distributed at a presentation on stress, burnout, and vicarious trauma. The survey asked questions about the short- and long-term impact of their job with respect to trauma symptoms, the judges' coping skills, and their ideas about prevention of VT. The sections on trauma symptoms and prevention strategies were open-ended. In contrast, the section on coping provided a list of possible activities that judges could identify, as well as space to record additional answers.

The results were organized into three sections: trauma symptoms, coping strategies, and prevention strategies.

### **Reported Trauma Symptoms**

Overall, 63 percent of the judges reported experiencing one or more short- or long-term VT symptoms. Female judges were significantly more likely than male judges (73 percent vs. 54 percent) to report the presence of one or more symptoms  $\chi^2(1, N = 104) = 3.83, p < .05$ . In addition, female judges reported more symptoms on average,  $F(1, 103) = 4.96, P < .05$ . When judges' experience and trauma symptoms were inspected, there appeared to be a split at the seven-year mark. Judges were categorized on the basis of having between zero and six years of experience ( $n = 38$ ) or seven or more years of experience ( $n = 67$ ). – Judges with more than six years of experience were more likely to report the presence of one or more symptoms  $\chi^2(1, N = 104) = 6.11, P < .05$ . Judges with more experience also reported a significantly greater number of symptoms than those with less experience,  $F(1, 103) = 6.56, p < .05$ .

Because of the open-ended nature of the questionnaire, symptoms were coded into thirty-nine categories that were developed for this study. These categories spanned a wide range of functioning, including interpersonal difficulties (lack of empathy, intolerance of others); emotional distress (depression, sense of isolation); physical symptoms (difficulty sleeping, loss of appetite); cognitive symptoms (difficulty concentrating); and actual diagnoses (major depressive disorder, posttraumatic stress disorder). The most frequently identified short- and long-term symptoms are listed in Table 1.

Next, the categories were further grouped into three symptom factors internalizing problems, externalizing problems/hostility, and unique trauma symptoms--on theoretical grounds, as shown in Table 2. Short- and long term symptoms were combined for subsequent analyses. Internalizing symptoms were intended to capture those related to anxiety, depression, and somatic problems. Externalizing/hostility included strong negative emotions (anger, frustration, cynicism) and interpersonal difficulties. The unique trauma factor was constructed by mapping symptoms of VT onto the three domains of PTSD symptomatology (reexperiencing trauma event, avoidance/numbing, and persistent arousal) as posted by Figley in his seminal work.<sup>9</sup> Construct scores were generated on the basis of these theoretical groupings, and judges were compared on the basis of sex and experience.

Female judges scored higher on the internalizing factor than male judges,  $F(1, 103) = 4.32, P < .05$ , but there were no sex differences on the externalizing/hostility or unique

trauma factors. Conversely, judges with seven or more years of experience scored significantly higher on the externalizing/hostility factor than those with less than seven years of experience,  $F(1,103) = 6.88, P < .01$ . Judges did not differ on unique trauma scores on the basis of experience, but scores on the internalizing factor approached statistical significance, with more experienced judges reporting higher scores.

### **Coping Strategies**

Judges were asked to identify coping strategies that they use to manage VT symptoms. Coping strategies were divided into three categories: personal, professional, and societal. The average number of strategies in each category, as well as the most frequently endorsed strategies, are shown in Table 3. There were no significant sex differences with respect to the number of strategies endorsed. Similarly, male and female judges were equally likely to identify one particular strategy as helpful. Although strategies from all three domains of coping strategies were chosen, the majority of selected strategies were in the personal coping domain.

The portion of the survey dealing with prevention provided an open-ended question for judges to identify potential strategies. Of the 105 judges, 73 percent provided at least one prevention strategy. These strategies included achieving balance between work and home life, developing healthy philosophies, and maintaining a sense of humor. The strategies were consistent with the "ABC" model of VT, which identifies three areas of intervention." The ABC model identifies the importance of Awareness (Le., being attuned to one's needs, limits, emotions, and resources); Balance (i.e., among activities, especially work, play, and rest); and Connection (to oneself, others, and to something larger).<sup>11</sup> Sample responses for all three areas are shown in Table 4.

### **Discussion**

The purpose of this study was to begin to document the VT experiences of judges. Although this was a preliminary investigation, the results indicate that judges do, unequivocally, experience trauma symptoms with respect to their work. The surveyed judges indicated a wide range of symptoms that they identified as stemming from their work, including cognitive (flashbacks), emotional (anger, anxiety), physiological (fatigue, loss of appetite), PTSD (flashbacks), spiritual (losing faith in God or humanity), and interpersonal (lack of empathy, sense of isolation from others). Clearly, judges' exposure to the graphic evidence of human potential for cruelty exacts a high personal cost.

Additional findings from this study suggest that age, sex, and experience may be important factors in predicting judges' experiences of VT. Furthermore, the respondents identified the importance of a range of coping strategies and generated numerous prevention possibilities. Both the coping strategies and suggestions for prevention were consistent with previous work in the area of VT in that they highlight the importance of awareness, balance, and connection across both personal and professional realms of experience.<sup>12</sup>

One of the starkest contrasts arising from this research is the disconnect between what judges identify as ideal coping and prevention strategies and the reality of the judicial culture. Although many of the judges surveyed indicated the importance of social support and debriefing, the reality is that some judges "work in isolation, they cannot consult about a case, they see horrific crimes, make weighty decisions and have to keep their mouths shut about everything."<sup>13</sup> We do not want to overstate the problem, but isolation is indeed a dynamic that can and must be addressed, consistent with judicial ethics. The importance of debriefing and consultation are identified by mental health

professionals as priorities for minimizing VT<sup>14</sup>; unfortunately, due to the sensitive and confidential nature of the information handled by judges, these options are not readily available. As one judge quoted in Zimmerman's study said: "I wasn't prepared for the isolation of this position. It slowly overtakes you, and then you realize how alone you are, despite your friends and family."<sup>15</sup> Some judges have written about their unique opportunities to learn from tragedies rather than isolate themselves, utilizing resources such as "domestic violence death review committees" that address broader community and court responses that may prevent domestic homicides.<sup>16</sup>

Another significant point of conflict between judges' needs and the prevailing judicial culture relates to workload. In reporting coping and prevention strategies, many judges commented on the need for balance and for setting boundaries around the workday. Some spoke of the need to be away from the office by a certain time, and others mentioned a more general need for balance between "work and play." Many of the judges also identified the increasing pressure to handle quickly or dispose of more and more cases by decision or settlement. The overwhelming workload judges carry also emerged in Zimmerman's study: "The sheer volume of each day's work makes me fear I'm just processing people and have lost touch with my better self. Am I becoming indifferent to horror?"<sup>17</sup> Thus, some of the characteristics that may define the experience of being a judge (massive dockets, isolation, inability to debrief), particularly in jurisdictions without systemic controls, are those same factors that have been identified as risk factors for VT. On the other hand, some judges reported the benefits of good administrative supports, which may be more apparent in specialized courts with judicial officers and court staff who are highly committed to their innovative endeavors.<sup>18</sup>

### **Study Limitations**

Although this study represents an important first step in the investigation of VT among judges, there were several limitations with the research design. First, the sample was not random. All participants were attending a professional development workshop, which itself has been identified as a prevention strategy. Second, questions about symptoms were asked in an open-ended manner (rather than a checklist form). This strategy was appropriate given the exploratory nature of the study; however, it relies on a certain amount of personal insight. For example, if an individual does not make the connection between work-related stressors and interpersonal difficulties, he or she will not provide that as an example of a VT symptom. However, that same individual might recognize the link if "interpersonal difficulties" were listed as one of several possible VT symptoms. As a result, interpretations about base rates of particular symptoms must be drawn very cautiously.

Future research could expand this area in several ways. First, this preliminary information could be used to generate a checklist of symptoms for a more structured assessment tool. This type of tool would produce more accurate base rates of specific symptoms in future research. In addition, there is a need to collect more data about the nature of judges' workloads and the nature of the courts. From our experience training judges, those who specialize tend to have fewer symptoms, most likely owing in part to more resources, more intensive training, and more connection with the community. Another research direction might be to adapt existing models of VT to judges. In order to develop these models, information about childhood or adult experiences of abuse, current life stressors, and personal support networks would need to be collected, consistent with the emphasis on individual, organizational, and life situation factors.

Another key issue relates to the differentiations among ordinary levels of work stress, burnout, and VT. Longitudinal data collection with a larger sample of judges would



facilitate this model building. It is also important to understand better the process that leads to VT over time, in the same way that some authors have identified the stages of burnout, in order to promote early identification and intervention.<sup>19</sup> To quote Ralph Waldo Emerson: "The moment we indulge our affections, the earth is metamorphosed all tragedies, all ennui vanish ..."<sup>20</sup> The key to prevention for many judges in this process leading to burnout and VT may well be staying engaged in their work.<sup>21</sup> The meaning of gender differences in experiences of VT needs further investigation. It may be that female judges experience more distress, paralleling elevated rates of anxiety and mood disorders in general when compared with male judges.<sup>22</sup> However, the extent to which this is a real difference as opposed to one encountered in reporting needs to be addressed. A workshop on this topic reported that individual judges greatly underestimated the impact of their stress and work on their personal functioning compared with the level of impact noticed by their spouses. The participants received a standardized self report inventory on stress, which verified that they see themselves under significantly less stress than that noticed by their spouses. This feedback generated positive insights and commitments to change from the judges. Some of the respondents in this study noted that they had not been aware of the profound impact of their work until after they changed assignments and were able to gain more perspective. Additional research will help illuminate this issue.

### **Conclusions**

This study highlights the need for greater awareness about the experience of VT among judges and judges' capacity to meet the demands of their complex role in society. Future research needs to clearly identify the process by which VT emerges, as do related phenomena such as burnout. This exploratory study adds to the growing amount of VT research targeting other professionals and draws attention to the multidimensional nature of the experience. The extent to which the prevailing theoretical model (which emphasizes individual, occupational, and organizational contributors to VT) applies to the experience of judges requires further study. Our preliminary data call attention to the significant number of judges who are profoundly affected by the nature of their work. There is an immediate need for broader discussions of VT in judicial circles and consideration of prevention and intervention strategies. Addressing this critical issue will allow the judiciary to continue to conduct its essential business with the concomitant public trust and confidence it deserves.

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Table 1 Most frequently identified short- and long-term symptoms		
Time Frame	Symptom	Percent
Short-term	Sleep disturbances	17%
	Intolerance of others	11%
	Physical complaints	8%
Long-term	Sleep disturbances	7%
	Depression	5%
	Sense of isolation	5%

Table 2 Symptom categories clustered into theoretical factors		
Construct	Categories of Symptom	
<i>Internalizing</i>	Somatic symptoms Sleep deficiencies Loss of appetite Anxiety Depression Stress	Overeating Sadness Feelings of helplessness Feelings of hopelessness Fatigue
<i>Externalizing/ Hostility</i>	Anger Intolerance for others Irritability	Frustration Cynicism
<i>Unique Trauma</i>	Fear of perpetrator Preservation regarding cases Difficulty concentrating Hyper vigilance Guilt flashbacks	Nightmares Cognitive flooding Hypersensitivity Feeling overwhelmed PTSD diagnosis

Category	Number Endorsed		Three Most Frequently Endorsed
	Mean	SD	
Personal	3.9	(1.9)	Physical activity 80.7% Rest and relaxation 74.3% Social contacts 65.1%
Professional	1.8	(1.1)	Attending workshops 60.1% Peer support 53.2% Reading educational material 29.4%
Societal	1.3	(1.2)	Public speaking on the role of the courts 41.3% Coordination of courts and community services 37.6% Court reform to facilitate the administration of justice 29.4%
Total	7.1	(3.1)	

Category	Sample Responses
<i>Awareness</i>	Do not dwell on decision once made – move onto the next case Enjoy the job you do – I like District Court and don't really want all the trauma at Superior Court Do your best at work – try not to take problems/ work home with you Don't try to save the world
<i>Balance</i>	Maintain balance, including outside friendships Make sure to have a "date night" with spouse
<i>Connection</i>	Laugh often develop collegial relationships in the work setting Get involved in "happy groups" – not totally court-related

## **ATTORNEY, INTERRUPTED: SEEKING MEANING, RECOVERY FOR A LEGAL LIFE LOST**

*Jenny B. Davis, Texas Lawyer*  
05-05-2008

It was a suicide no one saw coming. By every account south Texas lawyer Hermes Villarreal was a man at the top of his game. He had a beautiful, loving wife, three happy school-aged children, a successful personal-injury practice and an impressive track record of meaningful community involvement.

It wasn't enough, however, to protect him against a crush of acute depression. On April 16, 2005, Villarreal, a solo practitioner in Pharr, was admitted to a McAllen hospital. On April 19, 2005 -- the morning he was to be discharged -- he took his own life. He was 41 years old.

His family blamed the hospital for his death, and on March 5, 2008, a jury in the 389th District Court in Hidalgo County agreed, handing down a unanimous plaintiffs verdict for \$9 million in the negligence suit *Villarreal, et al. v. Rio Grande Regional Hospital Inc., Columbia Rio Grande Healthcare L.P., d/b/a Rio Grande Regional Hospital*.

"It was one of those trial moments in a career that you never forget," says plaintiff's lawyer Raymond L. Thomas, who helped try the case. But for Thomas, it wasn't just about the win. Villarreal had been his best friend.

"Hermes cared about other people. He didn't want to let anyone down. He didn't want to let his community down, his family down or his mother down, and when he wasn't able to keep it all going, it fed anxiety and depression," says Thomas, a partner in Kittleman, Thomas & Gonzales in McAllen. "He had the symptoms, and he didn't know what was wrong with him."

It started with tension headaches, says Clem Lyons of Rhodes & Vela in San Antonio, who also represented the Villarreal family. "For four or five years, he had tremendous headaches. ... Every time he'd go in [to a doctor's office] for a work-up, they said it was stress-related," Lyons says.

Villarreal's headaches, along with feelings of anxiety, remained vague until shortly before his suicide, says Mary Wilson, also a partner in Rhodes & Vela, who worked on the case.

"Just leading up to this hospitalization, he'd go through periods of insomnia where he was awake for days, and at work he had difficulty concentrating. He wasn't picking up on what people were saying, he couldn't focus on his cases and he had a sensation of his heart racing and thought maybe he was having some sort of a heart event. He told the ER doctor and the internist that he felt like he was under tremendous pressure in his legal practice. He thought he wasn't pulling it off and had felt like that for several days" before he went to the hospital, Wilson says. "He was an alpha male, an A-type personality and totally driven -- independent in every way and providing for everyone very well -- who had an acute psychiatric condition, and he needed care."

On the morning of April 16, 2005, "his wife found him writing on a legal pad that he thought he was going crazy," Lyons says. Villarreal initially wanted to go to a hospital in San Antonio for help but agreed when his wife suggested he stay closer to home, Lyons says.

Villarreal was admitted to Rio Grande Regional Hospital in McAllen, and because he said his heart was racing, he was put in the telemetry ward, where his heart could be monitored 24 hours a day via an EKG machine, Wilson says.

The defendants maintained that when Villarreal came to the hospital, doctors were not told about the note he had written that morning. As alleged in the defendants' third supplemental original answer, Villarreal also refused a psychiatric consultation and did not take certain medications ordered by his doctors.

On April 18, 2005, Wilson says doctors came to Villarreal's room to tell him that, based on the results of medical tests he had undergone, there was nothing physically wrong with him and the hospital could discharge him the following day.

At 5 a.m. on April 19, 2005, Villarreal summoned the nurse on duty and requested a razor, saying that he wanted to take a shower and shave his chest, because the EKG monitor leads attached to his chest were bothering him, Wilson says. The nurse complied, giving him a double-edged razor and leaving him unattended, ostensibly to shave himself, Wilson says.

Villarreal took the razor with him into the bathroom, where he locked the door, stepped into the tub, cut himself and then bled to death, Wilson says.

There was a nursing shift change around 7 a.m., says Wilson, where the night nurse informed the day nurse that Villarreal was in the shower; the oncoming day nurse looked in the room and saw the bathroom door closed. The nurse checked in on Villarreal again around 8:15 a.m. and noticed that he was not in the bed and his breakfast tray had not been touched, so she checked the bathroom door and discovered it was locked, Wilson says. When hospital maintenance workers opened the door at 8:25 a.m., she says, it was too late.

Villarreal's estate, wife, children and mother sued the hospital, alleging, in part, that its nurses were negligent by giving Villarreal the razor and failing to adequately monitor and check on him, according to the plaintiffs' fourth amended petition.

The defendants denied the plaintiffs' allegations, asserting, among other things, that Villarreal's death was a "tragic but unforeseeable event," according to their answer. The defendants also claimed that Villarreal's history of headaches was an "underlying and unforeseeable medical condition, which caused or contributed to his intentional acts of committing suicide," and this "pre-existing medical condition" made his "chance of avoiding the ultimate harm improbable."

Representing the defendant hospital at the trial, which spanned three weeks, were Bill Gault, a partner in the Brownsville, Texas, firm of Vidaurri, Lyde, Gault & Quintana; A. Scott Johnson, a partner in Johnson, Hanan & Vosler in Oklahoma City; and Terry Todd, a partner in Tulsa, Okla.-based Rodolf & Todd. Gault declines to comment, because the case is ongoing, and Johnson did not return two telephone calls seeking comment.

Although the jury returned its verdict on March 5, the final damage award is unknown, because Judge Leticia Lopez has not yet entered her judgment based on post-verdict motions, says Wilson.

As to whether there will be an appeal, it depends on what the judgment is, says Todd, who is not involved in the post-verdict motions. That amount will be determined following motions filed by Wilson's firm, which she says will be finalized and filed once the firm receives the trial transcript. But both sides agree that the plaintiffs will walk away with far less than the \$9 million verdict thanks to mandatory statutory damage caps.

Gault and Todd decline to speculate on the amount the court will ultimately award, but Wilson says the most the Villarreal can recover by law is \$1.64 million, and she will argue that \$1.64 million is the amount they should receive.

## **THE EPIDEMIC OF DEPRESSION**

A few months after Villarreal's suicide, Thomas says a DVD from the State Bar of Texas landed on his desk called "Practicing From the Shadows: Depression and the Legal Profession."

He doesn't remember exactly how it happened to appear on his desk, but he watched it. The 31-minute video includes commentary from psychiatric and social work experts explaining depression -- its symptoms and how it can successfully be treated -- along with interviews with four Texas lawyers who suffered from depression while practicing and were able to recover and continue their practices.

Thomas says it was like watching the story of Hermes Villarreal play out on a small screen. "I felt like I was looking in the mirror. Obviously, being his best friend, I thought, 'Where the hell was I?'" he says. "But at the same time, there was a lot of self-reflection. 'Am I on the same track? How many of my peers are on the same track?'"

One point Thomas says the video brought up was how the personality traits that make people good lawyers -- perfectionism, for example -- can also make them more prone to depression. "We tend to be perfectionists, and we tend to be extreme worriers. You can't stop working. You think, 'Something will happen if I don't keep going,' and if you combine that, you are set up" for depression, he says. "I think as lawyers, we consider ourselves superhuman, and we create this image for ourselves. Even though no one else expects us to live up to this image, we do."

But the video did more than just teach Thomas about depression and the pervasiveness of the disease within the legal profession. He says it also inspired him to help spread the word. "I don't think as a profession we do enough to educate our own lawyers or to help -- to be aware of the symptoms and to recognize the symptoms in our peers," he says. "Unless we continually talk about things we are not comfortable talking about, we could be the next victim."

Studies have shown that lawyers are at a significantly higher risk for developing the illness of depression than other professionals, according to a report by the State Bar of Texas's Special Task Force on Lawyer Mental Health Issues. The task force presented the report, called "Lawyer Mental Health: Acknowledging the Challenges, Raising Awareness and Providing Solutions," to the Bar's board of directors on April 27, 2007.

Among the other findings included in the report:

- "Those who suffer from perfectionism are at higher risk for suicide."
- "[L]awyers are notoriously reluctant to seek help for personal issues."
- "Research conducted at Campbell University in North Carolina indicated that 11 percent of the lawyers in that state thought of taking their own life at least once a month."
- "Male lawyers in the United States are two times more likely to commit suicide than men in the general population, according to a 1992 study by the National Institute for Occupational Safety and Health."
- "Most mental health concerns such as depression and anxiety are highly treatable."

Former State Bar president Martha Dickie commissioned the video and appointed the task force as part of her focus on lawyer mental health issues during her 2006-2007 presidency. "Lawyers and suicide – it's rampant," says Dickie, a partner in the Austin, Texas, firm of Akin & Almanza. Since the video was completed in January 2007, Dickie estimates the Bar has given out more than 1,500 copies, and she's still handing them out and sending them out, always by request. "The more we can talk about it, and the more people who can see this video, the more people we can save. I am absolutely convinced that this video is saving lives," she says.

Dickie decided to make mental health a priority when, at the start of her campaign for State Bar president, her friend and colleague, Kenneth Malcolm "Mack" Kidd, committed suicide on Jan. 3, 2005. Kidd was a justice on the 3rd Court of Appeals in Austin, and his suicide shocked the Texas legal community.

"There is a stigma attached to it," Dickie says of depression. "It's even harder for people who are successful. 'Look at everything he's done. He's too fabulous! He's too strong! Look what he came from and what he did!' But depression is fairly egalitarian, and sometimes the mighty, because they are such pillars, are less likely to get help."

That certainly seems to be true in Villarreal's case. Thomas says he didn't see it, nor did Terry Crocker, CEO of Tropical Texas Center for Mental Health & Mental Retardation, a community mental health facility where Villarreal served as a volunteer chairman of the board from 2001 to 2005. Crocker credits Villarreal with being "a big driver" behind the hospital's ability to expand into two new buildings: one in Edinburg, the other in Brownsville. Crocker says Villarreal's contribution to the expansion assisted significantly in the center's ability to service more than 14,000 patients across Cameron, Hidalgo and Willis counties, which Crocker describes as among the most poverty-stricken yet fastest growing counties in Texas.

"Hermes was very much a champion for the people," Crocker says. "It was a source of frustration to not be able to do something for someone who has meant so much to our agency, but it shows that this can happen to anyone -- depression and mental illness, in general -- and there is no one who is immune from being affected."

A commemorative portrait of Villarreal now hangs in the center's boardroom.

Villarreal's suicide also surprised Dahlia A. Perez, his legal assistant and lone office employee for 12 years. "I didn't see it coming. I had no indication. There was nothing different in the couple weeks prior to his death that I could see," says Perez, who now



works for Kittleman, Thomas & Gonzales. Perez also helps manage rental properties that the Villarreal family owns.

"I was at the office signing up a new case when I got the phone call that he hadn't made it. That was all I was told, and I didn't understand, because I had spoken with him several times from the hospital about some cases."

Under Thomas' direction, for a year following Villarreal's death, Perez continued to work from the office – located behind two retail stores in a strip mall Villarreal owned – to resolve the firm's outstanding cases. Then she moved to Thomas' office building in McAllen.

But she says, aside from the files, Villarreal's office is mostly as it was three years ago. "The office is still intact. We can't come to terms with moving the stuff out," she says. "His office is under lock and key, but when I go [to the building] to collect the rents, sometimes I go in and sit down. I find peace there."

The office space is, technically, for rent, but when people call to ask about it, Perez says she tells them, "'There's other office space available in that strip.' So I just show them that."

## **MANAGING EMOTIONS AT TRIAL**

After Villarreal's death, Thomas stepped in and took over his friend's remaining caseload, which, he says, consisted mainly of personal injury suits and criminal defense matters. "Remember, he was a perfectionist – everything was in perfect order," Thomas says.

Thomas also started representing Villarreal's estate in the probate proceedings but, at that time, had no formal involvement in the family's suit against the hospital, which was being handled by Rhodes & Vela. As the case got closer to trial, however, that changed.

"As it became more and more apparent that the hospital was not going to settle, we sort of commissioned [Thomas'] assistance," Wilson says, especially when it came to helping prepare Villarreal's widow and mother to testify at trial. Wilson also says that Villarreal's mother is a Spanish-speaker, as is Thomas. Working with Thomas, Wilson says, "totally made them better witnesses – just the level at which they knew each other, it was from the heart."

Thomas says at first he was reluctant to step in. "I was worried about being able to handle that emotionally," he says. "I had mixed emotions. It's what I do, I try cases, and I enjoy it -- but I just always thought I'd be a witness, and I had not prepared myself, mentally, to be a lawyer in the case, especially since the case was in the hands of excellent lawyers." Adds Thomas, "It was the most difficult case I have ever tried."

He says he didn't come out and tell the jury of his connection to the plaintiffs, but he says the jury "figured it out," especially following his emotionally charged direct examination of co-plaintiff Hermelinda Villarreal, Hermes Villarreal's mother.

During direct, he showed Hermelinda the watch he was wearing that day, a Cellini Rolex that her son had given Thomas. "I showed his mother the watch and said, 'Do you

remember this watch?' She started crying and said, 'Yes, I do.' And I said, 'Tell the jury how I ended up with this watch.' And she said, 'Many years ago, you closed a case for Hermes. He was worried about you and worried that you were working too hard. He wanted to get you a beautiful watch,' " Thomas recalls Hermelinda saying.

Hermes Villarreal had the watch inscribed with the date he and Thomas closed the case together – Dec. 6, 1996 – and with it, gave Thomas a note that read, "Ray, You need to take care of yourself and slow down. The reason for the watch is this: Every time you look at your watch, remember how precious time really is, and remember to spend it wisely with your family and loved ones."

"Isn't that ironic?" notes Thomas, a husband and father of two. "He was worried about me being overextended and working too hard."

At trial, Thomas also gave a portion of the closing arguments, says Wilson, and once again his connection to Villarreal made a difference. "It was absolutely compelling. He was able to say, 'I knew this man.' It was very brief but very powerful."

Wilson says Thomas included the story of the watch in that closing argument. "There wasn't a dry eye in the courtroom," she recalls.

This year on Sunday, April 20 at St. Anne's Catholic Church in Pharr -- the day following the third anniversary of Villarreal's death -- Villarreal's church dedicated its mass to his memory, says Thomas. "The priest announced the intention of the mass and asked that everyone pray for the soul of Hermes," he says. Thomas says he and his family are still sad, but he is hopeful that, if there can be a silver lining to the tragedy, it will come through spreading the word in the legal community about depression and how it can be successfully treated.

"If it causes one lawyer to look in the mirror and say, 'That's happening to me,' or, 'That's happening to one of my colleagues,' it will all have been worth it," says Thomas. "It's too bad it takes a tragedy like this for people to become self-aware, but perhaps this tragedy will prevent some others."

## COMPASSION FATIGUE AS SECONDARY TRAUMATIC STRESS DISORDER: AN OVERVIEW

by Charles R. Figley

There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care. Sometimes we feel we are losing our sense of self to the clients we serve. Therapists who work with rape victims, for example, often develop a general disgust for rapists that extends to all males. Those who have worked with victims of other types of crime often "feel paranoid" about their own safety and seek greater security. Ironically, as will be noted later, the most effective therapists are most vulnerable to this mirroring or contagion effect. Those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress.

Mary Cerney (Chapter 7) notes that working with trauma victims can be especially challenging for therapists, since some may feel that they, in the words of English (1976), "... have taken over the pathology" of the clients (p. 191). Cerney suggests:

*This affront to the sense of self experienced by therapists of trauma victims can be so overwhelming that despite their best efforts, therapists begin to exhibit the same characteristics as their patients that is, they experience a change in their interaction with the world, themselves, and their family. They may begin to have intrusive thoughts, nightmares, and generalized anxiety. They themselves need assistance in coping with their trauma.*

The professional work centered on the relief of the emotional suffering of clients automatically includes absorbing information that is about suffering. Often it includes absorbing that suffering itself as well.

Over the past 10 years, I have been studying this phenomenon. Although I now refer to it as compassion fatigue, I first called it a form of burnout, a kind of "secondary victimization" (Figley, 1983a). Since that time, I have spoken with or received correspondence from hundreds of professionals, especially therapists, about their struggles with this kind of stressor. They talk about episodes of sadness and depression, sleeplessness, general anxiety, and other forms of suffering that they eventually link to trauma work.

This chapter and those that follow represent our best efforts to understand, treat, and prevent compassion fatigue. We begin with a discussion of the conceptual development of the concept of trauma and related terms and ways of knowing about them.

Paul Valent (Chapter 2) presents a framework for the next century of investigation of traumatic stress. "Survival strategies" are assigned to each of the eight types of traumatic stressors, and each strategy is considered within the three reaction domains: biological, psychological, and social. This synthesis of decades of research and theoretical work appears to be a very useful framework for categorizing traumatic stress reactions, including secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD) among therapists and others who care for victims.

This chapter proposes a reconfiguration of post-traumatic stress disorder (PTSD) that is consistent with the current, scientifically based views of the disorder, as specified in the revised third edition of the DSM-III (American Psychiatric Association [APA], 1987) and of the new version described in DSM-IV (APA, 1994) and ICD-10. As noted in the introduction to this book, the criteria of a traumatic event in these diagnostic manuals take note of but do not discuss the implications of a person's being confronted with the pain and suffering of others. It will be suggested later that PTS and PTSD retain the same set of symptoms, and thus methods of assessment, but that parallel symptoms and

methods of assessment must be developed for STS and STSD. This chapter draws on the research and theoretical literature, primarily presented in the chapters to follow, to support this new configuration.

What follows is an explication of STS and STSD, later called compassion stress/fatigue, because they have received the least attention from traumatology scholars and practitioners. This is followed by an illustrative review of the theoretical and research literature that supports the existence of S1'S. The last section of the chapter discusses the implications of the proposed reconfiguration for diagnostic nomenclature, research and clinical assessment, and theory development.

## CONCEPTUAL CLARITY

The diagnosis of PTSD has been widely utilized in mental health research and practice, and its application has influenced case law and mental health compensation (Figley, 1986; Figley, 1992a, b). In a report of the review of trauma-related articles cited in *Psychological Abstracts*, Blake, Albano, and Keane (1992) identified 1,596 citations between 1970 and 1990. Their findings support the view that the trauma literature has been growing significantly since the advent of the concept of PTSD (APA, 1980). However, most of these papers lack conceptual clarity. They rarely consider contextual and circumstantial factors in the traumatizing experience or adopt the current PTSD nomenclature.

As noted in the introduction to this volume, although the psychotraumatology field has made particularly great progress in the past decade, the syndrome has an extremely long history. A field devoted exclusively to the study and treatment of traumatized people represents the culmination of many factors. One was the greatly increased awareness of the number and variety of traumatic events and their extraordinary impact on large numbers of people. As noted in the introduction, many identify the publication of the American Psychiatric Association's DSM-III in 1980 as a major milestone. It was the first to include the diagnosis of post-traumatic stress disorder.

With the publication of DSM-III, for the first time the common symptoms experienced by a wide variety of traumatized persons were viewed as a psychiatric disorder; one that could be accurately diagnosed and treated. Although a revision of DSM-III modified the symptom criteria somewhat (APA, 1987), the popularity of the concept among professionals working with traumatized people (including lawyers, therapists, emergency professionals, and researchers) grew, as did the accumulation of empirical research that validated the disorder.

After well over a decade of use, the term PTSD is more commonly applied to people traumatized by one of many types of traumatic events. Yet a review of the traumatology literature yields the following: Nearly all of the hundreds of reports focusing on traumatized people exclude those who were traumatized indirectly or secondarily and focus on those who were directly traumatized (i.e., the "victims"). But descriptions of what constitutes a traumatic event (i.e., Category [criterion] A in the DSM-III and DSM-III-R descriptions of PTSD) clearly indicate that mere knowledge of another's traumatic experiences can be traumatizing.

People are traumatized either directly or indirectly. The following excerpt is taken from the PTSD description in DSM-IV (APA, 1994) of what constitutes a sufficiently traumatic experience.

*The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves threatened death, actual or threatened serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury,*

*or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates (Criterion AI). Italics added; [po 424]*

The italicized phrases emphasize that people can be traumatized without actually being physically harmed or threatened with harm. That is, they can be traumatized simply by learning about the traumatic event. Later it is noted:

*Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. [p.424]*

This material has led to a conceptual conundrum in the field, although few have identified it. For example, I have pointed out (Figley, 1976; 1982; 1983a,b) that the number of "victims" of violent crime, accidents, and other traumatic events is grossly underestimated because only those directly in harm's way are counted, excluding family and friends of the victims. In a presentation (1982) and subsequent publications (1983b; 1985a,b; 1989), I noted a phenomenon I called "secondary catastrophic stress reactions," meaning that the empathic induction of a family member's experiences results in considerable emotional upset.

Parallel phenomena exist: fathers, especially in more primitive societies, appear to exhibit symptoms of pregnancy out of sympathy for those of their wives (i.e., *couvade*; see Hunter & Macalpine, 1963); a psychiatric illness can appear to be shared by the patient's spouse (*folie à deux*; Andur & Ginsberg, 1942; Gralnick, 1939). Other parallels have been reported in the medical and social science literatures, including copathy (Launglin, 1970); identification (Brill, 1920; Freud, 1959); sympathy (Veith, 1965); and hyperarousal, "mass hysteria," or psychogenic illness, which appears to sweep through groups of people, including children (see Colligan & Murphy, 1979). An emotional arousal appears to be associated with an empathic and sympathetic reaction. Also, in the process of dispensing this care, the support becomes exhausted. As noted elsewhere (Figley, 1983b):

*Sometimes ... we become emotionally drained by [caring so much]; we are adversely affected by our efforts. Indeed, simply being a member of a family and caring deeply about its members makes us emotionally vulnerable to the catastrophes which impact them. We, too, become "victims," because of our emotional connection with the victimized family member. [po 12]*

In a later treatise (Figley, 1985), I commented that families and other interpersonal networks (e.g., friendships, work groups, clubs, and the client-therapist relationship) are powerful systems for promoting recovery following traumatic experiences. At the same time, these same systems and their members can be "traumatized by concern." We can classify this trauma as follows: (1) simultaneous trauma takes place when all members of the system are directly affected at the same time, such as by a natural disaster; (2) vicarious trauma happens when a single member is affected out of contact with the other members (e.g., in war, coal mine accidents, hostage situations, distant disasters); (3) intrafamilial trauma or abuse takes place when a member causes emotional injury to another member; and (4) chiasmal or secondary trauma strikes when the traumatic stress appears to "infect" the entire system after first appearing in only one member. This last phenomenon most closely parallels what we are now calling STS and STSD.

Richard Kishur, a master's student studying under the author's direction, reanalyzed a large data set of a study of New York City crime victims and their supporters (family members, neighbors, friends). Utilizing metaphorically the transmission of genetic

material or "crossing over" that takes place between like pairs of chromosomes during meiotic cell division, Kishur (1984) coined the term "chiasmal effect." To him, this term best accounted for why there was such a strong correlation between the quality and quantity of the symptoms of crime victims and that of the supporters of these victims.

It is clear that a pattern of effects emerges in both victim and supporter. The crime victims as well as their supporters suffer from the crime episode long after the initial crisis has passed. Symptoms of depression, social isolation, disruptions of daily routine, and suspicion or feelings of persecution affect the lives of these persons. [po 65]

Even in the absence of precise, conceptual tools, however, the literature is replete with implicit and explicit descriptions of this phenomenon. Some of the most cogent examples are reports by traumatized people who complain that family and friends discourage them from talking about their traumatic experiences after a few weeks because it is so distressing to the supporters (Figley, 1989).

I previously (Figley, 1989) expressed my dismay about seeing so many colleagues and friends abandon clinical work or research with traumatized people because of their inability to deal with the pain of others. "The same kind of psychosocial mechanisms within families that make trauma 'contagious,' that create a context for family members to infect one another with their traumatic material, operate between traumatized clients and the therapist" (p. 144). Those who are most vulnerable to this contagion are those who "begin to view themselves as saviors, or at least as rescuers" (pp. 144-145).

In summary, there has been widespread, although sporadic, attention in the medical, social science, family therapy, and psychological literature to the phenomenon we now refer to as compassion stress/fatigue or secondary traumatic stress/disorder. At the same time, in spite of the clear identification of this phenomenon as a form of traumatization in all three versions of the DSM, nearly all of the attention has been directed to people in harm's way, and little to those who care for and worry about them.

Why are there so few reports of these traumatized people? Perhaps it is because the psychotraumatology field is so young, although the focus of interest stretches back through the ages. Beaton and Murphy (Chapter 3) note that perhaps the field is in a "pre-paradigm state," as defined by Kuhn (1962, 1970). Kuhn, in his classic treatise on theory development, reasoned that paradigms follow the evolution of knowledge, and, in turn, influence the development of new knowledge. Knowledge about experiencing, reexperiencing, and reacting to traumatic material evolves in *"fits and starts."* Prevailing paradigms are viewed, suddenly, as anomalies when new information and paradigm shifts occur. This certainly applies to the prevailing, limiting view of PTSD and the need to recognize that the process of attending to the traumatic experiences and expressions may be traumatic itself.

The concept of PTSD, developed through both scholarly synthesis and the politics of mental health professions (see Scott, 1993), was introduced in DSM-III (APA, 1980) as the latest in a series of terms to describe the harmful biopsychosocial effects of emotionally traumatic events. This concept has brought order to a growing area of research that is now a field of study (Figley, 1988a, b, c; Figley, 1992a, b). After more than a decade of application of the concept and two revisions of the DSM, it is time to consider the least studied and least understood aspect of traumatic stress: secondary traumatic stress.

### *Why STSD?*

It has been confirmed by a wide variety of sources (e.g., Ochberg, 1988; Wilson & Raphael, 1993) that the most important and frequently used remedies for people suffering from traumatic and post-traumatic stress are personal rather than clinical or

medical. These personal remedies include the naturally occurring social support of family, friends, and acquaintances, and of professionals who care (see Figley, 1988a, b, c; Flannery, 1992; Solomon, 1989). Yet little has been written about the "cost of caring" (Figley, 1975, 1978, 1982, 1985b, 1986, 1989, 1993b, in press; Figley & Sprenkle). It is important to know how these supporters become upset or traumatized as a result of their exposure to victims. By understanding this process, we not only can prevent additional, subsequent traumatic stress among supporters, but we can also increase the quality of care for victims by helping their supporters.

Scholars and clinicians require a conceptualization that accurately describes the indices of traumatic stress for both those in harm's way and those who care for them and become impaired in the process. Alternate theoretical explanations for the transmission of trauma that results in this impairment are discussed in the latter part of this chapter.

#### *Definition of Secondary Traumatic Stress and Stress Disorder*

We can define STS as the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1993a).

What is being asserted is that there is a fundamental difference between the sequelae or pattern of response during and following a traumatic event, for people exposed to primary stressors and for those exposed to secondary stressors. Therefore, STSD is a syndrome of symptoms nearly identical to PTSD, except that exposure to knowledge about a traumatizing event experienced by a significant other is associated with the set of STSD symptoms, and PTSD symptoms are directly connected to the sufferer, the person experiencing primary traumatic stress. Table 1 depicts and contrasts the symptoms of PTSD with those of STSD.

*(continued on next page)*

TABLE 1  
Suggested Distinctions Between the Diagnostic Criteria for  
Primary and Secondary Traumatic Stress Disorder

Primary	Secondary
<p><b>A. Stressor:</b> Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:</p> <ol style="list-style-type: none"> <li>1. Serious threat to self</li> <li>2. Sudden destruction of one's environs</li> </ol>	<p><b>A. Stressor:</b> Experienced an event outside the range of usual human experiences that would be markedly distressing to almost anyone; an event such as:</p> <ol style="list-style-type: none"> <li>1. Serious threat to traumatized person (TP)</li> <li>2. Sudden destruction of TP's environs</li> </ol>
<p><b>B. Reexperiencing Trauma Event</b></p> <ol style="list-style-type: none"> <li>1. Recollections of event</li> <li>2. Dreams of event</li> <li>3. Sudden reexperiencing of event</li> <li>4. Distress of reminders of event</li> </ol>	<p><b>B. Reexperiencing Trauma Event</b></p> <ol style="list-style-type: none"> <li>1. Recollections of event/TP</li> <li>2. Dreams of event/TP</li> <li>3. Sudden reexperiencing of event/TP</li> <li>4. Reminders of TP/event distressing</li> </ol>
<p><b>C. Avoidance/Numbing of Reminders</b></p> <ol style="list-style-type: none"> <li>1. Efforts to avoid thoughts/feelings</li> <li>2. Efforts to avoid activities/situations</li> <li>3. Psychogenic amnesia</li> <li>4. Diminished interest in activities</li> <li>5. Detachment/estrangements from others</li> <li>6. Diminished affect</li> <li>7. Sense of foreshortened future</li> </ol>	<p><b>C. Avoidance/Numbing of Reminders of Event</b></p> <ol style="list-style-type: none"> <li>1. Efforts to avoid thoughts/feelings</li> <li>2. Efforts to avoid activities/situations</li> <li>3. Psychogenic amnesia</li> <li>4. Diminished interest in activities</li> <li>5. Detachment/estrangements from others</li> <li>6. Diminished affect</li> <li>7. Sense of foreshortened future</li> </ol>
<p><b>D. Persistent Arousal</b></p> <ol style="list-style-type: none"> <li>1. Difficulty falling/staying asleep</li> <li>2. Irritability or outbursts of anger</li> <li>3. Difficulty concentrating</li> <li>4. Hypervigilance for self</li> <li>5. Exaggerated startle response</li> <li>6. Physiologic reactivity to cues</li> </ol>	<p><b>D. Persistent Arousal</b></p> <ol style="list-style-type: none"> <li>1. Difficulty falling/staying asleep</li> <li>2. Irritability or outbursts of anger</li> <li>3. Difficulty concentrating</li> <li>4. Hypervigilance for TP</li> <li>5. Exaggerated startle response</li> <li>6. Physiologic reactivity to cues</li> </ol>

(Symptoms under one month duration are considered normal, acute, crisis-related reactions. Those not manifesting symptoms until six months or more following the event are delayed PTSD or STSD.)

At the same time, we suggest that PTSD should stand for primary traumatic stress disorder, rather than post-traumatic stress disorder, since every stress reactions is "post" by definition.

#### *Contrasts Between STS and Other Concepts*

The STS phenomenon has been called different names over the years. We suggest that compassion stress and compassion fatigue are appropriate substitutes. Most often these names are associated with the "cost of caring" (Figley, 1982) for others in emotional pain.

Among the few dozen references in this general area, this phenomenon is called secondary victimization (Figley, 1982, 1983b, 1985a, 1989), "co-victimization" (Hartsough & Myers, 1985), and secondary survivor (Remer & Elliot, 1988a, 1988b). McCann & Pearlman (1989) suggest that "vicarious traumatization" is an accumulation of memories of clients' traumatic material that affects and is affected by the therapist's perspective of the world. They propose a team-oriented approach to both preventing and treating this special kind of stress.

Miller, Stiff, and Ellis (1988) coined the term *emotional contagion* to describe an affective process in which "an individual observing another person experiences



emotional responses parallel to that person's actual or anticipated emotions" (p. 254). Other terms that appear to overlap with STS or STSD include rape-related family crisis (Erickson, 1989; White & Rollins, 1981); "proximity" effects on female partners of war veterans (Verbosky & Ryan, 1988); generational effects of trauma (Danieli, 1985; McCubbin, Dahl, Lester, & Ross, 1977); the need for family "detoxification" from war-related traumatic stress (Rosenheck & Thomson, 1986); and the "savior syndrome" (NiCathy, Merriam, & Coffman, 1984). But "countertransference" and "burnout" are most frequently cited, and will be discussed separately in more detail in the following.

### *Countertransference and Secondary Stress*

Countertransference is connected with psychodynamic therapy and often appears to be an emotional reaction to a client by the therapist. Although there are many definitions, countertransference in the context of psychotherapy is the distortion on the part of the therapist resulting from the therapist's life experiences and associated with her or his unconscious, neurotic reaction to the client's transference (Freud, 1959). Most recently, Corey (1991) defined countertransference as the process of seeing oneself in the client, of overidentifying with the client, or of meeting needs through the client. Singer and Luborsky (1977), not bound by the limits of psychoanalysis, suggest that countertransference extends far beyond the context of psychotherapy. They include all of a therapist's conscious and unconscious feelings about or attitudes toward a client, and believe that these feelings and attitudes may be useful in treatment.

In the recent book *Beyond Transference: When the Therapist's Real Life Intrudes* (Gold & Nemiah, 1993), contributors recount how personal events in the lives of therapists affect the quality and characteristics of therapy. The most compelling part of the book, however, focuses on how clients, not the personal life experiences of the therapist, are stressful and difficult to handle. Countertransference was once viewed simply as the therapist's conscious and unconscious response to the patient's transference, especially if the transference connected with the therapist's past experiences. Johansen (1993) suggests that a more contemporary perception of countertransference views it as all of the emotional reactions of the therapist toward the patient—regardless of their sources. These sources include, for example, the life stressors—past or present—experienced by the therapist. But they also include the traumata expressed by the client and absorbed by the therapist. This, unfortunately, is rarely discussed in the literature, and is the major focus of this book.

A recent study (Hayes, Gelso, Van Wagoner, & Diemer, 1991) found that five therapist qualities appear to help therapists, in varying degrees, to manage countertransference effectively. These are anxiety management, conceptualization of skills, empathic ability, self-insight, and self-integration. The study surveyed 33 expert therapists regarding the importance of five factors, subdivided into 50 personal characteristics, which composed their five-item, Likert-response-type Countertransference Factors Inventory (CFI). Although all five were found to be important, expert therapists rated self-integration and self-insight as the most significant factors in managing countertransference.

In a follow-up study, Van Wagoner, Gelso, Hayes, and Diemer (1991) surveyed 93 experienced counseling professionals using the CFI to rate the factors for either therapists in general or excellent therapists in particular. Excellent therapists, in contrast to therapists generally, were viewed by the sample as (1) having more insight into and explanation for their feelings; (2) having greater capacity for empathy for and understanding of the client's emotional experience; (3) being more able to differentiate between the needs of self and client; (4) being less anxious with clients; and (5) being more adept at conceptualizing "client dynamics" in both the client's current and past contexts (p. 418).

One could argue, then, that STS includes, but is not limited to, what these researchers and other professionals view as countertransference. It is assumed that countertransference happens only within the context of psychotherapy, it is a reaction by the therapist to the transference actions on the part of the client, and it is a negative consequence of therapy and should be prevented or eliminated. However, STS, or event STSD, is a natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first's traumatic experiences. These effects are not necessarily a problem but, more, a natural by-product of caring for traumatized people.

### *Burnout and Secondary Stress*

Some view the problems faced by workers with job stress simply as burnout (Maslach & Jackson, 1984; d. Pines, 1993). A 1993 literature search of *Psychological Abstracts* located more than 1,100 relevant articles and 100 books since the term was coined by Freudenberger (1974) and carefully explicated by Maslach (1976). According to Pines and Aronson (1988), burnout is "a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations" (p. 9). The most widely utilized measure of burnout is the Maslach Burnout Inventory (MBI), developed by Maslach and Jackson (1981). It measures three aspects: emotional exhaustion (e.g., "I feel emotionally drained by my work"); depersonalization (e.g., "I worry that the job is hardening me emotionally"); and reduced personal accomplishment (e.g., "I feel I'm positively influencing other people's lives through my work"). More recently, Pines and Aronson (1988) developed the Burnout Measure (BM), which measures physical exhaustion (e.g., feeling tired or rundown); emotional exhaustion (e.g., feeling depressed, hopeless); and mental exhaustion (e.g., feeling disillusionment, resentment toward people). Emotional exhaustion appears to be the key factor the two measures of burnout have in common. Burnout has been defined variously as a collection of symptoms associated with emotional exhaustion.

1. Burnout is a process (rather than a fixed condition) that begins gradually and becomes progressively worse (Cherniss, 1980; Maslach, 1976, 1982).
2. The process includes (a) gradual exposure to job strain (Courage & Williams, 1986), (b) erosion of idealism (Freudenberger, 1986; Pines, Aronson, & Kafry, 1981), and (c) a void of achievement (Pines & Maslach, 1980).
3. There is an accumulation of intensive contact with clients (Maslach & Jackson, 1981).

In a comprehensive review of the empirical research on the symptoms of burnout, Kahill (1988) identified five categories of symptoms.

1. Physical symptoms (fatigue and physical depletion/exhaustion, sleep difficulties, specific somatic problems such as headaches, gastrointestinal disturbances, colds, and flu).
2. Emotional symptoms (e.g., irritability, anxiety, depression, guilt, sense of helplessness).
3. Behavioral symptoms (e.g., aggression, callousness, pessimism, defensiveness, cynicism, substance abuse).
4. Work-related symptoms (e.g., quitting the job, poor work performance, absenteeism, tardiness, misuse of work breaks, thefts).
5. Interpersonal symptoms (e.g., perfunctory communication with, inability to concentrate / focus on, withdrawal from clients / coworkers, and then dehumanizing, intellectualizing clients).

In addition to depersonalization, burnout has been associated with a reduced sense of personal accomplishment and discouragement as an employee (see Maslach & Jackson, 1981). From a review of the research literature, it appears that the most salient factors associated with the symptoms of burnout include client problems-chronicity, acuity, complexity-that are perceived to be beyond the capacity of the service provider (Freudenberger, 1974, 1975; Maslach, 1976, 1982; Maslach & Jackson, 1981). Moreover, Karger (1981) and Barr (1984) note that service providers are caught in a struggle between promoting the well-being of their clients and trying to cope with the policies and structures in the human service delivery system that tend to stifle empowerment and well-being.

In contrast to burnout, which emerges gradually and is a result of emotional exhaustion, STS (compassion stress) can emerge suddenly with little warning. In addition to a more rapid onset of symptoms, with STS, in contrast to burnout, there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate. The Self Test for Psychotherapists was designed to help therapists differentiate between burnout and STS. This measure is discussed elsewhere (Figley, 1993a) in some detail.

*(continued on next page)*

## Compassion Fatigue Self Test for Psychotherapists\*

Name \_\_\_\_\_ Institution \_\_\_\_\_ Date \_\_\_\_\_  
Please describe yourself: \_\_\_Male \_\_\_Female; \_\_\_\_\_ years as practitioner. Consider each of the following characteristic about you and your current situation. Write in the number for the best response. Use one of the following answers:

**1=Rarely/Never 2=At Times 3=Not Sure 4=Often 5=Very Often**

Answer all items, even if not applicable. Then read the instructions to get your score.

### Items About You:

1. \_\_\_ I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
2. \_\_\_ I find myself avoiding certain activities or situations because they remind me of a frightening experience.
3. \_\_\_ I have gaps in my memory about frightening events.
4. \_\_\_ I feel estranged from others.
5. \_\_\_ I have difficulty falling or staying asleep.
6. \_\_\_ I have outbursts of anger or irritability with little provocation.
7. \_\_\_ I startle easily.
8. \_\_\_ While working with a victim I thought about violence against the perpetrator.
9. \_\_\_ I am a sensitive person.
10. \_\_\_ I have had flashbacks connected to my clients.
11. \_\_\_ I have had first-hand experience with traumatic events in my adult life.
12. \_\_\_ I have had first-hand experience with traumatic events in my childhood.
13. \_\_\_ I have thought that I need to "work through" a traumatic experience in my life.
14. \_\_\_ I have thought that I need more close friends.
15. \_\_\_ I have thought that there is no one to talk with about highly stressful experiences.
16. \_\_\_ I have concluded that I work too hard for my own good.
17. \_\_\_ I am frightened of things a client has said or done to me.
18. \_\_\_ I experience troubling dreams similar to those of a client of mine.
19. \_\_\_ I have experienced intrusive thoughts of sessions with especially difficult clients.
20. \_\_\_ I have suddenly and involuntarily recalled a frightening experience while working with a client.
21. \_\_\_ I am preoccupied with more than one client.
22. \_\_\_ I am losing sleep over a client's traumatic experiences.
23. \_\_\_ I have thought that I might have been "infected" by the traumatic stress of my clients.
24. \_\_\_ I remind myself to be less concerned about the well-being of my clients.
25. \_\_\_ I have felt trapped by my work as a therapist.
26. \_\_\_ I have felt a sense of hopelessness associated with working with clients.
27. \_\_\_ I have felt "on edge" about various things and I attribute this to working with certain clients.

28. \_\_\_ I have wished that I could avoid working with some therapy clients.  
29. \_\_\_ I have been in danger working with therapy clients.  
30. \_\_\_ I have felt that my clients dislike me personally.

**Items About Being a Psychotherapist and Your Work Environment:**

31. \_\_\_ I have felt weak, tired, rundown as a result of my work as a therapist.  
32. \_\_\_ I have felt depressed as a result of my work as a therapist.  
33. \_\_\_ I am unsuccessful at separating work from personal life.  
34. \_\_\_ I feel little compassion toward most of my co-workers.  
35. \_\_\_ I feel I am working more for the money than for personal fulfillment.  
36. \_\_\_ I find it difficult separating my personal life from my work life.  
37. \_\_\_ I have a sense of worthlessness/disillusionment/resentment associated with my work.  
38. \_\_\_ I have thoughts that I am a "failure" as a psychotherapist.  
39. \_\_\_ I have thoughts that I am not succeeding at achieving my life goals.  
40. \_\_\_ I have to deal with bureaucratic, unimportant tasks in my work life.

\* Note, this instrument is under development. Please contact Dr. Charles R. Figley, Psychosocial Stress Research Program, Florida State University, MFT Center (F86E) (Phone: 904-644-1588; Fax, 904-644-4804) [11/93]

Scoring Instructions: (a) Be certain you responded to all items. (b) Circle the following 23 items: 1-8, 10-13, 17-26, and 29. (c) Add the numbers you wrote next to the items. (d) Note your risk of Compassion Fatigue: 26 or less = Extremely low risk; 27 to 30 = Low risk; 31 to 35 = Moderate risk; 36 to 40 = High risk; 41 or more = Extremely high risk.

Then, (e) Add the numbers you write next to the items not circled. (f) Note your risk of burnout: 17-36 or less = Extremely low risk; 37-50 = Moderate risk; 51-75 = High risk; 76-85 = Extremely high risk.

Scores for this instrument emerged using a sample of 142 psychotherapy practitioners attending workshops on the topic during 1992 and 1993. Psychometric properties of the scale are reported by Stamm and Vara (1993). Alpha reliability scores ranged from .94 to .86; structural analysis yielded at least one stable factor which is characterized by depressed mood in relationship to work accompanied by feelings of fatigue, disillusionment, and worthlessness. Structural Reliability (stability) of this factor, as indicated by Tucker's Coefficient of Congruence (cc), is .91.

### *Why Compassion Stress and Compassion Fatigue?*

Thus although STS and STSD are the latest and most exact descriptions of what has been observed and labeled over hundreds of years, the most friendly term for this phenomenon, and one that will be used here, is compassion fatigue (Joinson, 1992). Webster's Encyclopedic Unabridged Dictionary of the English Language (1989) defines compassion as "a feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (p. 299). Its antonyms include "mercilessness" and "indifference." My very informal research leads to the finding that the terms compassion stress and compassion fatigue are favored by nurses (Joinson first used the term in print, in 1992, in discussing burnout among nurses), emergency workers, and other professionals who experience STS and STSD in the line of duty. Therefore, the terms can be used interchangeably by those who feel uncomfortable with STS and STSD. Such discomfort might arise from a concern that such labels are derogatory. Feeling the stress, and even the fatigue, of compassion in the line of duty as a nurse or therapist better describes the causes and manifestations of their duty-related experiences.

## *Who Is Vulnerable to Compassion Fatigue?*

In the epilogue to this book, two models are presented to account for how and why some people develop compassion fatigue while others do not. At the heart of the theory are the concepts of empathy and exposure. If we are not empathic or exposed to the traumatized, there should be little concern for compassion fatigue. Throughout this book, authors discuss the special vulnerabilities of professionals-especially therapists-who work with traumatized people on a regular basis. These "trauma workers" are more susceptible to compassion fatigue.

This special vulnerability is attributable to a number of reasons, most associated with the fact that trauma workers are always surrounded by the extreme intensity of trauma-inducing factors. As a result, no matter how hard they try to resist it, trauma workers are drawn into this intensity. Beyond this natural by-product of therapeutic engagement, there appear to be four additional reasons why trauma workers are especially vulnerable to compassion fatigue.

1. *Empathy is a major resource for trauma workers to help the traumatized.* Empathy is important in assessing the problem and formulating a treatment approach, because the perspectives of the clients-including the victim's family members-must be considered. Yet as noted earlier and throughout this volume (see Harris, Chapter 5) from research on STS and STSD we know that empathy is a key factor in the induction of traumatic material from the primary to the secondary victim. Thus the process of empathizing with a traumatized person helps us to understand the person's experience of being traumatized, but, in the process, we may be traumatized as well.
2. *Most trauma workers have experienced some traumatic event in their lives.* Because trauma specialists focus on the context of a wide variety of traumatic events, it is inevitable that they will work with traumatized people who experienced events that were similar to those experienced by the trauma worker. There is a danger of the trauma worker's overgeneralizing his or her experiences and methods of coping to the victim and overpromoting those methods. For example, a crime-related traumatization may be very different from that of the trauma worker, but the counselor may assume that they are similar and so listen less carefully. Also, the counselor may suggest what worked well for him or her but would be ineffective-or, at worst, inappropriate-for the victim.
3. Unresolved trauma of the worker will be activated by reports of similar trauma in clients. Trauma workers who are survivors of previous traumatic events may harbor unresolved traumatic conflicts. These issues may be provoked as a result of the traumatic experiences of a client. In this volume, the chapters by Cerney, by Yassen, and by others confirm the power of past traumatic experiences on current functioning.
4. Children's trauma is also provocative for therapists. Police officers, firefighters, emergency medical technicians, and other emergency workers report that they are most vulnerable to compassion fatigue when dealing with the pain of children (see Beaton & Murphy, Chapter 3). And because children so often are either the focus of trauma counseling or are important players, trauma workers are more likely than are other practitioners to be exposed to childhood trauma.

## IMPLICATIONS FOR TRAINING AND EDUCATING THE NEXT GENERATION OF PROFESSIONALS

The chapters to follow more fully explicate the role of trauma in the lives of

professionals. They review in detail the scholarly and practice literature to identify what we know and have known about compassion fatigue (Le., STSD). Each of the contributors suggests his or her own theories, concepts, and methods of assessment and treatment. Few discuss the implications for trauma worker education, however.

As an educator, as well as a researcher and practitioner, this author is concerned about the next generation of trauma workers. Although we need to know a great deal more about compassion fatigue—who gets it when, and under what circumstances; how it can be treated and prevented—we know much already. We know enough to realize that compassion fatigue is an occupational hazard of caring service providers be they family, friends, or family counselors.

Recognizing this, we as practicing professionals have a special obligation to our students and trainees to prepare them for these hazards. A place to start is to incorporate stress, burnout, and compassion fatigue into our curriculum, and especially our supervision in practica.

We can use the relatively protected environment of our educational centers and the clients who seek help there as a place for discussing these issues. Some fundamental principles for preventing compassion fatigue might be useful. In addition, training programs could (1) institute policies that require processing all clinical material that appears to be upsetting to either the individual worker or another team member (including a supervisor); and (2) recognize that upsetting clinical material is all.d should be discussed confidentially with confidants (spouse/ partner), following prescribed ethical procedures, and that the confidant could, in tum, become upset; and (3) experiment with various methods for avoiding compassion fatigue while, at the same time, not sacrificing clinical effectiveness.

We must do all that we can to insure that trauma workers are prepared. As noted later in the book, we have a "duty to inform" them about the hazards of this work. But, at the same time, to emphasize that this work is most rewarding: to see people suffering from the shock of highly stressful events be transformed immediately from sadness, depression, and desperation to hope, joy, and a renewed sense of purpose and meaning of life. This transformation is equally possible for professionals who recognize that they themselves are suffering from compassion fatigue. We hope that the chapters to follow will help facilitate this transformation both in those in harm's way and in the professionals they go to for help.

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## **THE DANGEROUS LINK BETWEEN CHRONIC OFFICE CHAOS, STRESS, DEPRESSION, AND SUBSTANCE ABUSE**

*By Nancy Byerly Jones*

Have you ever found yourself screaming, “This isn’t a law practice, it’s hell with fluorescent lighting!”? You may not realize how great an impact office stress can have on your overall well-being. It is exactly this kind of stress that can cause a lawyer to sink into depression or start down the path of substance abuse.

Impaired or addicted lawyers usually turn to medical and mental health professionals for help. They can also get support through their bar association’s lawyer assistance program (LAP). To ensure the most secure foundation for recovery, however, it is also important to address the negative and costly influence on our lives of chronic chaos, disorganization, low morale, and similar problems in our offices. Too often, this important factor in our emotional welfare is overlooked, and, unfortunately, there are too few community or bar-sponsored resources for this type of help. This omission leaves us vulnerable to backsliding, short-lived success stories, and increased odds of repeating a vicious cycle.

Are your work habits and office environment putting you at risk? A few key questions to ask yourself include:

- Is your office in a state of constant chaos, disorganization, or high stress?
- Do you find yourself with the same stresses on your plate and the same problems within your office year after year?
- Are you setting goals for yourself and office that never seem to be achieved?
- Do you dread the start of yet another day at the office?
- Are you in control of your work, or is your work in control of you?

If you answered yes to even one of these questions, then your personal health and quality of life are likely to be negatively affected sooner or later. The extent of the negative impact depends on factors such as:

- How long the problems have existed.
- How often office morale is low and interoffice tensions are high.
- The frequency and severity of client complaints.
- How far (and long) we can stick our heads in the sand in an effort to avoid the truth.

If ignored for too long, chronic problems at the office can play a big part in setting the stage for battles with depression, substance abuse, and other stress-related problems. Traditional sources of help tend to focus on medical and psychological needs only, often overlooking chronic office stress as a factor to address. Medication, therapy, and support groups do have admirable success records. However, these success stories may only be temporary if chronic and stressful office issues are not factored in when creating and applying a comprehensive and realistic recovery plan.

Below you will find a few tools and suggestions for identifying and correcting office matters that may be adding stress to your life. Treat this information as a “starter kit” to

help you focus your attention on an often overlooked area that can dramatically affect the likelihood that a lawyer will sink into depression or turn to substance abuse as an escape.

### **A Look in the Mirror**

The following situations offer a small sampling of office patterns that, if ignored, can lead to chronic and crippling stress:

- Chronic, office-wide chaos.
- Unclear mission; no written long-term goals.
- Weak or haphazard internal leadership.
- Unclear and inconsistently enforced policies and procedures.
- Little, if any, true teamwork, cross-selling of services, or support of one another.
- Lack of loyalty to the firm and a distrust of partners or other coworkers.
- Poor communication and people skills.
- Criticism voiced publicly and frequently; compliments or appreciation rarely, if ever, offered.
- Low office morale.
- High employee turnover.
- Chronic procrastination.
- Poor planning and prioritizing, resulting in last-minute panics.
- Lack of time-management skills.
- File mismanagement and disorganization.
- Repeated failure to meet deadlines promised to clients.
- Frequent client complaints, many of which are of the same type (e.g., unreturned phone calls, not being kept informed about the status of their cases).

There is good news and bad news about this incomplete list of potential time bombs within our offices. The bad news is that these types of problems are all too common within many offices. The good news, however, is that there is a great deal that we can do to fix these problems and thus decrease work-related stress. All it takes is your willingness to get started, rather than waiting for someone else to “just fix it.”

Let’s be honest. We all have days when we grumble to ourselves,

- “Can I trade this job for whatever is behind Door #1?”
- “Nice perfume, but must you marinate in it?”
- “Daily panic and chaos...this is what I get for surviving law school?!”
- “Our office is the world’s largest natural source of sarcasm!”
- “Is there a sign outside my door that reads ‘Endless Interruptions Appreciated & Welcome’?”
- “Have I thanked you lately for your whining, chronic complaining, and negative attitude?”
- “If our cash flow was as big as your ego, we would be enormously rich!”
- “Thank you for being such a jerk; it helps make me look nicer!”

It is indeed a good thing our thoughts can’t be heard by our supervisors, peers, and employees. When these types of thoughts recur on a daily basis, however, you run the risk of losing your sense of humor, and the risk of becoming overwhelmingly stressed

increases. Couple chronic office stress with other health problems or tension on the home front and the odds for addiction or mental health problems increase astronomically. And yet, when faced with substance abuse problems or depression head-on, many lawyers fail to consider what role the “state of the office” may have played in getting them to that point. It makes sense that a lot of our stress-related problems could be eliminated or greatly reduced if only we took a proactive stance toward the state of our firms and offices before it’s too late.

### **What to Do**

The tips offered below suggest a few ways to get the ball rolling toward a healthier, stronger, and friendlier office, which also translates into happier and better-served clients. These tips are for those folks so fed up with the chronic stress at their offices that they are willing to roll up their sleeves, seek out whatever resources are needed, and do their part in improving their work environments. This necessarily includes a commitment to work on improving personal work habits and attitudes. In other words, the tips are for those who are ready to sever (once and for all) the frightening link between chronic office problems and excessive office-induced stress, depression, and/or substance abuse.

Finally, you should be aware that others in your office may refuse to help address the real issues. They prefer the risks associated with chronic office stress, and just won’t cooperate in your efforts to turn things around. If that is the case, and you feel you’ve tried your best and given proposed changes a fair time frame within which to take root, then it’s time to consider other workplace options. The bottom line in this situation presents a stark choice—Are you willing to accept and live with your current office environment as it is, or should you summon the courage to replant yourself and your skills in a different office with a different group of people?

Tips for a healthy office include:

1. Decide what kind of firm and reputation you want to build and in which direction you want your “ship” to be heading.
2. Take a hard, honest, and thorough look at the strengths and weaknesses of your entire office—its “crew,” the equipment, space, design, systems, policies, procedures, clients, marketing, and so on.<sup>1</sup>
3. Make a master list of all the changes needed and then prioritize them.
4. Create and follow a simple, annual action plan.<sup>2</sup>
5. Decide what steps need to be taken by whom and by when.
6. Make sure all employees understand the firm’s philosophy, mission, and goals. Of course, make sure all your partners are in agreement first!
7. Monitor your action plan regularly. Hold everyone (including yourself) accountable to do their parts. If there are no consequences for noncompliance, there’s no need to create a plan in the first place.
8. Obtain employee input on ways to improve efficiency, systems, and technology.
9. Voice criticisms privately.
10. Praise deserving employees openly.<sup>3</sup>
11. Ensure that the right person with the right background, training, and people skills is managing the day-to-day administration of your office. Don’t give this person too many hats to wear or he or she will be stretched too thin to give his or her full attention to the administrative duties.

12. Provide sufficient training for all employees. Offer a variety of teaching styles (classroom, individual one-on-one training, training manuals) to accommodate your employees' diverse learning styles.
13. Make sure all employees understand that a good attitude is just as important as their skills and that a consistently poor attitude may cost them their jobs. Adopt a zero-tolerance level for employees who are chronic troublemakers or poor team players, no matter how great their skills. The other employees they scare off over time and the energies required to put up with their bad attitudes far outweigh the value of their skills.
14. Lead by setting a good example and offering support.
15. Treat, value, and respect your employees as you would your best client.<sup>4</sup>
16. Give clear instructions and avoid last-minute planning whenever possible.
17. Review your interviewing and hiring system and techniques; take steps to avoid future "bad" hires.
18. Update your systems and procedures-avoid the dangerous pitfall of "We've always done it this way so why change now?" Beware, however, of making rules or policies that you are unwilling to consistently and fairly enforce.
19. Take risk management seriously. Malpractice-proof your firm through up-to-date risk management systems, and ensure that all employees understand the risks and how to avoid them through attentive, thoughtful, and timely client servicing.
20. Settle all unresolved conflicts with your partners and any others in your office (you need to demonstrate healthy conflict-resolution practices so that other employees will follow your example).
21. Read *The Lawyer's Guide to Balancing Life and Work*, by George W. Kaufman.<sup>5</sup>
22. Avoid becoming a "threshold" practice that takes any and every case that crosses your office door's threshold.
23. Develop a simple and realistic marketing plan no matter how small your firm.
24. Practice smart client selections in line with your marketing goals.
25. Stop procrastinating.<sup>6</sup>
26. Make a budget, stick to it, and hold others accountable to do the same.
27. Don't make promises you can't or won't keep.
28. Read and reread *Who Moved My Cheese? An Amazing Way to Deal With Change in Your Work and in Your Life*, by Spencer Johnson and Kenneth Blanchard.<sup>7</sup>
29. Hang on to your sense of humor!

Remember, it's easy to point out others' faults, but it takes courage to take an honest and thorough look at ourselves, our work habits, and our offices. It also takes a lot of character to make the really tough decisions, even if they prove unpopular, in order to create a less-stressful work environment.

### **Attitudes Worth Catching**

- "I'm so lucky to have work worth doing and to love my work."
- "I look forward to coming to the office each day."
- "Anyone here would help me out in a pinch if needed."
- "We're a diverse bunch of folks, but together we make a great team."

I have actually heard many lawyers and their support staff make these types of statements. In fact, I have been most fortunate to have witnessed hundreds of success

stories by courageous individuals, law firms, and legal departments. Each one has motivated and inspired me personally and professionally.

Likewise, each of those success stories involves lawyers and staff members who were stressed out, exhausted, and fed up with their work being in control of them instead of the other way around. In many cases, the lawyers had to face the reality that they were working in the wrong office or with the wrong mixture of personalities for them. However, with healthy doses of patience, determination, and resourcefulness, they all eventually carved out paths that led them to the right position and place. This, in turn, had tremendously positive effects on their personal lives.

You can do the same if you are truly tired of the chaos, stress, and in-house fighting that poorly managed offices generate. You don't have to cut through tons of red tape, and you don't need a doctor's prescription to get going. The only thing needed is your commitment and determination to take the ball in your hands and keep it moving in the right direction. You-no one else-are in charge of when you pick up the ball and run with it.

There is no doubt that unchecked chronic office stress is an often overlooked factor in depression, substance abuse, and other impairments. Just as there are many excellent programs and resources for these types of problems, there are many self-help tools to assist us in turning things around in our offices-if we really want to do so. Experienced legal management consultants can assist in the process, as can practice management advisors provided by a few proactive and very caring state bar associations for their members.<sup>8</sup>

The bottom-line question is this: Are you willing to accept the same work-related stresses in your life year after year and accept the fallout from them? Or are you willing to take the necessary steps to look for and create healthier and better working environments for yourself and for your employees? The answers may not always be easy to face, but the ultimate choice is indeed yours, thank goodness.

### **Stress Management Self-Audit Chart**

#### STRESS MANAGEMENT SELF AUDIT

Source: Nancy Beverly Jones, Easy Self- Audits for the Busy Law Office  
1999, ABA Law Practice Management Section

1. Do you feel that the stress in your life is out of control? \_\_\_\_
2. Do you feel stressed out the better part of most days? \_\_\_\_
3. Are you able to tune out your work when out of the office? \_\_\_\_
4. Are you able to tune out your personal problems when in the office? \_\_\_\_
5. Are you in control of your work, or is it in control of you? \_\_\_\_
6. Do you have trouble falling asleep? \_\_\_\_
7. Do you overeat or fail to eat as a result of stress? \_\_\_\_
8. Do you explode when angry? \_\_\_\_
9. Are you irritable more often than not? \_\_\_\_
10. How many vacations have you taken during the past 5 years? \_\_\_\_
11. Were these vacations relaxing? \_\_\_\_
12. Do you drink more alcohol than you once did? \_\_\_\_
13. Do you drink more than one drink each day? \_\_\_\_
14. Are you taking any medication for relaxation purposes? \_\_\_\_
15. Have you used or do you use illegal drugs of any kind? \_\_\_\_

16. How much exercise are you getting every week? \_\_\_\_
17. Do you have frequent headaches? \_\_\_\_
18. Do you often feel tired or sluggish? \_\_\_\_
19. Do you worry about committing malpractice? \_\_\_\_
20. Do you worry about the management of your firm? \_\_\_\_
21. Do you get to spend enough time with your family? \_\_\_\_
22. Do you get to spend enough time with your friends? \_\_\_\_
23. What are your favorite activities, and how often do you do them? \_\_\_\_
24. Do you have a mentor, good friend, or family member with whom it is easy to talk things over? \_\_\_\_
25. On a separate sheet of paper, make a list of everything that causes you stress (the big stuff, the little things like the way someone talks or acts, and all those stresses that fall in between). \_\_\_\_

25 (a). Categorize each stress according to the length of time it has affected you (e.g., one year or longer, six to nine months, less than 3 months)

25(b). Note those stresses that you have absolutely no power to control (e.g., the way someone else acts, who your relatives are, the things people say. You can begin teaching yourself not to waste energy and time worrying about uncontrollable aspects of life)

25(c). Review everything left on your stress list after excluding those stresses that are out of your control to change, and decide what, if anything, you are willing to do to reduce or eliminate those stresses (e.g., talk with someone with whom you had a disagreement, become a better time manager and less of a procrastinator).

25(d). If you decide not to do anything about some stresses that you at least have some control over, then begin teaching yourself to stop worrying about them, griping about them, or otherwise allowing them to have a negative effect on your life.

25(e). Are you willing to repeat this exercise frequently to remind yourself of what causes you stress; what, if anything, you might be able to do to eliminate or reduce certain stresses; and what areas you need to learn to accept as out of your power to control?

**Response and  
Explanatory Remarks**

**Improvement Strategy**

**Targeted  
Completion  
Date**

Notes

1. *Easy Self-Audits for the Busy Law Office*, Nancy Byerly Jones, published by the American Bar Association, 1999, 1-800-285-2221.
2. Id. at 7-8, 303 (discussion of and sample form for simplified strategic planning).
3. See *1001 Ways to Reward Employees*, Bob Nelson, 1994, Workman Publishing (available in most book stores along with his newer book, *1001 Ways to Energize Employees*).
4. Read *The Man Who Listens to Horses*, Monty Roberts, 1997, Random House Press (Trust me-this is a must-read for people managers as well as horse lovers and trainers!).
5. *The Lawyer's Guide to Balancing Life and Work*, George W. Kaufman, 1999, ABA Law Practice Management Section. To order, call 800/285-2221.



6. Read *It's About Time! The 6 Styles of Procrastination and How to Overcome Them*, Dr. Linda Sapidin with Jack Maguire, Viking Press, 1996.
7. *Who Moved My Cheese? An Amazing Way to Deal With Change in Your Work and in Your Life*, Spencer Johnson and Kenneth H. Blanchard, 1998, Putnam Publishing Group.
8. See a listing of the bar associations that staff practice management advisors and the Practice Management Advisor Planning Guide online at [www.abanet.org/lpm/bparticle12282\\_front.shtml](http://www.abanet.org/lpm/bparticle12282_front.shtml).

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## GAMBLING

By Paul R. Ashe

Gambling appears poised to replace baseball as our national pastime. Last year, 85 percent of the American public gambled in excess of \$700 billion. In addition, many trillions of dollars are gambled annually in various financial markets. It is estimated that 10 to 15 percent of those who gamble have a gambling problem. While less than 4 to 5 percent are considered pathological (compulsive) gamblers, many more people experience severe consequences from their gambling activities.

Pathological gambling is a mental health disorder in which an individual has a psychologically uncontrollable preoccupation with the urge to gamble, eventually resulting in damage to vocational, family, and social relationships. It is characterized by a chronic and progressive inability to resist the impulse to gamble. It was first diagnosed and recognized by the American Psychiatric Association in 1980 and was subsequently included in the *Diagnostic and Statistical Manual (DSM-IV)*.

A lawyer who is a compulsive gambler can be very dangerous. By the nature of their practice, lawyers are often exposed to fiduciary relationships involving large sums of money, which serve as the commodity or "drug of choice" for the gambler. A lawyer who may already be predisposed to gamble, whether on a casino game, horse or dog race, lottery ticket, or via the Internet, should be aware of some of the inherent danger signs that could result in complete devastation, including prison, bankruptcy, or death.

Gamblers Anonymous, an international organization founded in 1957, lists the following 20 questions (reprinted with permission from Gamblers Anonymous) as a means of determining whether a person is a compulsive gambler. Most compulsive gamblers will respond "yes" to at least seven of these warning signs.

1. Did you ever lose time from work or school due to gambling?
2. Has gambling ever made your home life unhappy?
3. Did gambling affect your reputation?
4. Have you ever felt remorse after gambling?
5. Did you ever gamble to get money with which to pay debts or otherwise solve financial difficulties?
6. Did gambling cause a decrease in your ambition or efficiency?
7. After losing did you feel you must return as soon as possible and win back your losses?
8. After a win did you have a strong urge to return and win more?
9. Did you often gamble until your last dollar was gone?
10. Did you ever borrow to finance your gambling?
11. Have you ever sold anything to finance gambling?
12. Were you reluctant to use "gambling money" for normal expenditures?
13. Did gambling make you careless of the welfare of yourself or your family?
14. Did you ever gamble longer than you had planned?
15. Have you ever gambled to escape worry or trouble?
16. Have you ever committed, or considered committing, an illegal act to finance gambling?
17. Did gambling cause you to have difficulty in sleeping?
18. Do arguments, disappointments or frustrations create within you an urge to gamble?

19. Did you ever have an urge to celebrate any good fortune by a few hours of gambling?
20. Have you ever considered self-destruction or suicide as a result of your gambling?

### **Betting on the Market**

One of the most common areas that affects lawyers and other professionals is the Internet. In addition to thousands of online gambling sites that offer traditional games such as blackjack and poker, the Internet allows for many other forms of gambling. Today, it is just as easy to place a bet on the New York Stock Exchange as it is on the New York Yankees. Unfortunately, some people “play” the stock market and approach the financial marketplace with the mentality of a gambler. All forms of investing involve risk to some degree. The problem gambler (mainly action-seeking gamblers) can find this risk as addictive as a game of high-stakes poker.

Online access has made market gambling easier, faster, and ultimately cheaper. According to experts, day trading is the prime example. Day trading is when investors buy and sell stocks dozens or even hundreds of times daily, closing out their positions at the end of the day. Day traders usually have no knowledge of the companies behind the stocks they trade, nor do they care to. Their only concern is the fluctuation in the companies’ stock prices, which keeps them glued to their computer screens. The vast majority of day traders lose money, with some even losing their homes, financial assets, and lives.

Paul Good, a clinical psychologist in San Francisco, developed 11 warning signs that may reveal whether an investor is actually a gambler in disguise. Anyone who exhibits five or more of these signs may have a gambling problem.

1. High-volume trading in which the “action” has become more compelling than the objective of the trade.
2. Preoccupation with one’s investments (e.g., excessive studying of investment newspapers or websites, thoughts about the market that interfere with work or one’s social life, constant calls to one’s broker).
3. Needing to increase the amount of money in the market or the “leverage” of one’s investments to feel excited (e.g., using options or future contracts, borrowing on margin).
4. Repeated unsuccessful efforts to stop or control one’s market activity (e.g., drawing on accounts previously declared off limits, contradicting or changing limit orders on losses or gains).
5. Restlessness or irritability when attempting to cut down or stop market activity, or when cash is accruing in one’s account.
6. Involvement in market activity to escape problems, relieve depression, or distract oneself from painful emotions.
7. After taking losses in the market, continuing to take positions or increasing one’s position as a way of getting even.
8. Lying to family members and friends to conceal the extent of involvement in the market.
9. Committing illegal acts, such as forgery, fraud, theft, or embezzlement, to finance market activity.
10. Jeopardizing significant relationships, one’s job, or educational or career opportunities because of excessive involvement in the market.

11. Relying on others to provide money to relieve a desperate financial situation caused by gambling in the markets.

Because of the financial risk inherent in market gambling, the addictive nature of trading, and the easy access to markets these days, some experts believe that problem gamblers should never invest. These experts view the stock market as a breeding ground for compulsive gambling, and the New York Stock Exchange and the NASDAQ as the largest casinos in the world. It is estimated that \$11 trillion was traded on the various exchanges last year alone, but only 5 percent of this amount was for non-speculative investments (*Problem Gamblers and Their Finances-A Guide for Treatment Professionals*, National Endowment for Financial Education and National Council on Problem Gambling).

### **Gambling as a Defense**

Compulsive gambling is not generally considered a valid defense to any criminal act performed by the gambler. Some courts, however, have allowed compulsive gambling to be offered as a mitigating factor in sentencing or disbarment proceedings. Unfortunately, most cases that have utilized the disease of compulsive gambling as grounds for action are unreported because they were not appealed. Legal disciplinary cases are unusual in this regard because most of these cases are reviewed by the state's supreme court. In fact, of 107 cases reviewed by this author, 87 cases involved lawyers. In attorney disbarment proceedings, state courts and bar associations typically refuse to allow compulsive gambling as grounds for a defense because, they argue, the primary goal in disciplinary proceedings is not to punish the individual lawyer, but to protect the integrity of the profession.

In every reported case of attorney discipline where a defense of compulsive gambling was raised, the lawyer was disbarred for a substantial period of time. However, proof of a causal connection between a gambling addiction and professional misconduct can be a mitigating factor that justifies a sanction less than disbarment. Further, a record of recovery and rehabilitation for an addiction, including gambling, should be considered a compelling mitigating circumstance in disciplinary proceedings.

In the event that lawyers or their clients are confronted with a case requiring a compulsive gambling mitigation defense, the elements of such a defense should include the following six R's:

1. Remorse – Demonstrate evidence of regret for past misdeeds.
2. Repentance – Show changes for the better made in light of one's past misdeeds.
3. Restitution – Detail and structure plans for repayment of debt or illegally obtained funds (in accordance with the Gamblers Anonymous fourth step, during which the compulsive gambler would set up a pressure relief group meeting and make a plan).
4. Rehabilitation – Outline the terms and types of treatment plans utilized.
5. Recovery – Delineate the type of lifestyle changes implemented to prevent a relapse or a return to criminal acts.
6. Resentment – Commit to not harboring any animosity towards the prosecuting agency or official.

It is crucial that you document commencement of the six Rs before the case is presented in court, which requires the compulsive gambler to begin the process as quickly as possible.

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### **Where to Turn for Help**

Any lawyer can obtain a list of local resources from your local lawyers assistance program, your state's Council on Compulsive Gambling, the National Council on Problem Gambling (800/522-4700 or [ncpg@erols.com](mailto:ncpg@erols.com)), or Gamblers Anonymous International Service Office (213/386-8769 or [isomain@gamblersanonymous.org](mailto:isomain@gamblersanonymous.org)).

## **INTERNET ADDICTION – LAWYERS GETTING CAUGHT IN THE NET**

*By Kimberly S. Young*

Donald is a solo practitioner from Pennsylvania who knew the benefits of the Internet. He relied upon e-mail to contact colleagues and clients and used online databases to conduct legal research. One evening, alone in his office, he accidentally stumbled upon an adult entertainment website and out of curiosity scanned through several of its pages. The next week, stressed after a long workday, he returned to the site for a little relaxation. "Just a few minutes won't hurt," he rationalized as he surfed.

Over the next few months, Donald searched for new pornographic websites as a way to relieve his job pressures. Soon, he found himself going to work early, taking more breaks, staying late, and even coming in on the weekends to surf. His behavior grew more and more out of control, and his life gradually became unmanageable. He cancelled appointments, missed deadlines, lost cases, and ignored his wife and family just to find more time at the computer. Repeated promises to stop failed until he finally admitted that he was addicted.

Welcome to the age of the Internet. The emergence of this new technology has also created a new clinical disorder. Internet addiction affects 5 to 10 percent of all online users, and treatment centers across the country and abroad have already developed specialty rehabilitation programs.

The legal professional has already seen the impact of this disorder with an alarming number of divorce cases, child custody battles, and criminal litigation prompted by Internet addiction. In a recent development, employees fired for Internet abuse have launched disability claims under the Americans with Disabilities Act against former employers for giving them access to the digital drug. The disorder is especially troublesome when lawyers themselves become hooked, only to become impaired professionals. To educate lawyers on the dynamics of the disorder and aid in its prevention within their own practices, this article reviews the warning signs, consequences, and treatment implications involved.

### **Are You Caught in the Net?**

How can you tell if you are already hooked? Perhaps you spend a little too much time online. Does that automatically mean you are addicted? No. The volume of time alone is not the best way to diagnose the disorder. We can't say, for instance, that ten hours per week is okay, but that the eleventh hour is a sign of an addiction. Instead, you must evaluate your online usage against the following set of behaviors that characterize the basic warning signs of Internet addiction:

1. Do you feel preoccupied with the Internet; i.e., do you think about previous online activity or anticipate your next online session?
2. Have you repeatedly made unsuccessful efforts to control, cut back, or stop Internet use?
3. Do you feel restless, moody, depressed, or irritable when attempting to cut down or stop Internet use?
4. Do you repeatedly stay online longer than originally intended?  
Have you neglected sleep, proper diet, or exercise just to surf?

- Have you experienced eyestrain, back strain, or carpal tunnel syndrome because of your Internet use?
5. Have you jeopardized a significant relationship, job, or educational or career opportunity because of the Internet?
  6. Have you lied to others to conceal the extent of your involvement with the Internet?
  7. Do you use the Internet as a way of escaping from problems or feelings of helplessness, guilt, anxiety, or depression?

Answering “yes” to five or more of the questions suggests that addiction is present. However, given the popularity of the Internet, legitimate business usage may mask the addictive behavior even when a person meets all of the criteria.

Internet addicts are commonly attracted to online pornography or adult sex chat rooms. They may also obsessively check stock quotes, day trade, play computer games, gamble in virtual casinos, chat online with strangers, or search for information not relevant to work. The immediate and often required access to the Internet becomes a constant distraction that can wreak havoc on the addict’s professional and personal life.

### **Consequences of the Addiction**

So what does this mean for you, a lawyer in a solo or small firm practice? Having such job independence most likely means that you have a private office free from a corporate “big brother,” making it that much easier for problems to develop. Since no one monitors your computer usage, counterproductive and maladaptive online behavior is easily concealed. Job productivity suffers as the Internet-addicted lawyer wastes enormous amounts of time and energy at the computer when he or she should be working. The addicted lawyer will gradually withdraw from colleagues and staff, miss deadlines, and even jeopardize cases—all to maximize unproductive use of the Internet.

Not only is work performance hindered, but family problems may also develop. The addictive behavior may extend to home computer use when addicts lie to their spouses about their Internet habit and spend less time with their children. Their habit may even lead to canceling family or social outings and an overall lack of involvement in the community, just to find greater amounts of time for the computer.

Despite these consequences, addicts believe they can handle their obsession. Soon, however, the addict discovers that time slips by and the behavior is not so easily contained. A period of deep regret may follow as the addict realizes that work is piling up and feels guilty for all that time wasted on the computer.

Addicts view their behavior as a personal failure of willpower and promise never to do it again, so a short period of abstinence follows. During this time, the addict temporarily engages in healthy patterns of behavior, works diligently, resumes interests in old hobbies, spends more time with the family, exercises, and gets enough rest. However, cravings eventually develop as temptations to go online emerge during stressful or emotionally charged moments. The addict recalls the self-medicating effects of the Internet and the relaxation and excitement it can provide. Soon, the rationalizations start again, and the immediate availability of the computer easily starts the cycle anew—and the addict feels too helpless to stop and isn’t sure where to turn.

### **Getting Unhooked**

Do you have to detach the modem or dismantle the computer just to kick the online habit? Complete abstinence is not possible when Internet use is required for work. Therefore, one goal of successful recovery is to moderate legitimate business use of the Internet while abstaining from those aspects of cyberspace that are most troubling. Begin by incorporating a tangible schedule of Internet usage that will give you a sense of being in control, rather than allowing the Internet to take control of you. Learn to set reasonable time limits pertaining to your computer use. For example, instead of a current 20 hours per week, set a new limit of only ten hours per week and schedule those hours in specific time slots. Keep your Internet usage on a routine schedule to help maintain discipline and avoid future relapse. Other ways to keep your Internet use under control include:

- Utilize external aids such as an alarm clock or an egg timer to remind yourself when it's time to log offline.
- Use another person's Internet account to increase accountability of online actions.
- Find new places to use the Internet that are more public and visible.
- Apply filtering software that blocks access to problematic websites.
- Cultivate new activities or interests that take you away from the computer.

Just cutting back on Internet usage is only part of the solution. Internet addiction often stems from underlying psychological or situational factors that increase the risk for the disorder to develop. For example, addicts often use the Internet to escape from stress, depression, anxiety, job burnout, work pressures, or marital discord. By seeking help, the addict fears family members and colleagues will discover the secret online habit, which may cause further problems in an already troubled marriage or fragile work situation.

Successful recovery means finding healthier ways of coping with these issues, which may include individual therapy, couples counseling, or support group participation. Although therapists and clinics that specialize in Internet addiction recovery are often difficult to locate given the relative newness of the disorder, any qualified mental health provider should be able to help you recover from your addiction.

**Dr. Kimberly Young is a clinical psychologist and director of the Center for On-Line Addiction, the first training institute and treatment clinic to specialize in cyber-disorders ([www.netaddiction.com](http://www.netaddiction.com)). Using e-mail, chat, and telephone therapy, the virtual clinic provides clients with immediate access to a healthcare specialist knowledgeable in this evolving field while protecting their privacy. She is the author of the first recovery book for Internet addiction, *Caught in the Net*. She can be reached at [ksy@netaddiction.com](mailto:ksy@netaddiction.com).**

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## LAWYERS WITH ADHD

*By Lynn Phillips*

Attention deficit hyperactivity disorder (ADHD), often called attention deficit disorder (ADD), begins in childhood and can persist in adulthood. ADHD manifests as a chronic pattern of behavior that includes difficulty focusing and maintaining attention, chronic disorganization, impulsivity, and difficulty perceiving time. Hyperactivity may or may not be a part of the pattern. ADHD affects the executive functions of the brain, such as prioritizing, planning, executing and completing, and paying attention to detail. Although ADHD often runs in families, it is highly treatable, usually with a combination of medication, lifestyle changes, and adaptive skills that “work around” its symptoms.

The National Institute of Mental Health ([www.nimh.nih.gov](http://www.nimh.nih.gov)) estimates that 3 percent to 5 percent of all children have ADHD. Nearly 25 percent of those related to a child diagnosed with ADHD also have ADHD (compared with roughly 5 percent of the general public), which adds up to nearly 8 million people. Of these, 80 percent to 90 percent are undiagnosed and may be unaware that they have the condition. The ABA’s most current estimate (summer 2006) is that there are 1.1 million lawyers in the United States; thus, roughly 44,000 lawyers may have ADHD, the majority undiagnosed.

In lawyers, one of the most obvious manifestations of the condition is their ongoing attempts to “get organized”—which always end in only short-term success, if any. They report falling behind in their work or being fearful they missed something important, and frequently they feel that they are not living up to their potential. By this point in their lives, many lawyers have learned to work around the manifestations of their ADHD symptoms. They struggle to stay focused on boring tasks, have trouble managing their time, and often start projects enthusiastically but quickly lose their excitement and, with it, the desire to finish the project. They are usually aware of being facile and quickly grasping and building on concepts, but planning for the eventual goal is a problem. They often have low self-esteem because of their inability to be consistent, stay focused, and curb impulses, and frequently they struggle with relationships—partly because they miss or misunderstand the social cues people give one another. They question why things that seem easy for others can be such problems for them.

Unfortunately, once out in the professional world, they tend to continue these coping mechanisms—procrastinating, working in fits and starts. Lawyers with ADHD typically are well acquainted with regret, although they may have established firm defenses against recognizing it. They develop reputations for being chronically late, having messy offices, or performing excellently some of the time and abysmally at others. Like the general population with ADHD, these lawyers usually do not realize they have a defined problem until they seek treatment for a different condition or, often, for their children’s attention problems. Nearly half the people with undiagnosed ADHD have a coexisting condition—such as depression or substance abuse. Undiagnosed, and sometimes even when treated, ADHD is not easy to live with; rarely does a person with ADHD make it through life unmarked.

### **What’s Wrong with Me?**

A diagnosis of attention deficit disorder often comes as an enormous relief—at last, the inconsistencies and spotty performances have an explanation. Years of self-referential questions now have answers: How can I be so bright and not be able to do this simple

task? Why am I always late when I try so hard to be on time? Why is my (office, car, desk, calendar) so disorganized? Where are my keys?

With diagnosis it seems the riddle is solved and all is well. Unfortunately, diagnosis is only the beginning of treatment. Appropriate medications may help by reducing some impulsive behaviors and concentration issues, but they most often simply quiet the background noise enough to allow the person to contemplate further changes.

If the above descriptions sound familiar and you think you or someone you care about may have ADHD, the following suggestions may help you or others manage it:

1. **Don't self-diagnose.** That said, if you've suspected you might have ADHD, you probably have already done a preliminary self-diagnosis. Please get a medical evaluation, and stay open to other diagnoses as well.
2. **See a doctor who is knowledgeable about ADHD.** Use online resources, hospital recommendations, and referrals from friends and colleagues (yes, they've had to learn about it, too). The doctor will likely be a psychiatrist who works with both children and adults. Discuss other conditions that the physician may need to know about: depression, anxiety disorder, bipolar disorder, alcoholism, and drug addiction; their symptoms may have a lot in common with ADHD, and those conditions will need attention as well. Adults with ADHD often are in trouble not from the ADHD itself, but from the effects of any number of coexisting conditions. For example, nearly 50 percent of children with ADHD also have learning disabilities—take time to learn about such disabilities because you may have made adaptations to accommodate one year ago. Keep in mind that you've already finished law school and passed the bar—learning disabilities don't mean you're not smart.
3. **Be patient with finding the right ADHD medication.** One size does not fit all. What works for your friend may not work for you. Pay attention to how you feel and function on a medication; if you see no improvement, say so.
4. **Educate yourself.** Getting a diagnosis is the beginning of a learning curve; ADHD is not a mystery illness. Magazine articles, TV shows, and books galore exist to help you. Of particular use may be Robert M. Tedesco's website, [www.addcopingskills.com](http://www.addcopingskills.com). Tedesco is a practicing attorney diagnosed with ADD who currently sits on the board of Children and Adults with ADHD (CHADD) and was on the board of the Attention Deficit Disorder Association (ADDA). Both organizations' websites feature a variety of articles and other material. Part of your job is to learn about the condition and discover what steps you can take to manage it more effectively. Take small steps to implement changes based on what you learn—at a minimum, start exercising regularly, eating well, and spending time at play (play is a great way to slow down a struggling brain).
5. **Manage coexisting conditions.** Although not everyone diagnosed with ADHD also has a concurrent medical disorder, as mentioned previously, about half do. People with ADHD are more susceptible to developing substance abuse disorders (drugs, alcohol, food), anxiety, depression, bipolar disorder, and other conditions. These conditions must be treated concurrently with the ADHD. Some lawyers who have struggled with these disorders for years find they make real progress only when they also address the ADHD. With younger lawyers, treating the ADHD actually seems to reduce their chances of later developing a substance abuse disorder. Keep in mind that your doctor must have all physically related facts about you, including past or current drug or alcohol abuse, in order to treat you.
6. **Don't make excuses.** Although a diagnosis of ADHD may be a life-changing explanation for you, it is not an excuse in the real world. The real world requires

behavior change, not behavior explanation. People in that world set timetables, make plans, and carry out tasks on schedule. You can make your life easier by accepting this truth early on.

7. **Decide how much to disclose and to whom.** Unfortunately, especially in the professional world, you cannot predict how others view ADHD and related disorders, so be discreet. The last thing you need is to have your newfound “solution” be seen as a limitation or stigma. Be selective about whom you tell, and where or when.
8. **But be excited.** The more interested and excited you are about understanding your ADHD, the more you will benefit. The more you know, the more you can make reasonable changes that enhance your personal performance.
9. **Continue to get professional help.** After you are diagnosed, many other professionals may be able to help with your recovery: psychiatrists, counselors, coaches, nutritionists, trainers, and organizers. Many people who have been recently diagnosed experience an initial “honeymoon” period in which understanding the disorder seems to solve all problems, but they soon feel deflated or burdened with the plans and changes yet to be made. Lawyer assistance programs, doctors or other treatment providers, and support groups and organizations such as CHADD can provide referrals.

### What’s Wrong with My Practice?

Lawyers with ADHD are often in solo or small group practice, for good or ill. Many like the adventure and independence — being the boss and escaping the constraints of larger firms. Yes, large firm practice offers top-of-the line software, a staffed law library, administrative assistants, law clerks, and paralegals. Paid vacations. Colleagues to watch your back and catch your mistakes. But lawyers as a group tend to be risk takers, and lawyers with ADHD even more so. Being in solo practice is a gamble, a bit like being on the high wire without a net. You love the excitement of the fat years, but how will you handle the lean?

Of course, a solo practice has some inherent drawbacks that can be particularly unmanageable for those with ADHD. Solo practice comes with every aspect of big firm practice, but there is only one person to do it all. Will you be able to handle the office upkeep — filing, billing, answering phones, etc.? Can you afford to hire a secretary? Whom will you discuss cases or conflicts of interest with, or debate ideas for the right way to proceed? Will your impulsivity be a blessing or a curse?

For the most part, lawyers with ADHD get into trouble with the bar for the same reasons other lawyers do: They fail to communicate with their clients, don’t release files quickly enough, let something slide, or miss a deadline. To protect your practice from a complaint, you may need to incorporate new protocols to keep things on track. They need not be complicated; in fact, they’re better when kept simple. Some people swear by their electronics—personal organizers, Palm Pilots, and BlackBerries are very helpful when used properly. The test is whether you, the lawyer, are able to use them effectively. Examples of changes to consider follow — do yourself a favor and don’t try to implement the entire list at once.

1. **Structure your time.** Structure works for ADHD. Once you have a system in place and use it enough so it’s becoming routine, the chaos that results from making constant choices recedes. A “system” may be an object or a procedure. Use a book-type calendar as a memory aid — a bound volume in which you jot notes to yourself, keep lists, and maintain all deadlines and appointments (writing seems to be an

important tool for ADHD people to use, possibly because it involves both hand and eye coordination). Next, plan specific times of the day for checking e-mails and returning phone calls — and follow that plan. Both of these suggestions will seem awkward and cumbersome at first, but they are relatively straightforward and can “set you up for success” in trying out additional systems. Although much information on organizational systems is available online, limiting the amount of time you spend surfing may be another protocol you’ll want to implement; fortunately, all these organizers write books, too. Definitely ask a friend or a professional for help with this stage so you’re not overwhelmed by the choices available. But keep it simple.

2. **Clean up the office.** The trick to getting through an office cleanup is to make going through the papers manageable for you. Your system may come from a book and/or might be pretty rudimentary, but you must use one—the simpler for you, the better. One lawyer decided to start with sorting his paper clutter into four boxes: Current Criminal, Current Civil, Past Criminal, and Past Civil. (This box system has merit: It immediately reduces obvious clutter, is portable, and prevents stacks of paper from toppling.) Once he had the papers corralled, he went through each box again, sorting the papers into a few relevant subcategories. At the start of the second sorting, he found it easier to stay focused because he didn’t have to make so many decisions about each paper right off the bat; by then, most fit into a smaller category. Be sure to undertake projects like this in small doses, or your ADHD brain will zone out; if it does, take a break. Your goal is not surgical precision — go for “organized enough.” Repeat when necessary. Knowing what is in the office and prioritizing the various matters is a giant step toward preventing bar complaints based on neglect.
3. **Hire someone part-time to do the billing and maintain files.** You are looking not for a paralegal or law clerk here but for a “manager.” Be sure your contract covers the relevant ethics and confidentiality requirements, then let him or her manage. (Until you have some history with this person, however, review all transactions monthly.)
4. **Experiment with tools to find what works for you.** Explore the various things that reportedly help with concentration — timers, rearranging your office, maybe even Mozart (many ADHD people find background music helps their concentration). Stick to your established timetable for e-mail and phone replies, or adapt them if they’re not working.
5. **Carry a small notebook for recording billable hours.** One of the most common complaints from lawyers with ADHD is difficulty with time reporting. Firms generally nag you to report billable hours; in solo or small group practice, the onus is on you. Keeping a notebook in your briefcase or suit pocket turns out to be considerably more efficient than later reconstructing time from cell phone and landline bills, e-mail folders, case notes, and so on. Jotting down things as you go along frees those hours for other things.
6. **Recognize the limits of your attention span.** Generally, people vary considerably in how long they can concentrate; some reach their limits after 45 minutes, others can double that before tiring. People with ADHD are often at or below the lower figure. Once you recognize your signs of drifting off, you can develop strategies to bring yourself back: setting a timer with a loud ring, planning a stretching break after a certain time, using deep breathing exercises. Some people play games or compete with themselves: “I can do anything for 15 minutes — I’ll stop when the timer rings.” It is not that people with ADHD cannot pay attention; it’s just more difficult for them to sustain it.
7. **Get copies of your jurisdiction’s rules and consult them often.** If you have them on hand, you’ll feel less pressured by the need to keep them all in your head. Contact

the bars and associations you belong to for additional materials such as practice management guides. Surprise yourself and actually attend one of their meetings.

8. **Enjoy yourself.** Remember that you like the law, or at least did at one point. If you have lost sight of that, try to figure out when and why. Nothing makes work easier than liking what you do. Having alternative outlets such as music, sports, art, or hobbies also helps you enjoy your work more.
9. **Take care of your physical plant.** Your physical plant is your body and mind. Exercise is an excellent remedy for the stresses created by ADHD. Leave the excessive caffeine and alcohol use to others — you cannot afford the resulting biochemical changes that may upset the positive effects of your medication or other adaptations. Eat right and get adequate rest (sleeping is not a waste of time).

ADHD is treatable and manageable. If you've tried making changes before and given up, if you think (or *know*) you have a coexisting problem, please contact your state lawyer assistance program (LAP) or go to [www.abanet.org/legalservices/colap/lapdirectory.html](http://www.abanet.org/legalservices/colap/lapdirectory.html) for more information. LAPs vary from state to state, but all have a variety of resources to offer. If you have already been diagnosed with ADHD, be sure to let the LAP know this, so the coordinator can refer you to a program or treatment professional who understands and has a successful track record with ADHD clients. Most of all, remember that a conservative estimate is that nearly 44,000 colleagues throughout the country are dealing with or suffering from ADHD and its wide-ranging impact. You are not alone.

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## The Many Faces of Denial

*Mirelsa Modestti-González, Ph D*

To err is human. So is to deny. If a person has at least a basic idea of what denial is, and thinks it is not something he or she ever engages in, he or she just has. Everyone, at some point or another, has entered a denial phase or has had a denial moment. Phrases like "This can't be happening," "You have to be kidding" and "There must be a mistake" are just some examples of denial. It is the main reason why people with alcohol or substance abuse problems do not seek help. Among judges, denial takes on another form, since it can be masked by a very legitimate intention to avoid public scandal or harm the image of the judiciary.

Denial is one of the defense mechanisms postulated by Sigmund Freud in his Psychoanalytic Theory. Although psychoanalysis has its followers and detractors, Freud's studies of the mind structures and mental processes are deeply respected by followers and detractors alike, and continue to be widely studied and researched.

Freud's anatomy of the human mind: Understanding conscious and unconscious processes.

One of the pillars of Freud's theory is the study of the mind structures. The Id, which resides completely on the unconscious part of our minds, is the most primitive, impulse driven part of the human mind. When we act on impulse, without measuring the consequences of our acts, we are letting our Id direct our actions. The Ego, an aspect of the mind that emerges from the id, develops outside its awareness and governs the person's interaction with the environment. It must balance desire, morality and reality. Our most rational decisions emerge from the Ego. The Superego, which develops from the ego, is the representation of the person's culture and imposes society's belief system onto the person. When we do something which we would not like to do, but do it because "we should" or because "it's the right thing", we are functioning straight from our Superego. Transactional analysis simplified these concepts by portraying the Id as the inner child (impulsive and selfish), the Ego as the adult (down-to-earth and rational), and the Superego as the parent (authoritative and opinionated) in all of us.

From a topographical perspective, Freud visualized the human mind in three domains: The unconscious, the pre-conscious and the conscious. These are not anatomical regions in the brain. They are really mental processes that are visualized as regions in order to better understand their functioning. The conscious mind is visualized as the tip of an iceberg, which is "visible," but is really the smallest part of the mind. The unconscious is much greater, but cannot "be seen." Early recollections, traumatic memories of childhood and adolescence, embarrassing or painful events are all pushed towards our unconscious mind. The thoughts, feelings and memories of the unconscious are completely unavailable to the conscious mind, but have a lot to do with our actions. The pre-conscious level stores material outside of our conscious awareness, but that can be accessed relatively easily by remembering (for example phone numbers, recent memories, etc.). Freud contends that when a person experiences situations that he/she perceives as threatening or uncomfortable, he/she uses defense mechanisms to deal with this information. Denial is one of the most common defense mechanisms. It involves "pushing" threatening information into the unconscious mind and thus, denying it.

Why does denial take place? Usually, people want to keep their lives in order. They want to feel in control, so they resist facing facts or situations that they fear would result in a loss, or a warning that something in them is “not ok”. When in denial, a person rejects a situation or fact that is threatening or uncomfortable to accept, even when it is utterly obvious for anyone else. The subject may simply deny the reality of the unpleasant fact, or he/she might admit the fact, but deny its consequences or how serious it is. This is called minimizing. At other times, the person may admit both the fact and its consequences, but deny any responsibility. This is called displacing, if the responsibility is cast upon a third party, or transference, if the responsibility is shifted towards the therapist.

Judges who deal with young offenders often see the parents in sheer denial. It is very hard for a parent to accept that his or her son or daughter has committed a crime. Even parents of ruthless, antisocial youngsters can be heard arguing that their son or daughter cannot be guilty of what the prosecutors contend. Some young or inexperienced lawyers, when they empathize too much with their clients, believe their account to the extent that they may even ignore certain aspects of the client’s version that, to an outsider, do not seem possible.

Denial was researched extensively by Anna Freud, the youngest of Sigmund Freud’s children. Basically, she classified denial as a mechanism of the immature mind, and stated that it affects the ability to cope with reality and learn from experience. Mature people may fall into denial when facing unexpected losses or traumas like death of a loved one or rape.

Elisabeth Kübler-Ross identified the five stages of grief experienced by people facing death (their own or a loved one’s). These stages are denial, anger, bargaining, depression, and acceptance. On the first stage, the person cannot believe the news he or she is confronted with. He or she tries to find proof of an error, or even a lie that will change the painful fact or situation. When no such mistake can be found, the person experiences intense anger (towards the news bearer, towards him or herself or even God). Then, the person enters a bargaining stage (“Maybe if I stop smoking and lead a healthy life, the cancer will go away...”). When faced with the fact that no amount of negotiation is changing the painful reality, the person enters a stage of depression. Finally, he or she accepts the unavoidable. Kübler Ross’ theory has been extended to other losses like separation or divorce, incapacitating accidents or illness or loss of employment.

Unlike some other defense mechanisms postulated by psychoanalytic theory, for instance, repression or projection, denial is easily detectable. The emotionally threatening or uncomfortable situation and its consequences are pretty clear for everyone except the person in denial. This is specially obvious in alcohol or substance abuse and smoking. Typically, the person denies having a problem and insists that he or she is in control of the situation, while family members or workmates keep confronting him or her with the problematic behavior. The ability to deny or minimize is an essential part of what enables an alcoholic or addict to continue his or her behavior despite overwhelming evidence that there is a problem.

### **Types of Denial**

**Simple Denial:** The person denies that an uncomfortable or threatening situation is taking place or that any specific action has happened. It can be carried out consciously,

by lying, or unconsciously, when the person fails to recognize or really believes that the situation does not exist, despite evidence on the contrary.

**Minimizing:** The person may accept the fact or situation, but denies that it affects anyone, or the extent of the damage. This denial may include alternative explanations which could diminish the impact of his or her behavior on the significant others. Typically, this is achieved by minimizing the impact of the troublesome conduct. It is an attempt to make the effects or results of an action appear less harmful.

**Denial of responsibility:** The person accepts the situation and its consequences, but denies that his or her conduct is responsible for the obvious impact of his or her behavior. This can be done by blaming somebody else, or shifting fault, or by trying to validate his or her actions. It is an attempt to make a wrong action seem right by justifying that decision or action.

**Denial of cycle:** It takes place when a person avoids facing that his or her behavior is part of a pattern or cycle. Through this type of denial, alcoholics and addicts fail to recognize the events that lead to their relapse, and bipolars fail to predict their mood swings. Because of this denial, domestic violence offenders and survivors do not recognize the cycle of violence they live in.

**Endorsed denial:** This form of denial is shared by the commanding figures in the person's family, community or work environment. The spouse, parents, boss or partners deny or ignore the problem, because acknowledging it would require certain actions to be taken, which could create a crisis or difficult situation.

**Transitory denial:** The person experiences denial at the pre-conscious level, for a very short time, and gradually lets the information sink in. As soon as the situation is less threatening, the person spontaneously accepts reality and takes action or seeks help.

**Denial of denial:** It is simply the denial of a denial process. It involves thoughts and behaviors which fail to recognize that the person is not being objective or honest. A person in denial of denial can be very defensive, thus making the help process very difficult.

### **Is there such thing as healthy denial?**

Some experts agree that certain amount of denial is actually healthy. If people were to acknowledge every possible danger or threat that they are exposed to, they would never leave home. They would not ride in cars, board airplanes or get on boats. If people were permanently aware of the fact that certain amount of suffering in life is inevitable, they would become anxious and depressed. Emotionally healthy people are able to enjoy life, give and receive love and maintain a positive attitude towards life, despite the knowledge that losses and pain will occur at some point. They take reasonable risks, and carry out normal lives. The truth is that this involves a certain amount of denial.

### **The twelve steps of Alcoholics Anonymous**

The concept of denial is very important when dealing with alcohol or substance abuse or dependency, or mental health issues. Denial is the single most important reason why alcohol or substance addicts do not seek help.



Alcoholics Anonymous (AA) is probably the entity that has dealt more with the denial process. Most of the twelve steps that guide this program address, directly or indirectly, the denial issue. Narcotics Anonymous (NA), Overeaters Anonymous and other recovery programs are based on or inspired by the twelve step program developed by AA.

The first step is specifically designed to overcome denial: "We admitted we were powerless over alcohol — that our lives had become unmanageable." This is the base on which the whole program is constructed. If a person cannot admit that there is a problem, all attempts to solve it are pointless. To be able to carry it out, step four requires a long, thorough look at denial: "We made a searching and fearless moral inventory of ourselves." It is not possible to search for anything if governed by denial. Since the recovery process cannot be judgmental, participants are encouraged to take an honest, fearless look at their conduct, not to be overcome by guilt, but to make affirmative change decisions. Step five requires not only that denial be overcome, but overtly challenged: "We admitted to God, to ourselves, and to another human being the exact nature of our wrongs." Admitting to God (as the person understands him or her) is an act of humbleness. Admitting to oneself is challenging denial, and admitting to at least one human being makes relapse into denial more difficult. Step eight cannot be met in denial: "We made a list of all persons we had harmed, and became willing to make amends to them all." This also requires affirmative action as well as humbleness. Step ten is designed to prevent a relapse in denial: "We continued to take personal inventory and when we were wrong promptly admitted it." Finally, step twelve deals with helping others overcome their own denial, since service to others in need of recovery is one of the basic principles of AA: "Having had a spiritual awakening as the result of these Steps, we tried to carry this message to other alcoholics, and to practice these principles in all our affairs."

Twelve step programs have a long standing history of success. They depend on the solidarity of people in recovery and the fact that no one knows more about overcoming addictions than those who have fought them and won. Likewise, nobody knows more about denial than those who have been in it. Since it stems from emotional needs, denial can become a very strong habit. Recovery from denial requires just as strong vigilance as recovery from alcohol abuse or addictions.

### **Dangers of denial in the Judiciary**

Alcohol or substance abuse, mental health conditions such as bipolarity or depression and social emergencies like domestic violence or child abuse are very difficult situations to deal with in any family. In the judicial family, facing these issues can become very complicated. Professional and social pressures make it very difficult for a judge or their spouse or children to seek help. The judge may experience simple denial, minimizing or denial of responsibility. He or she may fear that by seeking help, his or her problem will be exposed, and he or she may face separation of service. The spouse or children may have the same fears, or may be afraid that they could be criticized or in some way punished for exposing the judge. They may experience simple denial and/or minimizing.

To add to the confusion, there may also be endorsed denial by the judge's peers, support personnel or even the judicial system. Nobody wants to have such a thorny problem and though consciously, we may all agree that ignoring it doesn't make much sense, at the unconscious level, many people feel that if something is not talked about, it's not happening. The problem is that an addiction, mental health or violence problem is like a

time bomb: if not deactivated promptly and properly, it may explode without warning and have catastrophic consequences.

Judges who try to fight alone against alcohol, prescribed or illegal drugs or conditions like bipolarity or depression, are in an underhanded battle, because having to hide their problem enables denial. The high level of stress in their job makes them want to escape or take refuge, thus pushing them into relapse. Action must be taken to prevent, identify and treat mental health, addiction and violence issues in the judiciary. It is of paramount importance that judges receive, parallel to their professional training, lectures, workshops and written material to help them identify the aforementioned situations, as well as guidelines to seeking help. As part of the prevention program, we must teach our judges to recognize signs of stress and burnout and to learn to deal with judicial stress in a healthy manner.

Spouses and children of judges who suffer alcohol or substance addictions are on a very difficult path to recovery, since very few jurisdictions have programs that include relatives. The judges may be in endorsed denial and may fear that their spouse or child's problem could harm their judicial appointment.

Since confidentiality is such an important issue, the judges and their family members need to be reassured that the professionals and/or sponsors who will help them will observe very strict confidentiality measures. If the judicial assistance program offers a mental health directory, the psychologists or psychiatrists that appear in such directory should undergo specialized training on judicial issues, confidentiality requirements and the unique needs and situations judges confront.

The judicial career is a life altering experience, and along with the many emotional and professional rewards, comes a great deal of stress. The judge and his or her family live in a showcase: their private life is less private, and their problems may become public matter within minutes. Since their alternatives to seek help are limited by this situation, programs need to be developed that ensure that our judges and their families can be taken care of in an effective, sensible and low profile manner.

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## ISOLATION IN THE JUDICIAL CAREER

Isaiah M. Zimmerman

*“Before becoming a judge, I had no idea or warning, of how isolating it would be.” “Except with very close, old friends, you cannot relax socially.” “Judging is the most isolating and lonely of callings.”<sup>1</sup> “The isolation is gradual. Most of your friends are lawyers, and you can’t carry on with them as before.” “When you become a judge, you lose your first name!” “It was the isolation that I was not prepared for.” “After all of these years on the bench, the isolation is my major disappointment.” “The Chief Judge warned me: ‘You’re entering a monastery when you join this circuit.’” “I live and work in a space capsule — alone with stacks of paper.” “Your circle of friends certainly becomes much smaller.” “Once you get on the appellate bench, you become anonymous.”*

These are the voices of state and federal judges. They are culled from twenty years of notes taken from my work with the judiciary as a consultant or as a psychotherapist. They are spontaneous, and not in response to any leading question regarding isolation.

### JOINT EFFECT OF CODE AND CASELOAD

What is going on here? Why did approximately 70% of the judges interviewed come up with this observation on their own? When asked, most cited the combined effect of a crushing workload plus the restrictions imposed by the Code of Judicial Conduct. Indeed, the average judge, in my experience, brings work home on many evenings and weekends and lives with a constant tension of being behind in his caseload. Time for friends and family, recreation, and cultural pursuits is severely limited, and is constantly weighed against the demands of the court.

Some innovate. A federal trial judge told me, “On occasional weekends, my wife and kids come to my chambers. They play. I work. We get pizza or Chinese delivered, and time passes better than being separated.” Another couple, both of whom are state trial judges, report, “We work late in the courthouse every week day. But on the weekends, we see no one. We sleep or stay in bed most of the weekend, and absolutely bring no legal work home. As a result, we hardly see any friends and have almost given up on social life, but we’ve tried to preserve our intimate life. This way we’re also usually caught up with our work.”

As to the effect of the Code, judges report that it is more the “appearance” requirement that poses the biggest burden. They have to be vigilant and maintain an appropriate distance and demeanor at social and bar gatherings. Jokes and offhand remarks can backfire, especially in smaller communities. The immediate family is also drawn into the ambiguous image and behavior restrictions. A rural area judge writes, “We have no privacy. If my wife or I fail to say hello to a local, it will result in a slight. If I’m seen talking alone to someone longer than a couple of minutes, word will get around that I must somehow be close to that person. So, we’ve learned to be alert and careful when we step outside our home.”

Most judges believe it is necessary to appear confident and unperturbed in public. Thus, an overworked trial judge explains, “You develop the skill of moving a docket of 200 cases without giving the impression of hurrying anyone! But burnout is a widespread fact here that we don’t discuss. Often, I am bored and exhausted; but I can’t talk to anyone about it. I have to keep up the act of being on top of my game.”

Chief justices and presiding judges often exhort their colleagues to become more involved in their communities in permissible ways. But some colleagues object. A federal judge expressed it to me this way: "I would like to contribute more. But, with the little time I have left, I feel it first should go to my family, and then to my own time: to read, stay fit, and listen to some music." Another judge added, "You gradually lose your original group of friends, and you have no time or energy to make new ones. Discretionary time goes down to zero. With all the ethical restrictions that are obviously necessary, who has time to go out and break new ground?"

### **THE ISOLATION PROCESS**

Judicial isolation is essentially a part of a wide-ranging and deep acculturation process. Early in the judicial career, former lawyer colleagues immediately begin to show deference to the new judge by referring to him or her only by title. Despite protestation by the new judge when outside the court, this usually sticks and the judge accepts it.

The higher status conferred on the former lawyer casts wide social ripples. It is experienced by the judge and his immediate family with excitement and pride.

Despite the ritual requirement to appear modest and even unworthy, the net effect is one of a heady rise in esteem and social worth. The subculture of the courthouse reinforces the new identity through the powerful symbolism of the robing ceremony and constant deferential behavior. This even includes the architecture of the building and courtroom with its raised bench and solemnity. Despite the understanding that it is the office and role that are being honored, the man or woman occupying it is soon merged with the charismatic image. Slowly, former colleagues continue to pull away from the judge and act with more formality toward him or her. Friends, relatives and neighbors also acknowledge the rise in status and continually display heightened respect and deferential behavior. In other societies, this process is more pronounced. In our less formal American culture, judges still are usually placed at the apex of any survey of the degree of respect accorded various professionals. Inside himself, the judge may not accept the imposed image, but he is still likely to be swept along by the external niceties.

At a later stage, many judges find themselves adopting a duality in their sense of self. They play out "The Honorable" role at work, but shed it at home and with close friends. The power of the stereotype and the high qualities attributed to its bearer can impel even close friends to buy into it, at least to some extent.

Under the combined effect of having little time for personal life and being continually treated like a demigod, it should not surprise anyone that the phenomenon humorously referred to as "robe-itis" can emerge. The caricature conveys the image of a pompous martinet who never sheds his robe or exaggerated role, especially at home. The more serious and lifelike version is a judge who has become so absorbed by his professional role that he or she has lost much of his private persona and can no longer relate as a peer to most people. This is the end product of years of living and working in the absence of frank criticism and corrective feedback.

A further casualty of this isolating process is the weakening of honest and robust dialogue. At the appellate level it can sometimes be seen when oral argument is eschewed. Judge Coffin<sup>2</sup> cites the "dilution of collegiality" under conditions of an overburdened and expanded judiciary where judges are "polite strangers" to each other and dialogue is shallow. Over a span of years, a judge usually surrenders a continuing close relationship with his classmates. Despite meetings and work on bar projects, the

required degree of trust and emotional access seldom develops. Some of the judges quoted at the top of this essay were referring precisely to this invisible wall.

The subject of judicial isolation is so vexing also because one meets a great deal of denial on the part of many judges. They may claim in a public forum that they have many friends and are puzzled by all of this talk of isolation. On closer examination, I have usually found that this is true for some extroverted judges, but not for the majority, who tend to be largely introverted and overwhelmed by work.

Another unintended casualty of the Code and the long-range effect of interpersonal isolation is a withdrawal from intellectual and community involvement. The judge expends all his fine capabilities in court, but seldom outside. Sometimes ambition and reappointment or election is folded into a posture described by a federal judge: "You use extreme caution, not to say something you'll later regret, or something that may be held against you if you're under consideration for an appellate appointment. These cautionary attitudes certainly dictate that you're not likely to write or say much outside of your carefully crafted opinions."

I did ask a few judges if they could think of colleagues who used to be rich and exciting as thinkers and who have gradually withdrawn into smooth and social banality. The response described colleagues who exchange jokes and talk about sports in the judges' dining room, and do not respond to occasional efforts at serious conversation.

### **ROLE OF PERSONALITY TRAITS**

In my clinical experience, a substantial majority of judges' personality profiles are a composite (in varying degrees) of introversion, intellectuality, high idealism, and a strong work ethic. Given these personality traits, it is my opinion that, under the twin hammers of social isolation and chronic overwork, it is not surprising that so many judges adapt to their very difficult situation with the reaction patterns discussed above. Essentially, they fail to aggressively fight isolation and its associated negative consequences.

Let us now look at the other group, the roughly 30% of judges who appear not to suffer appreciably from isolation. Their profiles display a combination of extroversion, more emotionality nuanced intellectuality, idealistic tendencies tempered by pragmatism, and a strong work ethic also, but coupled with oppositional traits. These "more extroverted" brethren are equally competent judges, but they seem to experience less stress. They also appear not to feel so confined by the Code of Judicial Conduct. They strive for more public appearances, engage in more debates, and publish more widely.

A few examples of their venturesomeness may help paint a composite portrait: a couple of these judges appear occasionally on talk radio; one is a volunteer paramedic; some teach a variety of non-legal courses in colleges and prisons; several write fiction and act in small theater; others have written on important societal issues. Almost all of them report that when they sense isolation beginning to envelop them, they respond by a variety of vigorous outreach efforts. They reconnect with old friends, seek new social contacts outside the legal profession, and engage in various communal and cultural activities.

### **TRANSMUTING ISOLATION**

Isolation is not going to be removed from the judicial career. The strictures of the Code are the bulwark of judicial independence. Both heavy workloads and isolation will remain major elements of the judicial career. Indeed, under the pressures of a high-

profile trial, a judge can find great strength not only in his friends and family, but also in his years of monastic isolation. One state judge expressed it thus: "You have to accept isolation. Ultimately, it will serve you well when your independence is seriously threatened. You must cultivate your distance in order to make the hardest decisions of your life when your own life and that of your family is under threat because of a decision you've handed down."

A judge does not have to undergo a personality change in order to reduce the effects of unavoidable isolation upon his quality of life and collegiality. It also is not necessary to test the borders of the Code of Judicial Conduct. As Judge Deanell Tacha of the United States Court of Appeals for the Tenth Circuit has written: "In fact, the laws, regulations, and codes governing the conduct of judges leave a wide range of civic, philanthropic, and educational activities open for participation by judges. Indeed, judges are far freer to interact with the other two branches of government than they realize."<sup>3</sup>

A prescription for transmuting isolation into a healthy life and judicial career involves these elements:

- 1) Aggressively holding on to old and childhood friends. We all need witnesses to our stages of life.
- 2) Maintaining a close support circle of relatives and friends who are not competitive or envious, and with whom one can engage in robust and honest mutual appraisal and dialogue.
- 3) Taking initiative to engage in activities totally removed from the legal and judicial world, and to form friendships with some of the people you will meet in this way.
- 4) Learning the basics of stress management techniques so that you can work efficiently but not pay too high a price for it.
- 5) Periodically serving as a mentor to a new judge, so that you can teach by example most of these points.

Judicial isolation is an inherent part of the role judges must play in society. It can seriously diminish a judge's intellectual and social abilities. By understanding and actively employing the measures recommended, a judge can transmute isolation into a rewarding resource.

#### **Footnotes**

1. Linda Stewart Dalianis, "Judges Writing Journals: A Personal Perspective," *JUDGES' J.*, Spring 1999, at 13.
2. Frank M. Coffin, *ON APPEAL: COURTS, LAWYERING AND JUDGING* 216-17 (1994).
3. Deanell R. Tacha, "Renewing Our Civic Commitment: Lawyers and Judges as Painters of the 'Big Picture,'" 41 *U. KAN. L. REV.* 481, 488 (1993).

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Court Review - Winter 2000

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## ASSISTANCE – WHAT EXISTS

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This section contains a variety of articles starting with *The Harder They Fall – A Hand Up for Impaired Judges* describing Assistance Programs and a good discussion on addiction. *The Worst Kept Secret in the Courthouse* reviews the work of judicial fitness and disability commissions, state committees or programs to assist judges, public discipline entities and the importance of addressing a judge's impairment before it comes to the public discipline/removal stage. The article *Demystifying 12-Step Programs* sets forth the kind of help available in the community. The *Addressing the Problem of Courtroom Stress* article discusses courtroom stress on all who participate in trials, including jurors, judges, etc.

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### THE HARDER THEY FALL — A HAND UP FOR IMPAIRED JUDGES

*An edited transcript of a portion of the American Judicature Society annual meeting program on August 6, 2005.\**

#### **Participants**

Richard A. Soden, Goodwin Procter LLP, Boston

Richard P. Carlton, Deputy Director, State Bar of California Lawyer Assistance Program

William J. Kane, Director, New Jersey Lawyers Assistance Program

John W. Stiemke, Director of Clinical Services, Rush Behavioral Health, Chicago

Seana Willing, Executive Director, Texas State Commission on Judicial Conduct

Honorable Warren D. Wolfson, State of Illinois Appellate Court

*Editor's note: The program began with a role play.*

**Richard Soden:** We're going to role play a small scene between a judge and a director of a lawyers' assistance program (LAP).

**Warren Wolfson:** Mr. Kane, thanks for giving me a few of your minutes. I don't know if I'm wasting your time or not, but I'm just a little bit concerned about a friend of mine, Judge Bill Smith. Do you have a couple minutes?

**William J. Kane:** Sure, Judge.

**Wolfson:** The reason I asked to see you was because Bill and I were at a bar association dinner the other night and he was drinking pretty heavily — he got drunk, actually. I insisted on driving him home and he got very angry, but he finally agreed. I know that doesn't make him an alcoholic, and I'm not accusing him of anything. But there have been some other things that I've heard about him and seen about him, and I just thought I had to talk to somebody about it. You're not going to call him and tell him that I called you, are you?

**Kane:** This is a confidential consultation, Judge. Let's talk a little bit more about it. You mentioned that, of course, one episode of intoxication, or even one drunk driving doesn't make an alcoholic, but combined with the rumors it seems to be something that you ought to look at more closely.

**Wolfson:** I talked to the public defender the other day, and she told me it's gotten to the point where she won't let her lawyers have sentencing conferences in the afternoon anymore before this judge.



**Kane:** Now we're coming from one episode to a frequency or a pattern of behavior.

**Wolfson:** There are a few other things too. I've noticed in the afternoon he's kind of irritable; he never used to be. He used to be pleasant all the time. There have been some times where we've had lunch together, and I've been a little concerned because he had a couple martinis. I remember one time I even covered his call for him because I didn't think he should have been on the bench. The chief judge asked me about it, and I just said he had the flu and had to go home, because he's a good friend and I didn't want to get him in trouble.

**Kane:** Folks in their friendship and collegiality and their reluctance to even think about or talk about someone having an alcohol problem, can end up as enablers because what you're doing is failing to address something that is sensitive and may need some attention.

**Wolfson:** I don't want to be ratting him out, getting him in trouble.

**Kane:** Well, if he had some other illness, like diabetes or a heart condition, and he wasn't taking care of himself, we would put an arm around his shoulder and draw his attention to that, wouldn't we?

**Wolfson:** We had a judges' meeting a couple weeks ago, and the chief did bring up some of the things that he's been hearing. Bill really got angry. He almost stormed out, so we stopped talking about it because we didn't want to upset him.

**Kane:** That certainly isn't going to help things if he's reacting in a negative way, but there are ways to communicate with him and address the problem. These can be done in a caring and gentle and private way.

**Wolfson:** I tried to talk to him about things in the afternoon, but I found the next day he didn't remember talking about it.

**Kane:** You're very kind and understanding of your colleague, and I really admire that.

**Wolfson:** Well, he's a good judge. He's a family man, religious guy. He's been around a long time, and I don't want to do anything to hurt him.

**Kane:** Alcohol problems are equal opportunity issues. It doesn't matter whether somebody is a good, upstanding person or whether they have other problems in their lives. So I do understand that.

**Wolfson:** In fact, the other day the chief judge asked me what's going on with him. And I said, "Well, you know, he's had a lot of stress, he's had some family problems." Was that the right thing to do? I don't know.

**Kane:** Well, of course, if he has stress and family problems, they also could be a result of an alcohol problem. Have you thought about a private chat with him, taking some time and sharing your concerns?

**Wolfson:** I just didn't want him to think I was getting personal with him. I didn't want it to ruin our friendship.

**Kane:** These things get worse rather than better all by themselves, and this may be one of the noblest and most friendly, caring things you can do. You might consider having a chat with him, and if you're not comfortable doing it all by yourself, I could join you and just sit in the wings or on the side, either way, as you prefer. We have done these in the past and there's a partial checklist of things you could look at in considering what to do next. You should make little notes of the dates and times and places so you have concrete, documented evidence rather than the vague feeling and the rumors.

**Wolfson:** It sounds like you're turning me into an informer.

**Kane:** No, I think you're being turned into a helper who is helping in a profound way rather than in a vague way.

**Wolfson:** Now, are you going to report this to the judicial conduct commission?

**Kane:** Not at all. The Judges' Assistance Program is not only covered with confidentiality by court rule, but there's also federal regulations that forbid us from even disclosing that someone has asked for help. I consider these preliminary discussions as part of that.

**Wolfson:** Where do you see this playing out? I don't want to hurt his reputation or get him disciplined or anything.

**Kane:** If we start addressing the problem, you're probably saving his reputation. Imagine if you weren't there to drive him home from the bar association dinner the other night. You'd have it splashed all over the media about another judge who has a DWI, or worse.

**Wolfson:** If you could just set out what I'm supposed to do and what I'm supposed to look for.

**Kane:** I would find a resource, a judges' assistance program or a lawyers' assistance program or employee assistance professional. The first thing you might do, Judge, is choose the site. Talking to him in his office isn't as powerful as talking to him in your chambers or in a neutral site. Another thing is time of day. You might chat with him earlier in the morning rather than in the afternoon because it's much more likely that he would be fresh and receptive, because if he has the kind of a problem where he's taking a drink in the morning, you're not going to get through to him in the afternoon to the same extent you will in the morning.

The first thing you need to tell him is how much you care about him and how much you value him as a friend and a colleague. That is really a nondebatable message, the first prong. He'll be pleased to hear that. You can tell him that you admire his being a respected judge, and especially when he's working within his capabilities.

The second thing you have to deliver is the list of the specific elements that give rise to concern, things that are concrete and documented. Then, Judge, I would share with him how that made you feel. You can tell him, "I came to this very reluctantly. It's the last thing in the world I want to do. I didn't want to believe it myself".

**Wolfson:** He's going to be mad.

**Kane:** If you give enough of a caring statement, that might soothe his feathers in advance. You tell him that this is a private chat between the two of you. You can tell him about your concerns and that you feel compelled to address this because he might be headed for the judges' discipline system if you two don't have a chat.

**Wolfson:** Do you think I have any obligation to report this to the system?

**Kane:** Not yet. I think that you might give him a bite at the helping hand apple and you might tell him that you feel so concerned about his performance and the documented problems about his opinions and his lateness and the deterioration in his performance. You can say, "you know, if I don't follow through on this, it may be a matter for discipline, and I'm trying to avoid that."

**Wolfson:** I have a feeling I'm going to lose a friend.

**Kane:** You may be gaining a friend, Judge. This is a risk you're going to have to take, because the harm that could result in your remaining quiet wouldn't be a help. It would be a harmful thing to do. Remember, you're not diagnosing him. All you're asking him to do is present himself for an evaluation and then to follow through with the recommendations of that evaluation. You can assure him it's in total confidence. That now is the time to address the problem.

Of course, you and I know that this is the best kept nonsecret in the courthouse. There are people mumbling and muttering behind his back, there are people making allowances for his performance.

**Wolfson:** I guess it would have been easier for me just to say nothing.

**Kane:** It might seem easier and more comfortable to you, Judge. But if you look down the pike and see what happens in the future, you might be saying to yourself, "if only I had said something. If only I had offered a helping hand." I know how sensitive it is. People don't like to talk about alcohol problems; there's an unfortunate stigma that's associated with them that isn't associated with other diseases.

In many cases we see that when an alcohol problem affects somebody's professional performance, it's not an early stage case. It's very likely that the judge's family has been living with this for some time, maybe years, before it begins to surface on the job.

**Wolfson:** I guess I'll give it a try. Thank you very much for your time.

*End of role play*

**Richard Soden:** I'm chairman of the American Bar Association Commission on Lawyers' Assistance Programs. Over the years, the Commission has been interested in working with lawyers around the nation who are dealing with problems in their lives, and we've always tried to address the concerns of judges as well.

### **Assistance programs**

**Soden:** I'm going to ask Judge Wolfson to talk about the Illinois Lawyers' Assistance Program.

**Warren Wolfson:** At the risk of preaching to the choir, let me just remind you that we are talking about a chronic, progressive, incurable disease. That's why it's worth taking our time today to talk about it, to see if we can recognize it when we see it, and if we can understand it.

I've been part of the Illinois Lawyers' Assistance Program for the past 25 years, since the day it was formed. A group of interested and caring lawyers and judges got together and decided it was time to do something. The Chicago Bar and the Illinois State Bar put us together in a formal setting and for many, many years we operated on a purely voluntary basis. Finally, it got to the point where we couldn't do that any more. We went to the Illinois Supreme Court, and about two and one-half years ago the court, with the legislature, formally organized us, named our board, and decided to assess every lawyer in the state \$7 to fund us.

We go around talking to people about how this really is a problem in the legal profession. The experts say that 10 to 15 percent of all adults have some kind of alcohol control problem. The black robe of the judge and the law license of the lawyer offer no immunity. And I know that lawyers and judges are somewhere within that 10 to 15 percent, probably the upper regions of it because of the profession and because lawyers and judges have more money and the opportunity to use and buy.

If you look at the judicial discipline cases—the abusive language, the bizarre sexual behavior, the sexual and racial discrimination, using the office improperly to gain some favor for themselves or others—much of the time chemical abuse is there when those things happen. One of our goals at LAP is to keep lawyers and judges out of the grasp of the disciplinary agencies, and needless to say, out of jail.

The Illinois Lawyers' Assistance Program is basically an intervention program. We don't wait until all the destruction of life and property and health takes place. We reach people two ways. One is direct contact where the people who have the problems call us and ask for help. That's pretty easy because denial has been overcome when they call, and it's easy to get somebody to a place where help is waiting or to the kind of peer assistance that they need. Second is when somebody else calls and we have to put together an intervention that will break the denial of the subject. That is the harder way to do things.

We decided early on that judges would play an important role in the intervention process. We do not have a separate program for judges, but we do bring judges into our program and train them. When we're dealing with a judge as the subject, only other judges will take part in the intervention.

All of our intervenors are trained by health professionals, whether they're judges or lawyers. All of the people taking part in the intervention will have the information about the person. They will come in and tell the judge what they have seen and how they feel, what it's doing to them, and what it's doing to him or her. We hope to cover all parts of the judge's life—office, chambers, personal life, and family life.

One of the messages we send is that if you don't say anything, you're helping that person die. You have to take part and take the risk and maybe somebody will get mad at you.

Our supreme court has given us a rule that guarantees to anybody who comes to a trained intervenor the same kind of a relationship a client would have when he comes to

a lawyer. We have a statute that grants immunity to anybody who takes part in an intervention in good faith. The statute also provides that people are protected from testifying in any proceeding should they take part in the intervention.

Some of our trained intervenors are recovering, others are not. The only requirement that we have is that the intervenor care about his fellow lawyer, law student, or judge, and that he or she is willing to do something about it and devote the time to it.

The LAP in Illinois is trying to expand beyond simple substance abuse into psychological problems such as clinical depression, bipolar conditions, and personality disorders. We've brought in consultants to get their advice before we stumble into a terrible mistake dealing with people with mental disorders.

The judges play an important role in our program. We know that any good program will offer help and not punishment. It will be understanding and not accusatory, and it will offer hope and not desperation. We know we can do that, we know how to do that. All it takes is the will and the desire to do it. And that's what we're going to do.

**William J. Kane:** I congratulate AJS for addressing this issue. I think that this is very important, and I know we are way overdue in addressing the problem of offering help to judges.

Lawyers are advice-givers, not advice-takers. That's the barrier with lawyers getting help. Judges are order-givers, and they're neither advice-takers nor order-takers. That's a barrier with judges getting help. We want to think the best of our bench. We want to know that judges are the mortar holding society together, one of the last areas of respect that we have in our society. If we want to hold them on pedestals and on the bench, we have to acknowledge that they are human beings who can sometimes use help, and that offering that help can keep them on the bench and keep them on the pedestal.

When the New Jersey Supreme Court gave the Lawyers' Assistance Program responsibility for the Judges' Assistance Program, we were ready. We had an 800 number all ready just for the judges. We had a first-class brochure ready to be printed, and we hit the ground running with outreach that saturated and inundated every judge in the state several times in their mailboxes and personally. We went to all assignment judges, and we also deputized judges who are in recovery or who were sympathetic as indirect helpers and indirect promulgators for outreach. We have to keep doing this. You can have the best program in the world and it will just be window dressing unless you keep reminding people of it all the time. In fact, we may be spending 51 percent of our time in promulgation and 49 percent of our time in helping judges.

### **The Texas experience**

**Seana Willing:** I've been with the Texas Commission on Judicial Conduct for six years, the last two as its executive director. About four years ago the Commission started seeing a lot of high profile media coverage of judges involved in DWIs, public intoxication cases, reports of judges at bar association functions urinating in trash cans, and those types of stories. All cast public discredit on the judiciary. Those cases were filed with our Commission as disciplinary complaints.

The state bar had a Lawyers' Assistance Program, but its Judges' Assistance Program was virtually unknown and very inactive. In addition, probably half of the 3,600 judges under our jurisdiction are non-lawyer judges. Those judges could not obtain any benefit

from the state bar's program. So we saw a need for a program. We thought it would be appropriate, since no one else had stepped up to the plate, for the Commission to start a program to assist our judges with alcohol and drug impairments. Our program is called Amicus Curiae, or friend of the court. There are three people on our board, one of whom is a retired appellate judge who's a recovering alcoholic; another is a doctor of psychology; and the third is a district judge who started a drug impact court in Houston and is very involved in recovery programs for criminal defendants.

We started looking at the complaints that came in and tried to figure out a way of diverting those judges, who appear to have engaged in misconduct as a result of impairment, to resources in their community in a confidential setting where they can take advantage of a local A.A. group or get counseling.

The biggest obstacle was our Commission. Our members were not really open to the idea of assisting these judges. Their focus was on addressing the misconduct and protecting the public. Our Commission wants to have an answer in six months. They don't want the case to linger for too long. That's a major obstacle because recovery is not going to start and end in six months; it's going to be years. That's an issue we're still contending with, how do you keep a case pending in a disciplinary action for sometimes four or five years?

We started a self-reporting or a self-referral component because we realized that not all impairments are going to result in misconduct. The fact that a judge has a drinking problem is not in itself misconduct. But it would be nice if judges, especially non-lawyer judges, knew there was someplace where they can contact our program manager and get in touch with professionals.

We wanted to educate the judiciary about this program, and at the end of every program where we speak about the Commission, we talk about our Amicus Curiae Program. I agree wholeheartedly with Mr. Kane that at least 50 percent, if not more, of the success of the program is just getting the word out and educating the judiciary, the legal community, families, and others about the existence of the program.

Another challenge that we've had is a lack of trust about approaching the Commission to seek assistance for an impairment because the judge isn't going to believe that we'll maintain confidentiality; they're going to believe that we will report them to the Commission. We've set out in our materials clearly the separation between the Commission and this Amicus program, but it's been very difficult to get people to buy into it.

The lack of funding of the program has contributed to this because we don't have the funds for a separate 800 number. We don't have the funds to put together a very polished, professional-looking brochure. We're working towards getting the funding so that we can address those issues. We need to convince legislators that they need to fund the agency and fund this particular aspect of the agency.

What we are finding with the judges that have been participating in the program, whether it's been voluntary or whether they've been ordered to do so by the Commission, is that the initial evaluation to determine whether or not the judge's problem is alcohol, drugs, or more of a mental condition is very costly. We don't have the funds to pay for all these judges to be evaluated. The judges themselves very often don't have the funds to do it. They're reluctant to report it to their insurer.

It's a very frustrating process because we know that it can work. We're not 100 percent convinced that we're the ones who should be doing it, but so far no one else has stepped up.

### **California and federal courts**

**Richard Carlton:** I want to thank AJS for including me in this program. I think it's really a groundbreaking effort this morning. I am the deputy director of the Lawyer Assistance Program in California. I'm also the consultant to the Ninth Circuit federal courts on these issues. Like some of my colleagues, I've been working in lawyer assistance for 20 years, and I begin to get the feeling as I'm listening to what's being said here that the field of judicial assistance is where the field of lawyer assistance was 10-15 years ago. To me there's something exciting about that because I see something has started here that hopefully will go forward.

In 1993, I was invited by the California Judges' Association to join them in putting together a program that was really ahead of its time. The Association is a voluntary membership association, and the leadership felt that their members, particularly those judges who were experiencing personal problems that had already resulted in some kind of conduct inquiry or were likely to result in some kind of conduct inquiry, needed to have some confidential, reliable, trusted source that they could consult with about what to do when they got that first phone call or a letter from the Commission on Judicial Performance. So they created the Judicial Support Network, and they recruited judges from around the state to volunteer to be trained to become peer advisors and peer consultants. The notion was that a judge was probably not likely to approach a peer in his own courthouse or in his or her own county, but if they had someone who could put them in touch with a trained, confidential, trusted advisor peer from another county, there was a possibility that they would reach out to this assistance.

It was a great concept. Unfortunately, the program pretty much petered out over time. I think the reason was that there was a lack of broad institutional or cultural support. It didn't have any top down endorsement or support. The judicial council never bought in, and as the leadership in the California Judges' Association changed over time, the impetus and the strength to keep the program out there didn't continue. It's not part of judges' initial training when they come on to the bench. If they're lucky, they happen to see the brochure come across their desk at some point from the California Judges' Association. It's inadequately promoted and very, very rarely utilized.

I'd like to turn to my experiences with the federal courts. It began in about 1999, with the creation of what was originally called the Disability Committee. Later the name was changed to the Wellness Committee to broaden the concept and the support and better identify what it was we were trying to accomplish. The effort is broken down into three phases.

The first phase was a very comprehensive report on the full range of personal issues and challenges that judges are subjected to, and examined programming that was in place around the country, as well as in Canada, for both lawyers and judges at the time. The report recommended some comprehensive programming that the circuit should consider. I think what was most significant about that particular report is that it was the first time there was an open acknowledgement, in writing, that federal judges don't become somehow less human as a result of being appointed to the bench.

Phase two came directly out of the report and was a series of programs, including educational presentations on a variety of wellness topics that continue to be offered at the annual Ninth Circuit conference and some other educational programs that are targeted to various populations and judges who serve the Ninth Circuit. There is also something that we call PALS, the Private Assistance Line Service, which is a consultation and referral resource that I operate for the Ninth Circuit.

The third phase that we in the Ninth Circuit are looking very seriously at right now is something that my colleague, Isaiah Zimmerman, referred to recently as an attempt at massive cultural change in the federal courts so that health issues associated with aging can be talked about in an open, honest, and frank manner. This is something that, as you can imagine, is very scary for any of us to think about and look at. It's particularly scary for individuals who thought that they were set in their role for the rest of their lives.

This particular issue is so poignant and so important to the federal courts because the average age of the federal bench is now very close to 70. Twenty percent of all people over the age of 65 have a measurable reduction in mental acuity. Fifty percent of people over the age of 80 have a significant reduction in mental acuity. I'm just going to let that sit there for a second and sink in.

As a consequence, it's not surprising that over half of the calls that I have received from chief judges or from secretaries or court staff are expressing concern about senior judges who are every bit as much in denial about the fact that their mental skills just aren't quite up to the task any more than if they had an alcohol or a drug problem. We need to make it much more culturally acceptable for senior judges to plan for and think about and actually seriously consider either partial, or in some cases full, retirement.

### **The medical perspective**

**John Stiemke:** Rush Behavioral Health provides services for treatment of substance abuse as well as psychiatric issues. I've been working in the field of addiction medicine now for 23 years. I've been working with the Illinois Lawyers' Assistance Program for the past 11 years, answering their hotline, providing training, and doing assessments on impaired attorneys and judges.

The term impairment is difficult because it can mean lots of different things. Is it a disease? Is it a lack of will power? Is it a moral problem? What are we talking about? When we get into other areas, such as psychiatric illness where we're talking about mood disorders, depression, anxiety, bipolar disorder, personality disorders, and a variety of different things like that, there's even less understanding. In providing assessments for attorneys and judges, we can do anywhere from a one- or two-hour interview up to a three-day comprehensive, multi-disciplinary evaluation where we're doing psychiatric, psychological, medical, and substance use evaluations, as well as collecting a lot of collateral information.

It's not always clear what the problem is. One attorney was referred by a local judge who was concerned about the attorney's outbursts in the courtroom and wondered if there wasn't an underlying substance use problem. We did a very comprehensive evaluation, and ultimately determined that he had a large meningioma growing in his brain. Fortunately it was operable, and he was able to return to full functionality. We've also seen individuals who have been referred to us because they're falling asleep on the bench and had undiagnosed diabetes.



It's vitally important that you get good understanding of what recovery means. Recovery isn't just to stop drinking. There's all kinds of behavioral changes and attitudinal changes and beliefs that need to change over time in the recovery process. Recovery is a process, it's not an event. Just to stop drinking or to stop substance abuse doesn't mean that the person has recovered. It may take anywhere from 18 to 24 months to get into a solid, stable recovery program that involves significant lifestyle changes. And then there are issues around maintaining that recovery on an ongoing basis.

It takes a specialized program in dealing with professionals because when a professional gets into just the neighborhood drug treatment program, the clinical staff is not used to dealing with the narcissism that often is there. They're not used to dealing with the arrogance, the pride, all of the things we often see with professionals. And helping them in a peer group setting where they're with other individuals that come from the same background, providing the feedback, the confrontation, makes a big difference in their willingness to accept that they are, indeed, powerless over alcohol and drugs, that their life has become unmanageable, and if they continue to keep using it, it will stay unmanageable. They see the need for surrender, that they can't run the show their way anymore.

**Audience member:** In a perfect world, should a program for judges be separate from the lawyers' assistance program?

**Kane:** Our Judges' Assistance Program is our Lawyers' Assistance Program. It's under the same umbrella. But we have a different brochure, a different 800 number, and we do different promulgation. And only the director and the assistant director help the judges. But I think that for economy of scale, a quick start, not reinventing the wheel, that it's okay to have them both under the same umbrella. They can coexist.

**Wolfson:** I would be very reluctant to have a separate program. I might want to bureaucratically just call it something separate as long as you're in the same place. But I would be concerned about an elitist kind of setup. We've used judges very effectively to help lawyers, and we would hate to take them out of that system.

*End of Transcript. An unedited version of the transcript is available upon request.*

#### Article Sidebar - **Judges in lawyers' assistance programs**

All states have lawyers' assistance programs, and most if not all are available to provide assistance for judges (at least lawyer-trained judges). Some even make that clear by including "judges" in their name, for example, the Hawaii Attorney and Judges Assistance Program, the Indiana Judges and Attorneys Assistance Program, the Michigan Lawyers & Judges Assistance Program, and the Mississippi Lawyers and Judges Assistance Program.

Other programs expressly include judges in their mission statement. For example, the Alabama Lawyer Assistance program explains that it "provides programs and services to assist lawyers, judges, and law students in Alabama who may be impaired." The Arizona Member Assistance Program states that "for those who participate voluntarily, MAP offers confidential assistance to any Arizona attorney, judge or law student whose professional performance may be impaired because of physical or mental illness, emotional distress, substance abuse, compulsive gambling or other addictive behaviors." The Wisconsin Lawyers Assistance Program "provides confidential, meaningful

assistance to lawyers, judges, law students and their families in coping with alcoholism and other addictions, depression, acute and chronic anxiety and other problems related to the stress of practicing law.”

The New Jersey Lawyers Assistance Program recently began a Judges Assistance Program to offer “a helping hand for judges,” including a special brochure, separate toll-free HelpLine, off-site counseling, outreach to every judge, and meetings with all assignment judges. Although there is no separate program in Illinois for judges, judges have always played a critical role in the Illinois Lawyers’ Assistance Program. Three trained judges participate on any team that intervenes when a judge is the subject of concern. Illinois has a new brochure designed to describe to judges the confidential assistance the LAP can provide for them, a judicial colleague, or an impaired lawyer who has appeared before the judge. In February 2006, the Illinois LAP held a special half-day volunteer training just for judges, “specifically tailored to the role of the judge in the intervention process and in providing peer support to other judges.” Thirty judges attended, and an additional 12 joined 48 other attorneys for a subsequent day-long volunteer training program that included a special session for the judges.

Many of the LAP websites have a great deal of helpful information for lawyers, judges, family members, staff, and others who have questions about alcoholism, other addictions, and mental conditions such as depression. The District of Columbia Lawyer Counseling Program has a list of warning signs, for example, and the Idaho LAP has a *Survival Guide for Lawyers* that contains a basic introduction to the dynamics of alcoholism and chemical dependency, depression, and stress, and guidelines for getting help. Florida Lawyers Assistance has a list of signs and symptoms for chemical dependency and self tests for depression, mania, and alcohol and gambling abuse. The New Jersey LAP has “A Self-test About Your Drinking,” personal stories, and sections on understanding addiction, assessing the risk for addiction to pain medication, linking stress and substance abuse, demystifying 12-step programs, understanding depression, understanding compulsive gambling, and women and addictions.

There are links to LAP websites on the site of the American Bar Association Commission on Lawyers Assistance Programs ([www.abanet.org/legalservices/colap/lapdirectory.html](http://www.abanet.org/legalservices/colap/lapdirectory.html)). CoLAP was established in 1998 by the ABA Board of Governors to develop a national network of lawyer assistance programs, act as a national clearinghouse on the case law about addiction, depression, and mental health problems, and collect state rules and opinions on confidentiality and immunity. In 2006, CoLAP began a “Judicial Assistance Initiative” to develop a comprehensive national program that will effectively enable judges who need help to reach out and obtain assistance.

*Cynthia Gray*

*Article Sidebar - Editor’s note: Judicature asked several judges and former judges who are recovering from addiction to share their experiences and insights. Below and on the pages that follow three of them offer their personal stories.*

### **Personal story #1**

The tragic consequences of addiction to alcohol and drugs are publicized almost daily and are well known to everyone. The miraculous recoveries from these conditions are not as well known. The good news is that recovery from these seemingly hopeless conditions is everywhere. Permit me to share my story.

At 47, I was an outwardly successful trial lawyer and community leader. To the public, I lived the “American dream.” Only those closest to me knew that I was also a chronic alcoholic, living in a hopeless hell. I could not control or stop the downward spiral of alcoholism that could only end in the gutter or the grave. Since I could not kill myself, I knew that the shame of life in the gutter would be my fate. On December 13, 1979, because of my incoherent conduct, a courageous judge declared a mistrial during a jury trial; he had me hospitalized. From there, I went to a drug and alcohol treatment center. I was introduced to a way of life without alcohol or mind-altering drugs that enabled me to handle the pressures of my profession, life in general, and also have a good time doing it. With the help of family, colleagues, and friends both in and out of the profession, I became a better lawyer, husband, father, and citizen.

In early 1984, at the urging of colleagues, I became a candidate to replace a retiring justice on the Texas Thirteenth Court of Appeals. Because of my candor in acknowledging my problem as well as the facts of my recovery, my former alcoholism was not a problem, either in my original appointment or my subsequent election and re-election to the court. I retired from the court at the end of 2000, serving the last seven years as chief justice.

During my judicial service, as well as since, I have been active in the legal and judicial communities and in an alcohol recovery program. The lifestyle of the judiciary seems to make judges with tendencies toward addiction particularly vulnerable. It is easy to confuse respect and honor for the office with feelings of personal infallibility. The protection and isolation afforded by our colleagues and staff make it easier to hide our addictions from ourselves and others. Driven by fears of discovery and self-loathing, we often avoid facing our humanity until total disaster strikes. This can be avoided if we have the courage to seek the help that is always available. The principles used in recovery made me a better judge. In fact, I believe at times these principles gave me an advantage over many of my colleagues.

For people like me whose will power and intelligence were of no avail in halting the devastating effects of addiction, the intervention of spiritual help from others with similar problems was and is essential to recovery and the ability to live a happy and productive life. The real tragedy is not the disease, but that the good news of the joys of recovery are not as well known as the devastating effects caused by the disease. It is hoped that my story will help in spreading the good news.

***ROBERT J. SEERDEN, a retired justice of the Texas Court of Appeals, practices law and acts as a mediator and arbitrator in Corpus Christi.***

### **Personal story #2**

I was born and reared in Colorado. Mother was successful in real estate investment; Dad was a respected and beloved attorney. My four brothers and myself hiked, ice-skated, rode horses, and developed a sixth sense. We could discern in a short time whether or not each day would be a good day or a day of tension for our Mother when Dad stopped with clients after work to “have a few dippers.”

It was a no brainer for me, growing up, to decide not to drink alcohol. It was trouble. Throughout high school and college, I chose not to drink. Once I got married, my husband and I began to drink on our honeymoon and drank daily for the next 18 years. Alcoholism is a disease of deception. I was deceived into thinking that to be a trial lawyer, drinking was necessary; that I was more entertaining when I drank; that alcohol

was my friend; and that only with it could I sleep at night. This was reinforced by my colleagues who, except for one, drank like I did.

June 7, 1978, was my last drink (my husband, two years later). Since that time my life has improved in every way. Best of all, the cycle of alcoholism has been interrupted in our family. Our children and grandchildren are proud of us. Our son chooses not to drink.

As a lawyer and judge, again I have a sixth sense and have often been able to help other lawyers and judges by telling them my story. Without alcohol and by practicing the 12 steps, my fears and resentments are evicted; before they were prominent in my daily life and thinking. Without fear, I can be genuine and authentic to others. As a judge I often used the word "we." "We" are powerless over alcohol, and to have the best life, alcohol can no longer be a partner.

I learned this from a courageous judge, Bill O'Connell. Every day, on and off the bench, he would reach out to others. Following his example, I work closely with the Illinois Lawyers' Assistance Program helping law students, lawyers, and judges recover. Of the trio, judges are the toughest; because of their position they fear attending recovery meetings. However, when they are arrested and exposed in the media, attending recovery meetings becomes a welcome option to losing their job, license, reputation, and the respect of their family.

Living a program of abstinence and working the 12 steps opens new doors. We are called to be our best selves — 12-step meetings, exercise, meditation, and service to others keeps us centered on recovery.

It is a wonderful life, not perfect. When I stopped drinking alcohol (distilled sugar), my new "friend" became sugar. Donuts, ice cream, cookies, potato chips, etc. lead not to cirrhosis, but to diabetes. Now, one day at a time, I do not allow sugar to deceive me — my life is better without it — and I have joined a second 12-step program to restore my sanity and fullness of life. Each day without alcohol and sugar is a gift to myself — a gift that keeps me alive to help and serve others.

*SHEILA M. MURPHY is a retired Cook County, Illinois, circuit court judge currently practicing in the law firm of Rothschild, Barry, and Myers.*

### **Personal story #3**

My name is Bill Cain and I am an alcoholic. By the grace of God and the brotherhood of Alcoholics Anonymous I am sober today. I have been for the past 24 hours and certainly hope to be for the next 24 hours.

I was not born an alcoholic, and I do not consider beverage alcohol to be some kind of a curse on mankind. Thousands of people use alcohol in moderation without significant problems. I am simply not one of them.

I was a 21-year-old honorably discharged veteran of the Korean War and in my freshman year in college when I had my first drink. In those early years, alcohol provided an effective means by which I was able to overcome, at least in part, the social inhibitions that had plagued me since boyhood. For a decade or more alcohol was my friend and my crutch, though, slowly but surely, my rate of consumption of alcohol steadily increased. I cannot say with any degree of accuracy when alcohol evolved from being pliant servant to brutal task master. It was some time in my mid-30s. I will not

extend this narrative by a painful discussion of all the horrors of addiction to alcohol. Two of the worst of such were sleep deprivation and blackouts.

Shakespeare described the glory of peaceful sleep when Macbeth in his agony cried out, "Sleep that knits up the ravell'd sleeve of care. The death of each day's life, sore labour's bath, Balm of hurt minds, great nature's second course, Chief nourisher of life's feast." Day after day and night after night, with no more than a catnap leaves the human body exhausted and the mind driven almost to distraction. Looking back on it, it is easy to recognize what I could not then accept: my crutch was the culprit.

I was not an everyday drinker. I proved to myself repeatedly that I did not have a problem with alcohol, that I could "take it or leave it," and that I could "quit whenever I wanted to quit." I would from time to time quit drinking altogether for extended periods, on one occasion abstaining for nearing eight months. During these abstentions, relatively normal sleep patterns returned.

Blackouts are nightmarish experiences in which entire episodes of life are simply blocked out of memory. They fit no particular pattern that can be anticipated but simply come and go. Sometimes they are there, and sometimes they are not. It is frightening to snap out of a blackout sitting in your own living room when the last recollection that you have is sitting in a motel room more than 100 miles away. One is not "passed out" in a blackout. I conducted client and witness interviews during a blackout that I simply cannot recall. My wits must have been about me for I usually made notes or dictated a contemporaneous memorandum that were in the file and that I reviewed at a later time but with no independent recollection. I came out of a week-long blackout one Monday morning and asked my secretary to bring me the file in a relatively complicated appeal only to have her bring instead the appellate brief that I had dictated, she had typed, and I had filed the previous week. It was obviously my work, but to this day I cannot remember preparing it.

All of this leads to the pathetic condition of being sick, tired, nervous, apprehensive, frightened, and ashamed over something that one cannot or, more likely, will not acknowledge. For me, it all came to its climax in a rather traumatic experience that brought me to my first meeting in Alcoholics Anonymous. A local businessman and old friend, Gene S., with whom I had shared many a drunken spree, found his way into recovery, and when I finally stumbled and fell, it was Gene S. who held out his hand. With love, patience, compassion, and understanding, he guided my footsteps back to the path of sanity and sobriety. As one day at a time the dark clouds lifted for me, and the sun in all its pristine brightness shone forth again, so one day at a time Gene was there — a tower of strength, a pillar of hope. He was my sponsor in the great brotherhood, and I found to my surprise in Alcoholics Anonymous that I was not alone and that many others had lived the same nightmares. A blackout was not unique to me.

In those first few months of AA meetings, I followed Gene's admonition to be quiet and listen. I learned first of all that the battle against alcoholism is a one-day-at-a-time struggle in which those in recovery lean on each other. In the meetings, the doctor and the lawyer sat at the same table as the man who dug the ditch, the stay-at-home housewife trying to raise her family, and the unemployed laborer all trying to recover from a common problem. Some author whose name I cannot remember expressed it best in his admonition that alcohol was no respecter of persons: "The drunk lying in the two-inch carpet and the drunk lying in the two inch gutter are equally close to the ground."

From the beginning and through the years of recovery, the first two steps of the AA program have been for me, as for so many others, the day-to-day guide to life. “(1) We admitted that we were powerless over alcohol and that our lives have become unmanageable and (2) came to believe that a power greater than ourselves could restore us to sanity.” I try to make my last conscious thought each night to be to thank my higher power for giving me another 24 hours of sobriety and my first conscious thought in the morning to ask for just one more day.

Once in recovery, I discovered again to my surprise that I was not anonymous to anyone other than myself. My panic stricken efforts to hide my addiction from my clients and from the public had not been effective. Almost everyone knew I had a problem and all were enthusiastically supportive of me in my recovery. My family stood by me in the bad years and have shared with me the glories of recovery. When I determined to try to fulfill a lifetime ambition to become a member of the judiciary, I found that my recovery from alcoholism presented the least of my problems.

Today, recovery from addiction, whether it be alcohol or some other substance, is the focus of national attention, and the resources, public and private, committed to the cause of continuing recovery is heartening and encouraging. In Tennessee less than a decade ago, the Tennessee Lawyers Assistance Program was established and, under inspired leadership, is now functioning and remarkably effective. We have come so far since the day more than 70 years ago when Bill W. and Dr. Bob sat down in a small kitchen in Akron, Ohio, and founded what was to become the worldwide brotherhood of Alcoholics Anonymous. Some years after a small group of men and women in Columbia, Tennessee, banded together to form the Columbia group of Alcoholics Anonymous and purchased a small home on South High Street. A few years afterward, Gene S. brought a bewildered and broken 42-year-old lawyer to his first meeting. The rest is my story.

The cynic, or perhaps the realist, will ask if I do not know that I can never have another drink. Deep inside I know this, but I have never allowed myself the luxury—or danger—of thinking in such terms. Living my life as the great brotherhood has taught me to live it, for 10,415 consecutive 24-hour periods I have been sober, and, God willing, tomorrow is another day.

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JUDICATURE Volume 90, Number 1 July-August 2006

## THE WORST KEPT SECRET IN THE COURTHOUSE

by Cynthia Gray

*Deciding the appropriate sanction in cases involving impairment requires conduct commissions and courts to weigh the importance of public confidence against the fact that the judge is suffering from a disease.*

Imagine the anxiety of a litigant involved in a custody battle or criminal case, feeling out of place and apprehensive even if represented by counsel. Imagine the litigant's shock if she smells alcohol on the breath of the judge — the person authorized to make decisions that will change her life — or learns from her counsel that the case cannot proceed as scheduled because the judge is impaired, or reads in a newspaper that the judge was arrested for driving while intoxicated. Imagine the litigant's disillusionment if she learns that this is not the first or even 11<sup>th</sup> time this has happened. Imagine the loss of public confidence in the judiciary that results as she tells her story over and over to her family and friends.

Restoring public confidence in the judiciary is the duty of state judicial conduct commissions and supreme courts that review their decisions. No judge has ever been disciplined for suffering from alcoholism. But many of the signs and symptoms of alcoholism — hostile behavior, frequent absences, and inappropriate behavior and moods — are also the types of behavior that lead to violations of the code of judicial conduct—violations of the law, delay, and intemperate behavior, for example. Therefore, judicial conduct commissions inevitably receive complaints from litigants and witnesses, if not court staff, attorneys, or other judges, about misconduct that is attributable to alcoholism (and in some cases other addictions or impairments). Deciding the appropriate sanction in such cases requires the commissions and courts to weigh the importance of public confidence against the fact that the judge is suffering from a disease.

### **Mitigating factor**

Although the seriousness of the misconduct is a crucial factor in determining the appropriate sanction in judicial discipline cases — and presiding while intoxicated, for example, is very serious misconduct — state commissions and courts also consider whether there are aggravating or mitigating factors. One of the typical mitigating factors identified in all types of cases is whether the judge has evidenced an effort to change or modify his conduct. In a recent informal survey of the state judicial conduct commissions by the Center for Judicial Ethics, all 22-responding state commissions stated that the majority of their members "would agree with the statement, 'usually, a judge's efforts to receive treatment for an impairment are a mitigating factor when determining the appropriate sanction in a case in which misconduct appeared to be caused by the impairment.'" Thus, while commissions and courts do not accept alcoholism as an excuse for misconduct by a judge, they do recognize that alcoholism is a disease and consider obtaining treatment for the disease a mitigating circumstance when deciding what sanction is appropriate, imposing a sanction less severe than removal of the judge.

For example, the Florida Supreme Court publicly reprimanded a judge who had attempted to commit suicide after drinking alcoholic beverages heavily for three days.<sup>1</sup> After the incident, the judge voluntarily admitted himself to a substance-abuse clinic as an in-patient for a month of examination and therapy. He then entered into a rehabilitation contract with the Florida Lawyers Assistance Program and had complied with all its terms, including continuous monitoring and random testing for substance

abuse. He also joined Alcoholics Anonymous and had maintained 345 continuous days of sobriety prior to the hearing before the Judicial Qualifications Commission. At the hearing, many witnesses, including fellow judges, public officials, and practicing attorneys, testified that the judge was now functioning well on the bench. Finding this was a very strong case for mitigation, the court concluded:

*This record overwhelmingly describes a judge who has been an outstanding public servant for some twenty years, generously giving his time and energy for the betterment of this state and its judiciary, whose work is highly regarded by respected citizens, jurists, and attorneys. It shows that the events of March 1990 were an aberration caused largely by an undiagnosed and untreated disease, which now is under medical control and continuing supervision by capable support organizations.*

"The New York State Commission on Judicial Conduct considered removing a judge who had driven his automobile into a tree and pleaded guilty to driving while intoxicated, presided over an ex parte request for a temporary order of protection while under the influence of alcohol, having had three glasses of beer at lunch, and confronted two sheriffs officers while intoxicated and demanded to know why his son had been removed from the courthouse.<sup>2</sup> The judge acknowledged to the Commission that he was an alcoholic and sought treatment for his alcohol problems. He maintained that he had not consumed alcohol for over a year before the Commission decision.

Noting that "although serious, the judge's misconduct appears to have been the product of alcoholism for which he has subsequently sought treatment," the Commission concluded that he need not be removed from office, censuring him instead. The Commission also noted that the judge had been a judge for more than 26 years, and his conduct had never before been called into question.

Considering treatment for alcoholism as a mitigating factor does not ensure that there will be unanimity on the appropriate sanction, as illustrated by two contrasting opinions from members of the New York Commission. The majority opinion, which censured a judge for presiding while intoxicated, stated:

*We recognize that alcoholism is an insidious disease from which judges are not exempt and we acknowledge respondent's rehabilitative efforts. However, the public is entitled to a judge who does not come to court while under the influence of alcohol, and litigants should not have to wonder whether a judge has fallen off the wagon on a particular court date. There is also the humiliating institutional spectacle of local lawyers and court personnel knowing that a judge has an alcohol problem that he or she cannot control.<sup>3</sup>*

One member of the Commission, however, wrote a dissenting opinion in which a second member joined, stating they would have issued a confidential letter of caution. The dissent stated:

*I do not believe a judge, or anyone else for that matter, should be publicly sanctioned because of a one-time isolated failure to control an illness. Under present day medical, social and legal knowledge of this disease, a public sanction is simply unacceptable ... In addition, respondent's frank acknowledgment of his illness and his past and present record of commitment to fighting this disease should be taken into consideration in determining an appropriate sanction.*



Moreover, a judge's failure to commit to treatment may be considered an aggravating factor. The Oregon Supreme Court suspended for 30 days without pay a judge who drove while intoxicated.<sup>4</sup> He had entered a "diversion" program, and the DWI charges were dropped after three months of weekly substance abuse counseling. While in the diversion program, he attended Alcoholics Anonymous meetings and abstained from alcohol after completing the program, however, the judge resumed consuming alcohol, although he reduced his intake to one or two glasses of wine a night, and stopped attending AA. The judge had a history of misusing alcohol and admitted that he tends to minimize the facts when discussing his drinking.

The Commission on Judicial Fitness and Disability recommended that the judge be censured. The judge maintained that no official sanction was necessary and suggested that the matter could be handled informally. Noting it shared the Commission's evident concern about the likelihood of a repetition of the misconduct, the court stated that the judge's "position appears to us to so downplay the seriousness of his conduct that it leaves us in substantial doubt that he comprehends the gravity of his recklessness." The Court concluded that a 30-day unpaid suspension would serve not only to discourage such behavior generally, but impress upon the judge "an appreciation for the gravity of his conduct."

Similarly, despite a judge's defense of narcolepsy and mental illness, the Arizona Supreme Court removed him for falling asleep during court proceedings, making inappropriate Comments and circulating inappropriate materials, some of which were racist, sexist, or obscene, ex parte communications, and other misconduct.<sup>5</sup> The court stated a judge's personal problems do not permit it to ignore its duty to the public and that narcolepsy and possible mental illness provide only minimal mitigation given the judge's failure to seek adequate treatment, his failure to reveal his medical condition until it was exposed in a newspaper article, and his failure to use the assistance provided by the court to help him remain awake during court proceedings.

### **Probation**

As part of the second chance given to a judge who has mitigated his or her misconduct by undergoing treatment for alcoholism, a court or commission may take additional measures to monitor whether the judge's commitment to rehabilitation continues even after the sanction. For example, the Idaho Supreme Court suspended a judge for three months without salary for abuse of alcohol and imposed conditions on the judge, violation of which could result in his removal.<sup>6</sup> After six years in office, Judge Becker's behavior had changed; he became withdrawn, exhibited episodes of bizarre behavior, began having mood swings, and became less tolerant. Another judge and Judge Becker's law clerk each confronted him concerning his use of alcohol, but he told them he did not have a problem with alcohol. His family knew he had an alcohol problem and tried unsuccessfully to have him control his use.

On several occasions, court personnel, law enforcement officers, and other judges smelled alcohol on Judge Becker's breath while he was in the courthouse. Once, in the presence of his court reporter and at least two attorneys, the judge took a bottle of alcoholic beverage out of his desk drawer in his chambers, offered the attorneys a drink, which they declined, and then took a drink directly from the bottle.

After the Judicial Council had commenced its investigations, the judge's family and friends engaged in an intervention. As a result, the judge agreed to participate in a 30-day in-patient alcohol abuse treatment. The judge admitted that he resumed drinking after this inpatient treatment.

The court stated that while the judge's conduct detracted from the integrity of the judiciary, his addiction to alcohol, which had been the source of his misconduct, is a disease that cannot be cured but can be treated and controlled, and that the judge's removal would deprive the judicial system of an experienced judge who was elected by the voters in the district and who could be a good judge if he can control his addiction.

The court imposed conditions requiring the judge to (1) refrain from drinking any alcohol; (2) submit to weekly blood tests; (3) participate in at least two Alcoholics Anonymous sessions each week; (4) participate in relapse prevention therapy; and (5) participate in an after-care program weekly. The conditions also specified procedures for verifying compliance. The court stated that if it determined that the judge consumed any alcohol, it would immediately order his removal.

In addition to censuring two judges who had presided while intoxicated, the New York Commission authorized its staff to periodically observe the judges' public court sessions, noting that it would consider a new investigation and additional charges upon any observation that suggested that either judge was presiding while under the influence of alcohol.<sup>7</sup> Both judges had submitted evidence that their conduct was the result of alcoholism and that they had undertaken a detoxification program, abstained from alcohol, and performed their duties without impairment for many months prior to the Commission's decision.

The Pennsylvania Court of Judicial Discipline suspended a judge for six months and placed him on probation for one year during which he would be required to report monthly to the Judicial Conduct Board. The Board was required to file a monthly written report with the Court advising whether, to its knowledge, the judge had complied with the code of judicial conduct.<sup>8</sup> The court had found that the judge repeatedly drank to the point of extreme intoxication in bars close by his office, often during the hours of the normal work day when members of his community could reasonably expect that he would be conducting his duties. The court also found that, on these occasions, the judge was aggressive, confrontational, and abusive, resulting on one occasion in a fistfight in a local bar, and on more than one occasion in local law enforcement officers being summoned and required to make decisions as to whether to charge the judge before whom, presumably, they regularly appeared.

### **Removal**

Unfortunately, there are examples of cases in which the judge's misconduct was so persistent and severe, or the mitigation was inadequate or failed, and the judge was removed from office for misconduct even though it was the product of alcoholism.

In 1996, the Pennsylvania Court of Judicial Discipline suspended a judge for six months without pay and placed the judge on probation for the remainder of his term of office after finding that the judge had been visibly impaired by and under the influence of alcohol when he arrived one night to preside over night court.<sup>9</sup> The probation was subject to the judge's immediately entering a sobriety monitoring program contract with the Pennsylvania Bar Association's Lawyer's Assistance Committee, which contract would be approved by the court. Just over 11 months later, the Pennsylvania Court of Judicial Discipline removed the judge because he had violated the conditions of probation set forth in the contract.<sup>10</sup>

Finally, in a very sad case that illustrates the potential tragedy, in 2004 the Louisiana Supreme Court removed a judge for persistent intoxication while performing judicial

duties and for failure to perform work in a timely manner.<sup>11</sup> At the Judiciary Commission hearing, numerous witnesses testified that the judge was a good judge when he was not drinking, but that he had appeared visibly intoxicated on the bench and in chambers, and slurred his speech, was disoriented, unable to focus, shaky, and walked in an unsteady manner. Due to the judge's intoxicated state, court had to be canceled on some days. One morning, the judge's staff cleared the public from the hallways outside his courtroom so he could be carried out of his office by sheriff's deputies. Despite his staff's efforts, the public saw the judge as he was escorted from the courthouse.

The judge admitted that he was an alcoholic and had been for more than 30 years and that his illness had interfered with his ability to properly perform his judicial duties. He had sought treatment several times and at one time had maintained sobriety for approximately 11 years. In 2000, the judge started drinking to relieve pain caused by an undiagnosed medical condition. The drinking soon spiraled out of control even after the pain was cured by surgery. The judge was, sometimes involuntarily, hospitalized or admitted to various treatment programs six times between December 2000 and May 2003. The Commission stipulated that the judge had been sober since February 28, 2003.

The judge argued that his constituency accepted his alcohol problem because he had been re-elected after his alcoholism was made public. Noting it was unclear that the general public knew the extent of the judge's battle with alcoholism, the court concluded that general public awareness would not change the court's exclusive jurisdiction for the discipline of judges and declined to find that a COMSTOCK judge is not Subject to discipline if his constituency condones his behavior.

The court recognized that the judge suffered from a disease, but held that alcoholism is not a defense but a mitigating factor in disciplinary proceedings, stating the judge was "not being sanctioned for being an alcoholic; he is being sanctioned for his inappropriate behavior on the bench." The court recognized the judge's attempts to achieve and maintain sobriety as mitigating factors. However, emphasizing that "the public has a right to a decision by a sober decision-maker," the court concluded that the judge's persistent intoxication on the bench and in chambers resulted in an irretrievable loss of public confidence in his ability to properly carry out his judicial responsibilities. Stating it must focus on the position, not on the individual, the court explained:

*This behavior violates the sacred trust placed in judges to make decisions which affect the lives of citizens and places our system of justice at risk. A judge must hold himself to high standards so as to command respect for the office which he holds and the entire judicial system he serves. Although we feel compassion for Judge Doggett's struggle to maintain sobriety, we must, first and foremost, consider the grave implications which this misconduct casts upon the judiciary.*

### **Other impairments**

Although abuse of alcohol is the most common problem that commissions have addressed, other addictions or impairments have occasionally been the subject of discipline proceedings. For example, judges or former judges suffering from gambling addictions have been disciplined for being regularly absent during normal working hours to gamble in a casino,<sup>12</sup> or receiving loans from attorneys who regularly appeared before them.<sup>13</sup>

Sleep disorders have also been at issue in several cases. The Alabama Court of the Judiciary censured and suspended a judge for misconduct, although not for sleeping

during court proceedings.<sup>14</sup> Noting that the judge suffered from sleep apnea and circadian rhythm disorder, the court found that, even when a judge has an involuntary physical condition without fault on the part of the judge, the judge must be held to the same standard as one who is not disabled. The court noted that the judge's disorders were medically recognized sleep disorders, and he had sought remedies in the past.

The Delaware Court on the Judiciary censured a magistrate and suspended him for three months without pay for displaying a weapon in a fashion that made two court clerks feel that their personal safety was threatened and persistently *carrying* his weapon while at work in a way that it was clearly visible to the public and employees.<sup>15</sup> The court found that the judge had been "overwhelmed by a disability, *i.e.*, chronic sleep deprivation, that was likely exacerbated by the change in his schedule and a personal crisis unfolding at the time" and significantly interfered with his ability to carry out the duties of his office. Noting that there were legitimate concerns about the judge's current and future mental and physical status, the court stated the judge may be restored to judicial duties only after he has demonstrated fitness to return to judicial office. The court ordered that the judge continue regular treatment for existing medical conditions during his suspension and be evaluated for any substance abuse or sleep disorder problem and follow treatment recommendations, and that his treatment providers report on his compliance with these conditions and his ability to perform his duties.

Mental illness was addressed in two cases in Minnesota. The Minnesota Supreme Court reprimanded a judge, suspended him for 60 days without pay, and ordered him to abide by several conditions after the judge acknowledged that on multiple occasions over a period of several years, he had responded in an angry and undignified manner to staff members who were innocent of any significant dereliction of duty.<sup>16</sup> The judge's treating physician had testified that the judge had been diagnosed with a bipolar disorder and had been hospitalized for several periods relative to the disorder, that the medical management of his condition posed no adverse risk regarding his day-to-day responsibilities, and that the judge had taken responsible steps to deal with his unacceptable behavior.

The conditions imposed on the judge required that his conduct be monitored by a person or persons satisfactory to the Board on Judicial Standards; that the judge continue under psychiatric care at his own expense and notify the Board if his psychotherapy was terminated; that the judge authorize those who provide him with psychiatric and psychotherapy services to disclose to the Board, at the Board's request, all information relative to the judge's fitness to perform his duties; and that the judge be placed on probation under the supervision of the Board, preserving jurisdiction in the Board to seek from the supreme court additional or different sanctions, including removal from office, if warranted by his future behavior.

The Minnesota Supreme Court removed a judge from office for dismissing charges in three criminal cases without hearing from the prosecution; retaliating against attorneys who filed complaints with the Board; urging a defendant in an animal cruelty case to pick a sheriff's deputy with whom to fight; pleading guilty to criminal charges arising from his assault of a juvenile who had hidden his son's bike; and being convicted of criminal charges after he scratched the hood of a car with his keys in a confrontation in a parking lot.<sup>17</sup>

The court also ordered the judge's disability retirement due to mental illness and suspended his license to practice law for one year. The judge had not argued that his illness should mitigate any discipline imposed for his misconduct.

In response to the Board's request, however, the court articulated standards to be used to determine whether mental illness or similar disability should mitigate the discipline otherwise appropriate. Applying the same standards established for lawyers, the factors identified by the court were: (1) proof of a serious mental illness that (2) caused the misconduct, coupled with (3) proof of treatment that (4) has abated the cause of the misconduct such that (5) the misconduct is not apt to recur. The court noted that when a judge asserts mental illness or other disability as an affirmative defense to mitigate discipline, the judge has the burden of proof to establish the requirements by clear and convincing evidence.

Although sympathetic intervention and treatment are necessary to assist judges who are struggling with a disease that is destroying their physical health and personal as well as professional lives, the possibility of public discipline seems an important component of the solution to the problem of impaired judges because the threat to the judge's profession may be a strong incentive for a judge to be committed to getting treatment sooner rather than later. It is clear from the cases that the judicial conduct commissions and the courts that review their decisions do not find these cases easy but are committed to a flexibility and innovation that will balance concerns for the public interest and the judge.

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1. *Inquiry Concerning Norris*, 581 So. 2d 578 (Florida 1991).
2. *In the Matter of Purple*, Determination (New York Commission on Judicial Conduct September 29, 1997) ([www.scjc.state.ny.us](http://www.scjc.state.ny.us)).
3. *In the Matter of Gilpatric*, Determination (New York State Commission on Judicial Conduct December 14, 2005) ([www.sgc.state.ny.us](http://www.sgc.state.ny.us)).
4. *Inquiry Concerning Narblad*, 39 P.3d 860 (Oregon 2002).
5. *In the Matter of Carpenter*, 17 P.3d 91 (Arizona 2001).
6. *Judicial Council v. Becker*, 834 P.2d 290 (Idaho 1992).
7. *In the Matter of Bradigan*, Determination (New York State Commission on Judicial Conduct March 10, 1995) ([www.sgc.state.ny.us](http://www.sgc.state.ny.us)); *In the Matter of Gilpatric*, Determination (New York State Commission on Judicial Conduct December 14, 2005) ([www.scjc.state.ny.us](http://www.scjc.state.ny.us)).
8. *In re McCarthy*, Order (Pennsylvania Court of Judicial Discipline July 14, 2003), *aff'd*, 839 A.2d 182 (Pennsylvania 2003).
9. *In re Timbers*, 674 A.2d 1221 (1996). The judge smelled of alcohol and had glassy, bloodshot eyes; slurred speech; an unsteady walk; and a disheveled appearance. He could not comprehend the instructions a staff member gave as to how to conduct a preliminary arraignment. When another judge arrived at court to discuss an office matter with him, he called her a "fat fucking bitch."
10. *In re Timbers*, 692 A.2d 317 (Pennsylvania Court of Judicial Discipline 1997).
11. *In re Doggett*, 874 So. 2d 805 (Louisiana 2004).
12. *In re Lallo*, 768 A.2d 921 (Rhode Island 2001)
13. *Office of Disciplinary Counsel v. Cox*, 770 N.E.2d 1007 (Ohio 2002)).
14. *In the Matter of Cothren* (Alabama Court of the Judiciary January 22, 1998).
15. *In re O'Bier*, 833 A.2d 950 (Delaware Court on the Judiciary 2003).
16. *In re Complaint Concerning Rice*, 515 N.W.2d 53 (Minnesota 1994).
17. *Inquiry Into Ginsberg*, 690 N.W.2d 539 (Minnesota 2004).

## Article sidebar: **ASSISTING JUDGES WITH SUBSTANCE ABUSE PROBLEMS**

### **State committees**

Several state supreme court or judicial conduct commissions have adopted programs or procedures for assisting judges with substance abuse problems.

In early 1992, the West Virginia Supreme Court of Appeals created the Judicial Committee on Assistance and Intervention. The Committee has three members, a circuit judge, a magistrate, and a family law master. Proceedings before the committee are non-adversarial, formal, and confidential. Based on the interviews and psychological or medical evaluations, the committee can recommend a program of rehabilitation or retirement in a case of a judge's advancing years and attendant physical or mental incapacity. If a judge complies with the recommendations and rehabilitation is successful, the committee takes no further action, and all records are sealed and kept confidential. The committee refers the matter to the Office of Disciplinary Counsel, however, if a judge refuses to execute a waiver to grant access to psychological/ medical records or rejects the Committee's recommendations or if "after a period of rehabilitation and re-evaluation, the committee finds that rehabilitation has not been effective." The West Virginia Code of Judicial Conduct provides that "a judge who has knowledge that another judge is incapacitated or impaired, raising a substantial question as to the judge's fitness for office, shall inform the Committee on Assistance and Intervention of the judiciary."

In 1994, the Kansas Supreme Court created a committee "to provide assistance to any Kansas judge needing help by reason of a mental or physical disability or an addiction to or excessive use of drugs or intoxicants." The Impaired Judges Assistance Committee has three to *five* members who are active or retired judges. The rule creating the Committee provides that "a judge may approach the committee or one of its members directly on his or her own behalf or any person may suggest the need to intervene on a judge's" behalf."

The objectives of the committee are to:

1. identify judges who are impaired from responsibly performing their duties by *virtue* of addiction or abuse of alcohol or other chemicals, or due to senility, psychiatric disorders, or other reasons;
2. arrange intervention in those identified cases in such a manner that the judges involved will recognize their impairment, accept help from the committee and medical professionals, and be treated and monitored for a period of time so that they may return to their duties when able;
3. recommend avenues of treatment and provide a program of peer support where possible;
4. act as an advocate of judges who are ill and assist them in recognizing their impairment and obtaining effective treatment when possible, and in returning to the responsible performance of their profession;
5. educate the public and the legal community about the nature of impairments and develop a program which will generate confidence to warrant early referrals and self referrals to the committee so that impairments may be avoided, limited, or reversed.

Committee proceedings and reports are confidential except that the committee may refer the matter to the Commission on Judicial Qualifications if "the judge fails or refuses to

address the issues of concern" and if the Commission has referred a judge to the committee, the commission "shall provide progress reports and recommendations to the Commission."

In 2005, the New Mexico Supreme Court established a Committee on Confidential Healthcare to assist judges, their staff, and families deal with stress, depression, or alcohol or other substance abuse. The court directed the committee to develop educational programs and materials to assist judges, staff, and families to identify issues concerning alcohol and/or substance abuse, mental illness, or emotional distress and to understand what resources are available.

### **Commission programs**

In 2001, the Texas State Commission on Judicial Conduct established the Amicus Curiae program to identify judges who have impairments that may be affecting their personal lives and performance on the bench. The program provides a confidential resource for judges to obtain help for treating impairments. If a judge is referred to the program, the judge's actions still remain within the Commission's investigative responsibility. The program monitors and maintains contact with those judges to *provide* motivation and support. Implementation of the program is discussed by Commission director Seana Willing in the annual meeting transcript, and there is more information at <http://www.scjc.state.tx.us/amicus.php>.

The Pennsylvania Judicial Conduct Board has adopted a policy designed to encourage affected judges "to seek help at the earliest possible moment so as to ensure maximum protection to the public against misconduct resulting from their impairment." The policy allows a judge being investigated for misconduct involving substance abuse to petition the Board for permission to enter an approved rehabilitative diversion program prior to the filing of formal charges with the Court of Judicial Discipline. The petition must include a release giving the Board access to all information and records bearing on the rehabilitative program, a stipulation of facts relevant to the investigation with an agreement that the stipulation is admissible in any future proceeding, and consent to testing for drug or alcohol consumption during any probationary period.

When a judge satisfactorily completes an approved in-patient rehabilitation program, the Board will continue the matter for a 12-month probation, which may be conditioned on the judge's continued participation in a recovery program. If the Board deems the probation satisfactorily completed, "the Board will refrain from filing charges in the Court of Judicial Discipline and will dismiss the Complaint .... " However, if the Board determines that the judge "has abandoned the recovery program, or has violated the terms in any substantial way, the Board may direct the filing of charges before the Court of Judicial Discipline, or take such other action as may be appropriate in the circumstances."

*Cynthia Gray*

### **Article sidebar - DISCIPLINARY RESPONSIBILITIES**

Canon 30(1) of the ABA Model Code of Judicial Conduct requires a judge who has "knowledge that another judge has committed a violation of this Code that raises a substantial question as to the other judge's fitness for office ... inform the appropriate authority." The model code also provides that "a judge who receives information indicating a substantial likelihood that another judge has committed a violation of this

Code should take appropriate action." Most jurisdictions have similar provisions. Commentary to the Alaska code explains:

*A judge who learns that another judge is suffering from alcohol or drug addiction might direct that other judge to counseling or might seek the help of the other judge's colleagues or friends. On the other hand, if the other judge refuses to admit the problem or submit to ameliorative measures, and if the other judge's intoxication is interfering with his or her judicial duties (so as to constitute a violation of Canon 1 and Section 3A), then a judge who knows of this problem may be obliged to report it to the Commission on Judicial Conduct.*

The Arizona advisory committee addressed a hypothetical in which a judge, with the understanding and cooperation of his or her colleagues, takes an authorized leave of absence for three to six months, or longer, for health-related reasons such as alcohol rehabilitation or cancer treatment. *Arizona Advisory Opinion 03-3*. The committee noted that the question under these circumstances was "difficult and sensitive because it typically arises in a situation where a colleague is grappling with a serious illness or is earnestly trying to reform his or her life and is seeking support and understanding." The committee also noted that other judges may have an "unspoken fear" that by informing on a colleague, "they may set in motion a process that could result in the suspension or removal of an experienced judge and trusting friend." However, the committee concluded "that an illness, recuperation or rehabilitative period that results in an extended absence from judicial duties must be reported to the Commission on Judicial Conduct." The committee noted that the Commission is sensitive to such problems and has indicated its willingness to "keep the information confidential and monitor the judge's progress until he or she returns to active service."

The ABA Joint Commission to Evaluate the Model Code of Judicial Conduct has, in its final draft report, proposed the following new rule:

#### RULE 2.19: DISABILITY AND IMPAIRMENT

A judge having a reasonable belief that the performance of a lawyer or another judge is impaired by drugs, alcohol, or other mental, emotional, or physical condition shall take appropriate corrective action, which may include a confidential referral to a lawyer or a judicial assistance program.

#### COMMENT

1. "Appropriate action" means action intended and reasonably likely to help the judge or lawyer in question to correct the problem. Depending on the circumstances, appropriate action may include, but is not limited to, speaking directly to the impaired person, notifying the individual with supervisory responsibility over the impaired person, or making a referral to an assistance program.
2. Taking or initiating corrective action by way of referral to an assistance program can fulfill several laudable purposes. For example, an intervention can be the first step toward a successful recovery program. That action alone may satisfy the mandates expressed in this Rule. Depending on the gravity of the conduct that has come to the judge's attention, the judge may be required to take action in addition to or in lieu of a referral to a relevant assistance program. The Joint Commission's proposals will be submitted to the House of Delegates in February 2007.

*Cynthia Gray*



## DEMYSTIFYING 12-STEP PROGRAMS

*By Mary Greiner*

If you are bewildered by the workings of 12-step programs but think that you or someone you know might benefit from one, this article is dedicated to you. If someone (or more than one person) has recommended that you check out a 12-step program, but you don't think that you have an addictive or compulsive behavior, you can find information here in case you change your mind. If you are trying to get a loved one into recovery, you can read this article in the context of how 12-step programs such as Al-Anon might be of assistance to you as well. If you are merely curious, I hope you will learn more about the largest public health issue facing our country today.

The insights in this article come from personal experience, study of both 12-step literature and scientific research, and the gracious contributions of many friends and colleagues. My deepest thanks go to those in recovery who are willing to share their experiences, strength, and hope with others. Any errors are mine alone.

Alcoholics Anonymous (AA) is the original 12-step program. AA support groups focus on recovery issues related to use of the drug called alcohol. For some people, alcohol is a physically and emotionally addictive drug. Al-Anon was the second 12-step program to be developed. It is a recovery program for the family and friends of alcoholics, and focuses on recovery from the compulsive behaviors generated by trying to cope with a loved one's alcoholism. Some call alcoholism a "family disease" because almost everyone in the family of an alcoholic develops certain ways of thinking, feeling, and acting that may originally have served to protect the family members but soon begin to interfere with each person's ability to function fully in the world.

Other 12-step programs have been developed to focus on other drugs or compulsive behaviors. There are programs for people addicted to narcotics, nicotine, and refined sugar; and programs for persons engaging in compulsive behaviors such as overeating, gambling, gaming, sex, love, emotion, shopping, Internet use, pornography, and so forth. Further, there are 12-step programs for people with dual diagnoses (for example, addiction/compulsion combined with a mental disorder such as depression).

The common denominator in all these programs is that the participants find themselves using something or someone outside themselves to change how they feel. Twelve-step programs are based on the premise that inner serenity comes when people find a way to live without addictive and compulsive behaviors. Active members of 12-step programs find that their lives get better as a result of participating in the group process, a dynamic as complex as human nature.

### **Myths and Common Concerns**

**They are a bunch of losers.** This myth comes in many forms, from the belief that meetings are made up of scuzzy old farts in dirty trenchcoats, to the assumption that all attendees are there because they were ordered by the court to go. Those in denial about their own problem might assume that only people who can't "hold their liquor" or are "stupid enough to get caught" attend meetings.

Another fallacy driving this myth is that addiction is a moral deficiency rather than a disease. Although the American Medical Association acknowledged that alcoholism is a

disease in 1956, and former U.S. Surgeon General C. Everett Koop declared nicotine addiction to be a public health issue, there are still folks out there who consider quitting to be no more than a matter of willpower. For those who have never been addicted, it can be hard to understand that addiction is a disease needing treatment, just like diabetes. Without treatment, the disease is fatal. With treatment, the disease may not be cured, but the quality and length of life can be greatly enhanced.

As for the “losers” who attend meetings, members include state supreme court justices, former governors, senior corporate executives, financially successful entrepreneurs, managing partners of nationally known law firms, religious leaders, and renowned artists of every genre. Other members include felons who have served their time; functionally illiterate people who struggle to read the literature; and people who have lost their jobs, homes, and families as they spiraled down through their disease. There is no “typical” member of a 12-step group. Addiction is an equal opportunity disease.

**What will people think of me? What if I see someone I know there?** Members of 12-step programs are glad to have new members and see them not as “losers” but as people ready to do something about their problems. All people have problems; who is in a position to judge another for seeking a group process-based solution? Twelve-step groups have a tradition of anonymity. If you believe you have something to lose by being seen at the group meeting, remember that so does everyone else attending the meeting. If others are willing to face that risk, why shouldn't you?

**If I go, I will be admitting that I have a problem.** Meetings are often described as “open” or “closed.” The open meetings are open to anyone who wishes to attend, so your presence will not be considered an acknowledgment that you have a problem. You can find out whether a meeting is open or closed by checking for the codes describing the meeting in the relevant directory, or by calling the telephone number of the appropriate group and asking for open meetings.

**You have to stop using to go to the meetings.** “I want to stop, but I can't,” said Ben when asked why he didn't go to a 12-step meeting. “I don't want to embarrass myself by going there ‘loaded,’ so I'm waiting until I have a clean day to go.” If you can relate to Ben's comment, just go to the meeting! You do not have to stop using before you go. You will not be the first person to start attending meetings while under the influence. The only requirement for membership is a desire to stop. Once you begin attending meetings, you may well acquire that little extra tool you need to lay “it” down, whatever your “it” may be.

**It doesn't work.** Actually, research indicates that 12-step programs work better than other forms of treatment most of the time. Yes, it is true that 12-step programs are not for everyone. One of the main reasons “it” does not work for someone is because “it” works only when the someone “works it.”

*Georgia went late and left early, when she went to meetings at all. She focused on what was wrong with the meeting and made no effort to read the literature, find a sponsor, or meet anyone in the meeting (after all, they should have introduced themselves to her!). She proved 12-step meetings didn't work for her.*

Allen was on the verge of losing everything, and out of fear, he threw himself 110 percent into the process. He went to meetings daily, met people, listened to a guy he could relate to and asked him to be his sponsor, and he read the approved literature.

Soon, Allen was helping out before and after the meetings with setup and cleanup, and joining a group after the meeting for coffee. Although he still had all his problems, within two weeks, he began to believe that life would get better, and it did.

**The groups are a cult.** To qualify as a cult, there must be a leader, usually a charismatic individual. In 12-step groups that are operating in accordance with the model, there are no leaders at all. There are only volunteers who serve the needs of the group for a set period of time. The only paid employees are at the national or international level, and those employees do not govern the individual groups.

**I am happy with my religion and don't need another one.** Excellent! No 12-step group holds itself out to be a religion. In fact, the literature reflects only a spirit of cooperation. The group offers the person suffering from an addiction or compulsion a form of spirituality that should be consistent with any religious program that an individual may choose to follow.

**I don't want anyone telling me how to live and what to believe.** The Higher Power or "God thing" can be a real turn-off for some people. This issue is so big, in fact, that the founders of AA considered it worthy of an entire chapter in the book *Alcoholics Anonymous* (familarly known as the Big Book). In the chapter entitled "We Agnostics," readers are encouraged to consider whether there might be any power greater than themselves. (See "The Bekins Van" for an illustration of the lengths to which some people will go to avoid such reflection.)

**I don't need a group.** You may not. Although the group process just might teach you a few things about the balance of independence and interdependence, you do not have to open yourself to learning a new way of solving your problems if you do not want to. Many people with addictions or compulsive behaviors grew up in families where they learned that people are not to be trusted. You will never find trustworthy people unless you learn how to open your heart to those who earn your trust.

**My drinking/using is situational, not really an addiction or compulsive behavior. If only she/he/they would act right, I wouldn't have to drink/use.** You might want to try going to an open meeting. You might learn more about your own behavior if you listen with the intent of seeing how the meeting content might apply to you and not your problematic loved one. Go at least six times before you make a decision that there is nothing there for you. It takes a while for the message of recovery to come through.

**The meetings will be depressing, boring, dark, unhappy, etc.** Why would anyone want to go to a meeting described by such adjectives, especially when so many of us must go daily to places characterized by those qualities in the course of our professional lives? Recovery meetings are like that only in the minds of the people coming in already feeling depressed, bored, and unhappy. While a few meetings may well be like that, the vast majority are not.

*When Marcie finally got up the courage to go to a meeting, she found one held in a church that was on the way home from work. The meeting was listed as a women-only meeting, and she thought she would be more comfortable in such a setting. As she drove into the parking lot of the church, she wasn't sure where to go, so she parked among a collection of other cars and walked in the nearest door. The hallway loomed in both directions, and she again felt panic. Then she heard laughter floating down the hall. She shrank as small as she could make herself, and walked into the well-lit room. There were, maybe, 20 women in there. Many of them noticed her, and said,*

*“Welcome. Come sit here.” Marcie felt instantly welcomed, and saw a look on those women’s faces that she wanted—that look of joy, calm, and freedom from worry. She wondered how everyone seemed to know right away that she was a newcomer. Only later, after several months of attendance, when another newcomer walked in, did Marcie know how they recognized her as a newcomer. Marcie saw in the newcomer’s face what she had felt on walking into that room—fear, shame, the edge of panic, and even some anger. Even later, Marcie was told by newcomers that they saw on her face what they wanted for themselves, and Marcie realized that, indeed, she did feel the joyousness, serenity, and sense of personal freedom that she had wanted when she first entered the doors of AA.*

## **Just for Lawyers**

Most states have some kind of lawyer-related program, many of which are totally independent of the licensing authority of the state. You can find out about the one in your state by calling the ABA Commission on Lawyer Assistance Programs (CoLAP) at 312/988-5359 or online at [www.abanet.org/cpr/colap](http://www.abanet.org/cpr/colap). Locally, you can find help through your state bar association by asking for a contact number for the LAP or LCL (Lawyers Concerned for Lawyers). You may find a listing in your bar phone directory or an advertisement or article in your bar literature. These professional groups serve as an excellent adjunct to 12-step groups because the topic of discussion often revolves around how to practice law according to the principles and suggested behaviors of 12-step groups.

**I don’t like other lawyers.** You may find that the lawyers in these meetings are very different from those you meet in other professional settings. Helpfulness, friendliness, and joy actually fill these rooms! You may experience a level of humility in your fellow lawyers that you have not experienced elsewhere.

**I’m afraid I won’t be able to try cases without drinking.** There are many solutions for “stage fright” other than alcohol or drugs. It’s amazingly comforting to hear one of the top trial lawyers in town talk about his special spot in the courthouse where he prays for strength before every trial!

**I am supposed to entertain clients, prospective associates, etc.** The only people who will notice you are not drinking are those who have a problem of their own or are worried about yours. The former will try (usually subtly) to get you back “in the fold,” and the latter will be relieved. You can learn from the others in your recovery group how to handle these situations. Comments such as “Not tonight, thanks” are usually enough. You can learn some excellent ways to respond to the persistent ones at your meetings.

## **Don’t Be Afraid**

I hope that the myth that keeps you away from recovery has been addressed here. The main reason people stay away is fear—fear of the unknown, fear of how participation will look to others, or fear of living fully without the addictive substance or behavior.

If you are considering attending a group but are not quite ready, remember the words of Herbert Spenser: “There is a principle which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance—that principle is contempt prior to investigation” (Alcoholics Anonymous, 3d ed., Alcoholics Anonymous World Services, Inc., 1976, p. 570).

## **The Bekins Van – A True Story of Finding a Higher Power**

Larry listened to the AA recovery story of Carla without relating to much of what she said, except on the topic of a Higher Power. Carla had a tragic story of violence, prostitution, and homelessness as a result of her drinking and drug use. Carla didn't want any hint of any kind of God in her recovery. She said, "If there is a God, how could all those horrific things have happened to me? And if there is a God, He sure as h\*\*\* hasn't helped me so far, so why should I start believing now?" Carla's sponsor, however, insisted that she find something to make her Higher Power. Carla looked out the window just as a Bekins moving van was rolling past. In a moment of rebellious temper, Carla boldly announced that the Bekins van would be her Higher Power. She was surprised when her sponsor cheerfully accepted her choice.

As Carla's story unfolded, Larry heard how a Bekins moving van seemed to go by whenever Carla was struggling with an urge to drink or drug, or when she encountered an old, abusive boyfriend on the street who tried to woo her back into a relationship, or when she was really mad at someone because of a comment she thought had been directed at her. Each time Carla saw the Bekins van, she would think some more about her options and would make choices based on her recovery rather than the self-destructive behavior she was about to take. Carla began to believe that these "coincidences" were more than that, and she began to develop a concept of a Higher Power, a spiritual presence in her life.

Larry was impressed by the story, but didn't think it would apply to his life. He joked with his friends about it, yet what happened to Carla just seemed stuck in his mind. Several months later, he went with some friends to a recovery conference high in the Rocky Mountains. He enjoyed the few days in the mountain air, the hiking, and the people he met, but he still didn't quite relate to the God stuff in people's stories. Driving toward home with his friends when the conference was over, he was taking his turn in the back seat as they headed toward one of several mountain passes. Suddenly, out of nowhere, a huge thunderstorm blew up, and they were caught in a combination of wind, lightening, hail, and rain. His friends were debating the merits of pulling onto the shoulder, next to a drop-off of several hundred feet, versus continuing to drive in near-zero visibility.

Just then, through the pouring rain, Larry saw, on the other side of the road, a Bekins moving van. He felt a sense of calm that he hadn't experienced in years, quickly followed by the excitement of a heartfelt "aha!" He knew they were going to be okay. He yelled to his friends, "Look! There's a Bekins van! We're going to make it!" His friends looked at him as if he had just arrived from another planet, but Larry didn't care. He felt safe and knew that his journey to find a Higher Power had begun right then.

## **A Variety of 12-Step Meetings**

The following descriptions will give you a general idea of the types of meetings available. Your particular locale may vary somewhat from this list. In some areas, the meeting directory will tell you the type of meeting via a code system described in the directory (for example, "O" usually stands for an open meeting).

**Open/Closed.** Open meetings are open to whomever wishes to attend. Closed meetings are limited to those who have the desire to stop their troublesome behavior, whether drinking, gambling, etc.

**Newcomer.** Meetings where foundational issues provide the focus, such as “Why do I need and how do I find a sponsor?” “Why attend meetings at all?”

**Speaker.** One person will tell his or her story of recovery-what it was like during the addictive phase of his or her life, what happened to interrupt the addictive pattern, and what it is like now to live in recovery.

**Step speaker.** A speaker uses personal examples to illustrate how the 12 steps have influenced his or her life choices. The speaker may also offer an explanation of the deeper meaning of each step.

**Discussion.** A chairperson starts the meeting by introducing a particular topic, and members discuss the topic. The meeting may be designed to give everyone an opportunity to share or to allow a few people to share in the time available. Everyone always has the option to pass.

**Step meeting.** The topic is about one or more of the steps and how it applies to the attendees’ lives. The meeting may begin with a chairperson introducing a topic from a specific step or by everyone reading all or part of a step from the literature (e.g., in AA the book *Twelve Steps and Twelve Traditions*), then discussing how it applies to their personal situations. Some meetings are always on certain steps, e.g., 10-11-12. (Meetings that focus on the 10-11-12 steps can be more spiritual in content.)

**Big Book study.** “Big Book” is a pseudonym for the main literature of the recovery group. For example, in AA the book is titled *Alcoholics Anonymous*, not a name some folks would willingly use in public. These meetings use a portion of the literature to facilitate discussion of how the reading applies in one’s own life.

**Gender specific.** Men and women have their own meetings, not so much to complain about the opposite sex, but because relationships and sexual matters have often been a source of tremendously painful wounds. Gender-specific environments can feel safer and allow for more personal sharing.

**Other specialties.** These are groups run in a language foreign to the majority (e.g., English meetings in Germany), groups formed to serve particular ethnic or cultural groups, and groups for gays and lesbians. There are also groups based on a common profession. Some groups eschew any mention of God or spiritual matters and refer to themselves as agnostic or atheist groups.

**Smoking/non-smoking.** Smoking meetings can be dense enough to get your fix on passive smoke alone. Non-smoking meetings often include smokers who are willing to take a break from nicotine for the benefit of that particular meeting.

**Candlelight.** Usually held late at night, these meetings can be more spiritual.

### **How to Find a Meeting**

Now that you have decided to go to a 12-step meeting, how do you find one? Lawyer assistance programs. Almost every state has a program, some of which are totally independent of the licensing authority of your state. You can find your local program through word of mouth, notices in bar journals, or by calling your state or local bar

association. You can also make contact via the ABA Commission on Lawyer Assistance Programs at 312/988-5359 or [www.abanet.org/cpr/colap](http://www.abanet.org/cpr/colap).

**Telephone.** Look in the white pages of your telephone book under the organization's name, e.g., Alcoholics Anonymous.

**Online.** Many groups have their own website, such as [www.aa.org](http://www.aa.org), [www.al-anon.org](http://www.al-anon.org), [www.gamblersanonymous.org](http://www.gamblersanonymous.org), [www.debtorsanonymous.org](http://www.debtorsanonymous.org), [www overeatersanonymous.org](http://www overeatersanonymous.org), and [www.codependents.org](http://www.codependents.org). Other websites that contain useful information, directories of meetings, and links to other websites include [www.anonymousone.com](http://www.anonymousone.com) and [www.onlinerecovery.org](http://www.onlinerecovery.org).

**Personal referral.** You may know someone in recovery. Expect to have your inquiry received with enthusiasm and confidentiality. Even if your contact person lives on the other side of the world, you can count on receiving encouragement and support.

### **Meeting Etiquette and Vocabulary**

Nobody likes to break an unknown rule of conduct. While there are very few "musts" in 12-step meetings, the following information may help you to understand how meetings operate. Meeting times. Depending on your location and the type of meeting, the length will be approximately one to one and one-half hours. You will be accepted for any part you can attend, and you will benefit more if you are there for the entire meeting, as well as for conversation before and after the meeting.

**Introductions.** In some meetings, everyone introduces themselves, and in others only those actually speaking introduce themselves. First name only is part of the anonymity (even if we recognize each other). You will hear people follow their name with "and I am an [alcoholic, compulsive gambler, etc.]" Those who are not ready to say that out loud may simply use their names or say "I'm not sure," or even "... and I have a problem with [alcohol, gambling, etc.]" Recovery date. In some parts of the country, people will also give the date on which their recovery began, such as "I am [name], and I am an alcoholic, and I have been sober since [date]." Others choose to say "and I was [sober, clean, abstinent] today." Still others choose not to mention it. This is strictly personal preference.

**No cross talk.** Each person shares without interruption unless the chairperson stops them for talking too long or inappropriately (abusive comments, language beyond colorful). Any feedback is saved for after the meeting. If you have a lot of advice for other people, you may not be focusing on your own issues.

**Conference-approved literature.** The written material generally used in a meeting has been published or sanctioned by the relevant international service center. This material is referred to as "conference approved." The limitation of material used during meetings avoids controversy.

**Sponsor.** A person who shares his or her experience, strength, and hope with you as you learn your way around recovery. Sponsors often help provide structure and guidance during the early fog of recovery, and offer advice on how to have healthier relationships. Sponsors are not parents, hotels, bankers, or bailbonders. Sponsors cannot give you what they do not have for themselves, so if you find a sponsor who is a lot of fun, but who has not worked the steps, you will get more fun than recovery.

**Thirteenth step.** The so-called thirteenth step refers to newcomers being “hit on” by people who have not yet learned how to have a relationship other than the proverbial “one-night stand.” Healthy groups frown on this type of fraternization, and you can find folks in the group who can assist you in avoiding unwanted advances. While this type of activity does not happen often, many people who are vulnerable in this area choose to go to same-gender groups to avoid it. The thirteenth step is also the reason same-gender sponsors are suggested, as newcomers often confuse their healthy dependency on a sponsor with “love.”

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Addressing The PROBLEM of COURTROOM STRESS by MONICA K. MILLER and DAVID M. FLORES with ASHLEY N. DOLEZILEK

Courtrooms can be stressful places; legal actors and courthouse visitors experience occasional acts of violence, gruesome trial evidence, and a number of daily, low-level stressors. Each of these sources has the potential to affect both judges and jurors.

In June of 2006, Darren Mack allegedly shot Judge Chuck Weller through his Washoe County, Nevada, courthouse office window. Reportedly, Mack was dissatisfied with Weller's decisions concerning child support and alimony.<sup>1</sup>

Violence directed at judges and their families represents a growing phenomenon; violent events of 2005 include the highly publicized shooting at the Fulton County Courthouse in Atlanta and the murder of federal judge Joan Lefkow's family in Chicago. As a result of the growing threats of violence, judges in some jurisdictions are carrying concealed weapons,<sup>2</sup> and writers (e.g., critics, advocates, journalists) have called for measures to examine and address the issue of courtroom violence.<sup>3</sup>

These unexpected stressors contribute to the significant sources of stress judges and jurors routinely experience. For example, experts have acknowledged that graphic evidence and testimony is capable of having adverse effects.<sup>4</sup>

Recent high profile cases include that of Dena Schlosser, who was accused of cutting her baby's arms off with a knife, and the retrial of Andrea Yates, who faced capital murder charges for the drowning of her five children. These cases not only contain gruesome evidence, but also may prove traumatic to the judge and jurors who attempt to comprehend such acts. The decision-making process may be especially stressful if judges or jurors are asked to apply laws that conflict with their personal beliefs.<sup>5</sup> Judges and jurors also experience stress due to more mundane aspects of the trial process.<sup>6</sup> Jurors can experience stress as a result of the disruption of their daily routines. Judges can experience stress due to the responsibilities of trial management. These examples illustrate the variety of courtroom stressors. High levels of stress have the potential to affect the decision making of jurors and judges and have a generally negative effect on the justice system.

This article describes courtroom stress and recommends possible remedies. It first presents a definition of stress and an explanation of why it is important to study courtroom stress. Next, it discusses the causes and symptoms of stress experienced by judges and jurors. After speculating about how stress can affect legal decision making, it describes the various remedies that have been proposed to address or prevent such stress. It concludes with recommendations for reducing stress in the courtroom.

### **Definition of stress**

The concept of stress has been defined in an array of different ways.<sup>7</sup> Different aspects, including precipitating events, psychological and physiological responses, and appraisals of the individual, have been differentially emphasized in the varying conceptualizations. The biopsychosocial model provides an integrative account of stress by incorporating the psychological, biological, and behavioral effects of environmental demands. Cohen, Kressler, and Gordon posit that when confronted with environmental challenges, people cognitively appraise whether the event represents a threat and/or overwhelms available coping resources.<sup>8</sup> Perceptions of stress result when environmental demands are deemed threatening and coping resources are regarded as challenged or even insufficient.

This perception of, and attempt to adapt to, the stress-inducing environmental demands are accompanied by behavioral, emotional, and physiological changes in the individual. This biopsychosocial model complements the foregoing examination of courtroom stress, which considers both the causes of stress (i.e., stressors) and its manifestations (i.e., symptoms) for judges and jurors and the subsequent implications for the justice system.

While stress can certainly reach extreme or abnormal levels, it is important to note that a lower level of stress is part of a normal reaction to an environment that taxes one's ability to cope. This common occurrence would be normal, even expected, in some courtroom settings (e.g., in trials for heinous crimes). As such, it is important to determine what measures are most appropriate to prevent or alleviate excessive stress that hinders performance.

### **Studying courtroom stress**

In order for the judicial system to function properly, it is important for legal actors (e.g., judges and juries) to be of sound mind and body. The level of emotion and tension found in courtrooms is a major contributor to the heightened stress levels of those involved in legal cases.<sup>9</sup> Many researchers have raised concerns about jurors' mental and physical health risks.<sup>10</sup> Some researchers and judges believe that it is important to study juror stress because the legal system is responsible for jurors' comfort. Because the government requires jury service of its citizens, many believe that the government should take steps to protect them.<sup>11</sup> Judges have indicated that they feel a duty to reduce the stress level of jurors, as reported in a survey by the National Center for State Courts.<sup>12</sup> Specifically, 97 percent of judges answered "yes" to the question "Do you believe courts have a responsibility to prevent, address, or minimize juror stress?"

Similarly, some experts have noted the importance of studying judicial stress.<sup>13</sup> Zimmerman notes that judges can experience stress due to "heavy dockets, restrictions on their public speech and behavior, intense media exposure, wide public ignorance of the role of the court, and the relative isolation of the judicial position." Because of the uniqueness of the position, judges often do not seek the care they need, which leaves them vulnerable to the negative effects that accompany untreated mental and physical health problems (e.g., occupational stress and substance abuse). As with any profession, untreated problems can negatively affect job performance. Some people are concerned that heightened levels of stress can have negative consequences for the legal decision making and performance of judges.<sup>14</sup> For example, stress is capable of producing psychological and physical symptoms that have the potential to distract judges and impair their decision-making abilities.

### **Causes of juror stress**

Serving such a major function in the legal system is likely to be stressful for many jurors. Jurors may experience stress from being out of their normal schedules and reporting for jury duty in an unfamiliar courthouse. They are forced to view evidence that may be emotional, gruesome, or highly technical. Courtroom proceedings (e.g., jury selection) are usually unfamiliar, and the instructions they receive from the judge may be difficult to understand. Despite the unfamiliar and confusing conditions, jurors must make decisions that could include assigning serious financial penalties or sentencing defendants to prison or even death. Researchers have sought to discover more about the factors that cause stress. Findings indicate that jurors encounter stress at every stage of trial.<sup>15</sup> The National Center for State Courts surveyed 401 jurors about their reactions to

50 potential stressors. Table 1 presents the percentages of jurors that experienced each stressor and reported that it was stressful.

Some jurors experienced stress when they received the summons or reported for jury duty. Disruption of jurors' daily schedules and the inconvenience of finding childcare also led to jurors' stress. Thus, jurors experienced stress before they even reported for jury duty. Trial procedures also contributed to juror stress. Some encountered stress related to the selection process. This includes having to give personal answers to questions in front of other potential jurors and strangers, awaiting trial assignment, and being required to keep trial-relevant information from family and friends.

Furthermore, the nature and content of the trial led to jurors' stress. Testimony and evidence presented and viewing of gruesome evidence both served as sources of stress. Various aspects of the decision-making process generated additional stress for jurors; they admitted difficulty in understanding instructions, difficulty appraising the guilt or innocence of defendants in criminal trials, and inability to reach a unanimous verdict. Finally, some jurors indicated that they experienced stress due to factors outside the trial process. Some feared being publicly identified, and some had safety concerns. Others felt stress due to potential reactions to the verdict and subsequent media exposure.

Bornstein and colleagues<sup>16</sup> found that the two most stressful elements of jury duty were related to the complexity of the trial (e.g., understanding difficult instructions and evidence) and decision-making responsibilities (e.g., understanding the consequences of the verdict for the parties involved). As the NCSC and Bornstein studies illustrate, jurors experience some level of stress during every stage of the trial. This stress is likely to manifest itself in a variety of symptoms.

### **Symptoms of juror stress**

Researchers have studied the physical and mental health effects of serving as a juror.<sup>17</sup> Stress can manifest itself in a myriad of physical or emotional symptoms, including sleeplessness, nervousness, depression, and intrusive thoughts.<sup>18</sup> These symptoms are similar to those experienced by others, such as crime victims and clinically depressed patients. Further, jurors' stress symptoms are often the same symptoms used to diagnose mood or anxiety disorders, though the severity of jurors' symptoms generally falls short of a diagnostic threshold. Symptoms do not always become apparent immediately, but may appear weeks or months after the trial.

Stress symptoms are not uniform across jurors; for instance, jurors serving on "traumatic" trials experience different levels of symptoms than jurors on "non-traumatic" trials. As identified by Shuman, traumatic trials include rape, murder, and aggravated kidnapping trials. Non-traumatic trials include offenses such as burglary and possession of a controlled substance. Jurors in traumatic trials generally experienced more severe symptoms as compared to jurors serving in non-traumatic ones.

The study found no evidence to support a formal diagnosis of depression or post-traumatic stress disorder (PTSD); however, traumatic trials had significant negative short-term effects. Serving in traumatic trials led jurors to experience depressive symptoms nearly six times more often than serving in non-traumatic trials. Similarly, jurors experienced a higher level of depressive symptoms than the general population. These studies demonstrate the existence of juror's stress symptoms. They are not alone; judges also experience stress and suffer from stress-related symptoms.

### **Causes of judge stress**

Judges experience numerous causes of stress, some of which are similar to those of jurors (e.g., exposure to gruesome evidence) and some that are unique to their position (e.g., managing difficult trial schedules). The NCSC study found that jurors felt stress as a result of testimony and evidence, fear of being publicly identified, safety concerns, and media exposure. The NCSC study did not investigate judicial stress, however, so it is not clear if judges also perceive these factors to be stressors. In certain circumstances, judges may even experience more trauma than jurors. While jurors may, at times, be able to avoid potentially traumatic trials, judges cannot. For example, a rape victim could be excused from a rape trial during the voir dire process, sparing her from the potentially distressing experience. Judges usually cannot be excused from stressful cases.

Judges also face a number of unique stressors related to their job duties, such as managing a heavy caseload, deciding on motions, concern about being overruled by higher courts, maintaining a positive public image (especially in jurisdictions where judges are elected) and feeling responsible for the stress that the jurors experience. Judges can also experience “role overload, role insufficiency, [and] role ambiguity”<sup>19</sup> often because they are “expected to be wise, responsible, efficient case managers who are knowledgeable about all aspects of civil and criminal law, as well as local procedures.” Simply put, their jobs and duties are rarely clearly defined. Thus, some judges struggle to define their role within the judicial system. To complicate matters, judges often do not get detailed training, mentoring, or impartial feedback.

Eells and Showalter investigated the sources of judges’ work-related stress.<sup>20</sup> Judges reported that the most common stressor was dealing with poorly prepared, inadequate, or abusive counsel. Cases involving active judicial management and decision making discretion also were stressful, as were highly emotional cases subject to public scrutiny. Chamberlain and Miller interviewed nine judges and learned that the most common stressors include heavy workload, being in the public eye, having safety needs overlooked, and campaigning for reelection.<sup>21</sup> Safety concerns could also lead to judges’ stress. The Administrative Office of Pennsylvania Courts surveyed 1,112 state judges in order to identify the stressors and safety issues they experienced.<sup>22</sup> The survey found that 52 percent reported experiencing one or more incidents of inappropriate or threatening communication(s) or physical assault. Of those individuals reporting incidents, over 70 percent indicated that the threatening action took place inside the courthouse.

### **Symptoms of judge stress**

Involvement with trauma victims is associated with a wide variety of negative emotional, physical, and cognitive effects, including severe anxiety, loss of sleep, alterations in personal worldview, and occupational burnout.<sup>23</sup> Recently, researchers in the legal community have expressed concern that judges may be susceptible to similar consequences. Chamberlain and Miller found evidence of three main categories of stressors: secondary traumatic stress (caused by witnessing others’ trauma), occupational burnout (caused by work related factors such as a heavy workload) and safety (caused by fear of being personally victimized). Researchers and legal professionals have suggested that judges may experience what has been labeled “vicarious trauma.”<sup>24</sup> This framework for understanding stress reactions suggests that disturbing trial evidence and testimony can have lasting effects on the mental and physical health of judges. In a preliminary investigation of this issue, Jaffe and colleagues surveyed 105 judges; 63 percent reported experiencing one or more symptoms, including disruption of sleep patterns, intolerance of others, physical problems, depression, and a sense of isolation.

Similarly, Eels and Showalter found stress to be correlated with a range of cognitive, emotional, and behavioral symptoms.<sup>25</sup> Judges reported difficulty making decisions, feelings of tension, work blocks, lack of interest in activities, and negative feelings about one's profession. Other reports indicate that legal professionals experience a variety of deleterious mental, physical, and emotional effects, including depression, substance abuse, objectionable behavior, exhaustion, and burnout.<sup>26</sup> It would not be surprising that such stress would affect juror and judge decision making.

### **Impact on decision making**

There is much research investigating the effects of stress on behaviors such as sports performance, cognitive tasks, and testing. Unfortunately, there is no research that directly tests how stress affects judges' and jurors' performance. Nevertheless, some assumptions can be made based on the existing research. Arguably, symptoms such as anxiety, depression, and substance abuse could affect performance by impairing decision-making abilities. As Eells and Showalter found, some judges report difficulty in making decisions. This might mean that stress affects their decision-making skills and the decisions themselves. It is also conceivable that stressful events, such as threats of violence, could make judges pause before issuing their sentencing decisions.

Finally, Jaffe found that stress makes some judges intolerant of others at times. This might affect a judge's patience with legal parties; as a result, a judge may not let the parties fully express themselves. This could have negative effects, as research has shown that allowing parties to be heard leads to greater perceptions of fairness. When the system is seen as fair, parties are more satisfied with the outcome and are more likely to comply with the judge's ruling.<sup>27</sup>

Similarly, jurors experience a variety of stressors that could potentially affect their decision making. First, jurors reported that it is stressful to answer personal questions in front of strangers during voir dire. As a result, some jurors could choose not to disclose important information that would normally preclude them from serving as a juror on that trial. For instance, rape victims are often excluded from being jurors on rape trials. Nonetheless, a rape victim may be too embarrassed to admit her victimization during voir dire; thus, she would not be excused. Her undisclosed experiences could potentially affect her decisions and lead to a biased verdict.

Other sources of stress could affect jurors' decisions as well. Exposure to gruesome evidence and complex or upsetting testimony could lead jurors to make decisions based on emotions rather than logic. Stress related to difficulty in understanding instructions, determining the guilt or innocence of a defendant, and reaching a unanimous verdict could make it difficult for jurors to come to a just decision. For instance, stressed jurors may (perhaps unintentionally) quit trying to understand complicated instructions or come to a consensus. Instead, they may rely on their emotions or biases in coming to a verdict. Finally, fear of publicity and reactions to the verdict could influence jurors. Fearing retaliation from the defendant or the defendant's supporters could lead jurors to be less punitive. Although the effects of stress on decision making are speculative, these examples highlight some of the potential ways that stress could negatively affect the justice system. To avoid such outcomes, researchers and mental health professionals have developed a few interventions.

### **Stress interventions**

Researchers have designed a variety of strategies to alleviate courtroom stress.<sup>28</sup> Alerting jurors and judges to the potential causes and symptoms of stress and providing information about ways to cope could prove beneficial to both types of decision makers.

Interventions, such as post-trial debriefings, pre-trial informational programs, and individualized combination interventions have been suggested and could help alleviate juror and judicial stress.

*Post-trial debriefings.* The most commonly used intervention, the post-trial debriefing, involves talking with a professional about the trial experience at the conclusion of the trial. Jurors discuss their emotions and thoughts in order to minimize the negative impact of the trial. Feldmann and Bell developed a post-trial debriefing that was similar to crisis debriefings for victims of crimes, natural disasters, or similar traumas. This model, sometimes labeled a “critical incident stress debriefing,” was developed for use with individuals in high-stress occupations such as police officers and emergency medical personnel. The positive effects of post-trial debriefing efforts have been reported by a number of sources.<sup>29</sup> However, the support gained from these reports is largely anecdotal and lacks the methodology to draw reliable scientific conclusions regarding the efficacy of post-trial debriefings.

Bornstein and colleagues conducted a study that measured jurors’ stress before and after a post-trial debriefing.<sup>30</sup> It also had an experimental component; researchers randomly determined which jurors would receive a debriefing. Finally, a one-month follow-up survey assessed stress symptoms. Jurors reported low levels of stress overall, which was likely due to the relatively unemotional nature of the cases (e.g., contract disputes or minor automobile accident cases). Jurors perceived the debriefing intervention as helpful, however stress levels were similar at pre- and post-debriefing. Although stress levels were lower on some measures at the one-month follow-up than immediately after the trial, this reduction was not moderated by whether or not jurors received the debriefing. This likely indicates that stress decreases naturally with the passing of time.

Professionals in psychiatry or psychology led the interventions described above; interventions administered by judges or other court personnel are an alternative approach. Judge-led debriefings have many benefits over professional debriefings. First, they are less expensive to conduct. Many people feel that speaking to a psychologist or psychiatrist carries the stigma of mental health counseling; an informal, judge-led debriefing can help avoid this negative association. Jurors may be more comfortable discussing their emotions in a less formal setting with a judge with whom they shared the trial experience. In this circumstance, the debriefing may be viewed more similarly to communicating with a friend, rather than a counselor.

Some judges are reluctant to utilize judge-led debriefings, however. They may be concerned that they could learn things (e.g., juror misconduct) that would jeopardize the integrity of the trial or influence their post-trial decisions. Additionally, judges generally do not have the skills to conduct a post-trial debriefing. For this reason, professionally led debriefings could ultimately be more successful at reducing jurors’ stress levels. Debriefings led by professionals or court employees would also avoid the legal issues that accompany judge-led debriefings. These examples illustrate the complexities that surround debriefings. Simply put, both judge-led and professional-led debriefings have their pros and cons.

Professional debriefings are also a possibility for judges who witness stressful trials. While no studies have investigated the possibility, it is likely that debriefings could help judges manage stress. If a courthouse has a specially trained employee to address trial stress, the judge could take advantage of that service. Otherwise, an outside professional could help judges address their needs.

**Pre-trial interventions.** Pre-trial interventions are designed primarily to prepare jurors and judges for the stress they may experience during the course of a trial.<sup>31</sup> They educate judges and jurors about the potential effects of stress, provide information needed to recognize symptoms, and teach a variety of coping techniques. In contrast to post-trial interventions, which attempt to treat symptoms of stress that have surfaced after a trial, pre-trial interventions are designed to be proactive and to prevent the onset and escalation of stress. Videotaped interventions are a form of pre-trial intervention that provides a cost-effective alternative to other forms of debriefings. For example, the Washington Victim and Witness Services offered a 15-minute pre-trial video entitled "Jurors are Victims Too!"<sup>32</sup> It was designed to educate jurors about stress, validate their feelings, and prepare them for delayed stress symptoms. While preventing juror stress is a laudable goal, some judges hesitate to use such techniques. Some are concerned with biasing jurors' perceptions and decision-making processes. Critics argue that any type of pre-verdict intervention could alter verdicts, thereby jeopardizing the defendant's right to a fair trial and threatening the integrity of the judicial system.<sup>33</sup> In some circumstances, the legal system allows, and even encourages, jurors to be influenced by their emotions. For instance, jurors are allowed to rely on their emotions when considering how the crime impacted the victim or his family. Pre-trial interventions potentially weaken jurors' stress reactions and emotions, potentially creating unfairness in the trial process. Judges could also benefit from pre-trial interventions. In preparation for a trial that is expected to be particularly stressful (e.g., a gruesome child murder case), a judge could use stress reduction techniques before the trial begins. Even simple measures like taking a day off or engaging in a relaxing hobby could reduce judges' general stress levels and help them cope with oncoming stress.

Judges could also periodically take a refresher course in stress management, which would remind them of the coping mechanisms and signs of stress. These measures could be formalized into a pre-trial intervention program. While the interventions just discussed are designed to help jurors and judges in general, not all individuals will respond to the stressors of trial in the same manner. Thus, some experts recommend specialized interventions.

**Combination interventions.** Nordgren and Thelen suggest that the needs of each juror should be taken into account, and that the appropriate intervention should be based on both the needs of the jury as a group and the jurors as individuals.<sup>34</sup> This strategy, called Graduated Jury Stress Management ("GJSM"), contains five levels that are administered according to the stress level of the individual juror. Although GJSM is designed to be a post-trial intervention, some aspects (i.e., written instructions) could also be redesigned to be appropriate for a pre-trial intervention.

In the first level, jurors receive written materials containing information about stress reactions and potential coping strategies. The second level involves jurors with mild stress levels. The judge gives jurors basic stress management information along with the standard post-trial discharge instructions. Jurors with moderate stress receive a third level of intervention that is labeled "flexible defusing." This level includes a 15-20 minute debriefing during which a mental health professional explains normal stress reactions, offers coping strategies, and assesses individual jurors to determine if further debriefing is necessary.

"Jury Stress Debriefing" comprises the fourth level and is intended for those individuals with more significant levels of stress. This stage was adapted from critical stress debriefings that are utilized with emergency workers. Jurors discuss their experience, symptoms, and coping strategies with a professional. The interventions at this level are

not considered counseling, and are primarily intended to assist jurors in returning to their normal lives. A fifth level of intervention is reserved for those with the most severe stress. An extended period of individual therapy focusing on relieving the juror's stress-related symptoms may be necessary. These five levels represent a scheme that provides an appropriate level of intervention for each juror. In another comprehensive scheme, Miller and Bornstein suggest that a combination of pre-trial intervention (e.g., a video intervention) and some form of tailored individual intervention (e.g., the Graduated Jury Stress Management) is the best way to combat jury stress.<sup>35</sup> Giving jurors information in a pre-trial video would help them prepare for potential stressors and symptoms of stress that could occur during the trial. After the trial, the court would provide individualized help to meet each juror's needs.

Miller and Bornstein note that determining what type of treatment each juror needs could be challenging. Considering the amount of stress that judges already experience and their lack of formal training in diagnosing stress, it does not seem feasible to rely on the judge's observations to diagnose the jurors' stress levels. Psychological tests could be developed to determine the level of intervention that each juror needs. This testing would provide a more accurate assessment of jurors' stress levels, and would minimize the use of judges' subjective observations.

While combination interventions have been suggested for jurors, there does not seem to be any equivalent for judges. If methods of measuring trial-related stress were developed (as Miller and Bornstein recommend), these measures could also help identify whether a judge is in need of some level of intervention.

Overall, stress interventions can help educate jurors and judges about the potential symptoms of stress and ways to prevent and cope with it. While the type of intervention may vary, the goal of all interventions is the same. Post-trial debriefings are used to help jurors and judges cope with the stress caused by the arguments heard and the evidence seen during the trial. Pre-trial debriefings serve to preempt the potential shock of viewing gruesome evidence and hearing disturbing testimony. Combination interventions, such as GJSM, use different levels of interventions specifically tailored for each juror's needs. Debriefings and interventions indicate the court system's willingness to help jurors and judges deal with stress.

### **Recommendations**

We recommend the following policy and procedural changes to address courtroom stress.

*Attitudinal changes.* Perhaps one of the most needed changes involves modifying attitudes toward stress interventions. The legal system should support a culture that accepts interventions as a normal part of the trial process. A culture of acceptance would allow judges and jurors to seek help when needed, without fear of stigmatization. Courtrooms that have implemented juror stress interventions have recognized this need and acknowledge the existence of jurors' stress. The legal system has been slower to recognize the needs of judges. Court personnel should take steps to change unsupportive environments.

Changes are needed in the expectations that society, court systems, and judges themselves have about how judges should handle stress. Because of their positions as problem solvers, judges may think that they should be able to handle stress without any assistance. The broader legal system may feel similarly. This is unfortunate, as it prevents judges from seeking help when they need it.



Similarly, judges may think that they should not react to safety threats. Although 70 percent of judges said that they had experienced incidents of a threatening or inappropriate nature, 42 percent admitted that they had not changed their behavior.<sup>36</sup> It is particularly notable that 25 percent of judges who admitted to being physically assaulted or accosted had not changed their behavior. The reasons are unclear and may vary by judge. Some may not want to change their behavior because they see such changes as an admission that they can be influenced by threats or acts of violence. Some may not have access to information or programs that can help them protect themselves from violence. Yet others may feel that reacting to threats shows weakness or implies that they are unable to be a successful judge.

Judges should be allowed time off to attend to their stress, for example through stress management courses or counseling. Their benefit packages should include coverage for counseling so that judges do not have to bear the cost. Courthouses could invite guest speakers to address the topic of stress and encourage judges to attend. Such steps would communicate that dealing with stress is a “normal” part of the job that is not shameful. These measures can begin to change the attitudes that can prevent judges from seeking help when they need it.

Unsupportive environments are detrimental and can be dangerous. While the needs of jurors are sometimes considered, it is also important to protect judges. When judges feel safe to address their stress-related needs, they can be more productive and healthy. This would, in turn, have a positive effect on the judicial system.

***Changes in trial procedures:*** Alternative dispute resolution is a practice that takes cases out of the courtroom and resolves disputes through various practices such as arbitration and mediation. Collaborative lawyering is one attempt to remedy the stress produced in legal actions such as divorce cases. This process keeps parties out of the courtroom where, by tradition, one party is pitted against the other. It instead allows parties to participate in a more meditative process and resolve the dispute in a more amicable fashion. By minimizing the adversarial nature of trial, the procedure potentially reduces stress associated with resolving disputes in court. Collaborative lawyering also lessens judges’ caseload, because many disputes are handled without trial. Despite the potential benefits, collaborative lawyering is little used.

***Judicial mentoring programs.*** Bremer suggests that judicial mentoring programs are necessary to help new judges adapt to their occupations.<sup>37</sup> Such relationships should continue throughout the judges’ careers. Mentors can act as important confidants and help newer judges recognize and address their stress. Mentors can also help new judges conduct their duties in ways that minimize stress. Bremer suggests that older judges enjoy the mentoring process, which could increase job satisfaction and indirectly reduce stress. Because mentoring relationships help both parties, formal mentoring programs should be encouraged.

***Jury innovations.*** Courtrooms across the country are adopting measures to address jurors’ needs.<sup>38</sup> Some measures include providing free daycare, internet access, free parking, and free public transportation. Some jurisdictions are increasing jurors’ pay and allowing jurors to ask questions and take notes during trial.<sup>39</sup> While such measures may seem inconsequential, they may actually help address jurors’ stress. These innovations address jurors’ concerns about lost wages, getting behind in their work, and trying to remember all the details of a case. These measures can reduce the impact of some stressors.

*Changes in time management.* Jurors could be allowed to take short, periodic breaks or even time away from the courthouse. While this may interrupt the trial process, a few hours away could allow jurors to relax and address family and work issues that could preoccupy their attention. Nevertheless, breaks should be brief (perhaps a day or less). Long breaks increase the chances that the juror will be exposed to trial information that could interfere with the integrity of the trial.

Judges should also take time off. They could have short retreats to participate in sports or hobbies. They should also be allowed longer sabbaticals, which would allow them to take off a week, a month, or even longer. These measures will allow judges and jurors time to relax and reduce their stress before returning to their duties in court.

*Adoption of educational interventions.* Court administrators should institute appropriate interventions to address stress. A combination approach suggested by Miller and Bornstein could prove helpful and relatively cost effective.<sup>40</sup> They suggest a pre-trial video that helps judges and jurors recognize stress symptoms and utilize coping mechanisms. This video is paired with a multilevel intervention program that provides varying levels of intervention tailored to the individual needs of the judge, the jurors, and the jury as a whole.

A specially trained staff member could show the video before the trial. After the trial, the staff member could administer the stress measures to determine what level of intervention is needed for each juror. Because some jurors might be in a hurry to go home or to work, they will have the option of delaying their participation. Jurors who do not wish to participate will be given information on who to contact if they experience stress at a later point. The staff member would also assess the judge's level of stress at the judge's request.

As previously mentioned, some judges do not approve of pre-trial videos because of the potential that the videos could affect jurors' decision making. Specifically, some judges feel that the defendant's rights should be protected, even though the videos could protect jurors from the harms associated with experiencing a gruesome trial. Such benefit is speculation at this point, as it is unknown whether pretrial videos actually help reduce juror stress. In addition, it has not been determined whether pre-trial videos do, in fact, affect jurors' decisions. Even if jurors' decisions are affected by watching videos, it is possible that a court could determine that the benefits (e.g., protecting jurors from harm) outweigh the cost to the defendant.

The Supreme Court was faced with a similar dilemma of weighing the benefits of protecting child witnesses against the cost of the defendants' constitutional right to confront their accusers. The Court determined that, in some instances, measures can be taken to protect witnesses, even at the cost of the defendants' rights.<sup>41</sup> Specifically, a child witness is allowed to testify by video camera even though this method could arguably violate the defendant's rights. The Supreme Court determined that judges could weigh the state's interests in protecting witnesses from harm against the defendant's constitutional rights. If the court feels that protecting a witness outweighs the potential harm to the defendant, then it can take measures to promote those benefits (e.g., allowing a witness to testify by video camera). The Court has never been faced with the issue of protecting *jurors* from harm, however. Nevertheless, it might be permissible for a court to protect its citizen jurors by providing them with a pre-trial video.

**Implementation of safety measures.** Protecting judges and jurors from harm is an essential component of preventing stress, as previous research has determined that both groups have concerns about safety. Courthouse personnel can conduct comprehensive facility assessments, update security equipment, institute standard operating procedures, and inform all courthouse employees of relevant safety procedures.<sup>42</sup> If possible, court administrators should acquire and implement professional safety assessments. Courthouses can offer safety procedures such as police escorts to the parking lots. Safety education and awareness programs should offer judges safety tips, training (e.g., self defense) and easy access to safety devices (e.g., personal alarms). Judges' home safety is also a concern as judges' families may be at risk of experiencing violence. Such safety measures potentially help reduce courtroom stress.

**Program development.** Psychologists should focus on developing programs that focus on preventive measures and debriefings; counseling should be considered only as a last resort. Preventive measures are of utmost importance because they promote well-being and help jurors and judges avoid some stress. Debriefings or defusings assume that judges and jurors are normal individuals experiencing abnormal stressors. In contrast, counseling carries a stigma that prevents help-seeking and dissuades positive attitude change. Specific psychological measurements should be developed for use in the courtroom, as discussed above. Thus, we recommend debriefings and defusings for both judges and juries.

**Research.** Research is needed to gain a fuller understanding of courtroom stress. Researchers can continue to identify the causes and symptoms of judges' and jurors' stress. Miller and Richardson suggest a "model of judicial stress" that has the potential to identify the causes and outcomes of judicial stress.<sup>43</sup> A comprehensive test of this model would identify the factors that put some judges at an increased risk for experiencing stress. The theoretical framework suggested by vicarious trauma is a good starting point for researchers who are interested in studying judges and jurors.

Further, psychologists can develop stress measures, interventions and coping strategies. Researchers also need to address the effects of stress related to safety concerns. Another area of study would involve the effects of stress on decision making. Specifically, researchers could examine the role of emotions and cognitive overload. Such research would provide the foundation for addressing stress in the courtroom.

**Monetary support.** These recommendations will require a great deal of financial support. Money is needed to conduct research, train staff, purchase safety devices, implement interventions, and hire more employees. This is typically a problem for most courthouses, as funds are limited. Nevertheless, funding is needed to ensure the safety and health of judges and jurors. Thus, we recommend that the government provide more money to reach these goals.

**Conclusion** Judges and jurors play an integral part in the trial process. Research has indicated that both groups experience a variety of stressors and symptoms of stress. While a number of interventions have been suggested, most have not been tested for effectiveness. Nevertheless, a number of interventions and changes have potential to reduce the amount of stress judges and jurors experience. While it might not prove practical to implement comprehensive jury and judge stress interventions in all jurisdictions, it is important that measures are taken to address courtroom stress and safety. These are minor costs to pay to protect the judges and jurors who are critical to the efficient functioning of the American justice system.

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Table 1: Stressors experienced by jurors during each stage of trial\*

Potential stressor	Percentage of jurors experiencing stress**
Pre-trial stage stressors	
Receiving summons	34%
Report for jury duty	32%
Disruption of schedule	45%
Alternate childcare/work schedule	25%
Answering personal questions	39%
Awaiting trial assignment	33%
Trial stage stressors	
Keeping trial information secret	25%
Testimony/evidence	20%
Gruesome evidence	28%
Understanding instructions	13%
Determining guilt	44%
Reaching unanimous verdict	49%
Post-trial stage stressors	
Public reaction to verdict	15%
General stressors	
Being publicly identified	16%
Safety concerns	16%
Media exposure	6%

\*From National Center for the State Courts, *Through the Eyes of the Juror: A Manual for Addressing Juror Stress*, available at [http://www.ncsconline.org/WC/Publications/Res\\_Juries\\_JurorStressIndexPub.pdf](http://www.ncsconline.org/WC/Publications/Res_Juries_JurorStressIndexPub.pdf) (2002).

\*\*Note that this is the percentage of jurors who experienced the potential stressor AND reported that it did, in fact, cause them stress.

The authors would like to thank Jim Richardson for his helpful comments.

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## PERSONAL EXPERIENCE

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The remaining three articles are all personal stories about how those with substance abuse issues were able to get help; *From Disciplinary Action to Recovery, A Judge Saved My Life*, (addressing the importance of a judge intervening with a fellow jurist or lawyer) and concludes with *I Am an Alcoholic, I Am Also a Judge*.

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### FROM DISCIPLINARY ACTION TO RECOVERY: ADPs AND LAPs

By Paul J. Virgo

Admitting to an addiction such as alcoholism or a psychiatric condition such as depression is the worst nightmare of many lawyers: *What will people think? Will anyone ever hire me again if word gets out?* It may be difficult to picture or appreciate the steps an attorney must go through to face such an admission. In all too many cases, lawyers face the truth only when also faced with a disciplinary action. But help is available now that was not there in the past. The founding and evolution of lawyer assistance programs (LAPs) and alternative discipline programs (ADPs) have been instrumental in expanding recovery and support opportunities so that lawyers can help themselves, or their colleagues, when addictions or health conditions result in unprofessional performance and client complaints.

In my law practice I represent lawyers facing recovery issues and their fallout — specifically, the almost inevitable collisions with the disciplinary system. I am fortunate to practice in California, which is home to a highly evolved LAP and ADP. California is the only state in the nation with a state bar court, made up of independent professional judges dedicated to ruling on attorney discipline cases. If the bar investigation of a complaint determines that an attorney's actions involve probable misconduct, the office files formal charges with the state bar court. The court hears the charges and has the power to recommend that the California Supreme Court suspend or disbar attorneys found to have committed acts of professional misconduct or to have been convicted of serious crimes. The ADP is a program initiated in the state bar court for lawyers whose involvement in the discipline system may have been a result of substance abuse and/or mental health problems. The ADP offers the possibility of reduced disciplinary sentences for lawyers who make a binding commitment to participate in a treatment program overseen by the LAP.

#### LAPs: A Path to Recovery

The mission statement of the California LAP, founded in 2002, is to “support recovering attorneys in their rehabilitation and competent practice of law, enhance public protection, and maintain the integrity of the profession.” We are extremely proud of the success rate the LAP has achieved despite its infancy.

Many lawyers enter a LAP as a result of a disciplinary proceeding; others voluntarily self-refer — a very important provision that allows lawyers to take advantage of program benefits before they become involved with disciplinary processes. All participation in the LAP is voluntary, and all records are strictly confidential.

Figures for the California bar's LAP clients in 2005 indicate that 37 percent suffered from substance abuse, 35 percent from mental health conditions, and 28 percent from dual or



multiple diagnoses. A total of 693 lawyers used the program's services, of whom 19 were terminated for failing to comply with the recovery terms of the participation agreement. Some of these lawyers, however, did return to the program.

The 2005 report noted an increase in the number of self-referred lawyers, a trend in evidence since the program's inception. The increase in self-referrals bodes well for decreasing the impact that later—or no—intervention has on the state bar's disciplinary system. During the first two years of operation (2002 and 2003), nearly two-thirds of participants faced some type of disciplinary proceeding. In 2004 only half the new participants were involved with disciplinary proceedings, and during 2005 this percentage dropped to just over one-quarter.

### **The Disciplinary System**

The prosecutor's office and the state bar court maintain closely coordinated interaction. The state bar court refers attorneys with pending disciplinary proceedings and investigations to the LAP; an attorney cannot be accepted into the ADP (which offers the possibility of a mitigated disciplinary sentence) without first being accepted into the LAP and complying with all of its requirements. ADP cases now make up 44 percent of the caseload of the state bar court. As a precondition to admission into the ADP, each participant must establish a connection ("nexus") between the admitted misconduct and substance abuse and/or mental health problems, then must make monthly court appearances to report the status and progress of program involvement. Because of the three- to five-year commitment required by the LAP/ADP, the decision to enter the program is a highly personal one for lawyers. Some choose not to take this avenue, especially in low-level discipline cases.

The disciplinary benefits of participation in the LAP/ADP program are not limited to the possibility of a reduced sentence. In 2005 the statute creating the LAP was amended to provide assigned judges from the state bar court greater flexibility in allowing LAP/ADP participants to serve recommended periods of actual suspension at the start of their ADP participation, instead of at the end. Currently, an actual suspension of six months or more is generally served "up front," and a suspension of six months or less is served after completion of the program.

Some prosecutors have questioned the structure of the LAP and its interrelationship with the discipline system; they wonder whether lawyers' disciplinary sentences should be reduced simply because they have substance abuse issues (unless there are traditional mitigating factors recognized by the California Supreme Court, of course). Implementers of the programs, however, firmly believe in their ability to assist participating lawyers in recovery and rehabilitation and at the same time to protect the public and the integrity of the profession.

### **Solos and the ADP**

Lawyers involved in the ADP are primarily solos or small firm practitioners. In fact, practicing alone or in a small firm is often a contributing factor in these lawyers' disciplinary problems. Large firms frequently have specific committees or other checks that protect affected lawyers — and the firm — from the complications of client complaints and disciplinary proceedings. If an attorney falters, others can look after that lawyer's clients and cases during the affected attorney's recovery (assuming the lawyer is not simply fired).

This safety net is usually not available to the sole practitioner, who must continue to bring in business, administer the office and finances, and service all clients' legal needs. Most of our clients are able to continue to practice while enrolled in the LAP/ADP program. Some are not so fortunate. They must temporarily give up their practices in order to meet the immediate demands of their recoveries (e.g., inpatient treatment). Some may arrange for other lawyers to tend to their practices. Because this is a significant development in the client's case, however, it must be divulged to the client, thereby compromising confidentiality.

### **Institutional Involvement**

An attorney who contacts the LAP is assigned a case manager licensed to treat substance abuse and mental health problems, who initially addresses any exigent or life-threatening issues, handles medical needs, and—very importantly—provides emotional support. The lawyer immediately begins participation in professionally facilitated LAP support groups and other self-help programs as needed and may be referred to medical and psychiatric professionals for evaluation if necessary. The case manager and group facilitator stay with the lawyer throughout the program of structured recovery. An evaluation committee consisting of medical doctors, psychiatrists, psychologists, and other licensed health care professionals determines the extent of the lawyer's participation and at what point the lawyer has successfully completed the program. This structure avoids some of the challenges faced by solo clinicians who might have to provide assessment, monitoring, and treatment. Of course, in some instances, this latter approach may be preferable.

### **Personal Challenges**

What does the program require of its participants? The criteria for formal completion of the program are (1) maintaining three years of continuous sobriety or, in cases of mental health, stability; (2) making lifestyle changes necessary to maintain ongoing recovery or stability; (3) satisfying the terms of the participation agreement (a contract between the lawyer and the LAP); and (4) participating in the prescribed program for three to five years or a period established by the evaluation committee. This is a huge challenge, albeit necessary to recovery.

One of the most rigorous requirements of the program is that each individual must take full responsibility for his or her transgressions—whether they involve criminal activities or family relationships. Some participants find it particularly difficult to stop blaming others for the choices they themselves made; many others, however, easily accept this responsibility as part of their individual programs of rehabilitation. Yes, some are motivated solely by the desire to save their licenses, but much more than a license is at stake if they do not begin to help themselves.

### **Conclusion**

It is clear that our LAP and ADP are working for participants. These attorneys have faced the entire range of problems: alcohol and drug abuse, manic depression and bipolar disorder, sexual and gambling addictions, and other serious personal challenges. But the success stories are numerous. The attorneys are honoring the obligations to their clients, making restitution, repaying unearned fees, and attending classes in topics such as ethics and client trust-account sessions sponsored by the bar. They are rebuilding their lives and their practices.

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## A JUDGE SAVED MY LIFE

*By Judge Robert J. Seerden*

*The lawyer stopped his client and said, "Don't get on that elevator. There is that crazy man," referring to me.*

In most instances, members of the judiciary are recognized as respected members of the community. I am honored to have been a Texas appellate court judge from 1984 until my retirement in 2000. Even today, I am generally referred to by the members of the community as "judge." I believe I am generally considered to be a fairly respected member of the community in which I live. Prior to 1980, I did not always merit such respect.

For example, I remember an incident in early 1979 in Victoria, where I lived and practiced law. A gentleman and his lawyer, who was an acquaintance of mine, were approaching an elevator into which I had just stepped. The lawyer stopped his client and said, "Don't get on that elevator. There is that crazy man," referring to me. Though I was an active, successful lawyer for 20 years, I was in the early stages of the downward spiral of alcoholism that could only end in the gutter or the grave. I had progressed to where I was not able to function properly. My willpower and intelligence could not halt the devastating effects of alcoholism.

Then, on Dec. 13, 1979, my conduct became so egregious that a friend and colleague, 24th District Court Judge Clarence N. Stevenson, declared a mistrial during a jury trial in which I was participating and ordered me hospitalized. I thought that life as I had known it was over. However, from the hospital, I went to a drug and alcohol treatment center and I was introduced to a life without alcohol, which enabled me to handle the pressures of our profession, and life in general. This way of life also has allowed me to have a good time and be comfortable in my skin. With the help of family, colleagues, and friends — both in and out of the profession — I became a better lawyer, husband, father, and citizen.

In early 1984, at the urging of colleagues, I became a candidate to replace a retiring justice on the 13th Court of Appeals. Because of my candor in acknowledging my alcoholism, as well as the facts of my recovery, my former addiction has not been a problem, either in my original appointment or my subsequent election and reelection as a judge.

During and since my judicial service, I have been active in the legal and judicial community and in an alcohol-recovery program. Since the creation of the Texas Lawyers' Assistance Program (TLAP) in 1989, I have been active in that program as well. The program, with the aid of volunteer lawyers and judges throughout the state, offers assistance to lawyers and judges and law students with problems arising from alcohol, drug, and substance abuse as well as depression and other mental illness.

Contact with TLAP is completely confidential and its services are strictly for the purpose of assisting those seeking information or assistance. It is completely separate and apart from the disciplinary process.

A direct word to Texas judges' is also in order. Attorneys aren't the only ones affected by the stresses of the profession. The lifestyle of the judiciary seems to make judges with tendencies toward substance abuse, dependency, and depression particularly

vulnerable. It seems easy to confuse respect and honor for the office with feelings of personal infallibility. The protection and isolation afforded by our colleagues and staff make it easier to hide our addictions or depression from others and ourselves. Driven by self-loathing and fear of discovery, we often avoid facing our humanity until disaster strikes. This can be avoided if we have the courage to seek the help that is always available. It also takes courage for a judge to confront a colleague concerning his personal life; however, if the colleague is suffering, as I was, the rewards and satisfaction to both parties can be overwhelming. A judge taking action or help a lawyer or another judge, at seeking self-help, is a good thing. It certainly is not hurting a lawyer or judge in any way to offer help. By taking action, you can make a real difference in someone's life!

Please remember that the confidential resources of TLAP are also an invaluable tool for judges. A private line is accessible for judges at (800)219-6474.

It took a judge to intervene in my life in order to save me from the devastating effects of addiction. And for that, I am eternally grateful.

*ROBERT J. SEERDEN*

*served as chief justice of the 13th Court of Appeals in Corpus Christi.*

## **I AM AN ALCOHOLIC. I AM ALSO A JUDGE**

*BY Vincent F. Leahy*

I am, not an alcoholic judge, although I am an alcoholic because I cannot drink alcohol in safety, and I am a judge because on September 10, 1979, the Governor of Massachusetts swore me in as an associate justice of the Probate and Family Court for the County of Middlesex. But the two have nothing to do with each other. As an alcoholic, I am grateful that I have been successfully recovering since January 9, 1964. I have had no alcohol or substitutes since that day. (I never used other mind-altering substances, so I cannot comment on them. People who do use them claim, "It's all the same.") I believe that I was born an alcoholic. I know it is a physical impossibility for me to drink alcohol in safety. Nothing in my background could have "caused" my alcoholism from an emotional, traumatic, or psychiatric point of view. I came from a big, happy family. The nine children are all still alive, the oldest one 80. There is great love among us, and on rare occasions we all get together.

My parents were married 53 years, and I never heard a harsh word between them. Neither drank, and they were loving toward all of us. My father was a successful lawyer, and we had all the things we needed or wanted. I don't think any of us was spoiled.

I grew up in a happy household and achieved many honors. I cite some of them, not to brag, but to illustrate that no demons drove me into alcoholism. I was an athlete in grammar and high schools, playing football, baseball, hockey, and track. I was president of my high school class of about 400 and was "most popular."

I was a good, but not brilliant, student. I attended Harvard before and after World War II, where I played freshman football and was captain of the baseball team my first year. During the war, I attended the Massachusetts Maritime Academy, then in Hyannis. I was graduated first in my class among those studying to be deck officers, and was appointed the battalion commander, the highest cadet rank. I then served as an officer in the Navy, doing mostly convoy work in the North Atlantic aboard a destroyer. When hostilities ended, I returned to college, was graduated in 1948, and entered Harvard Law School.

I was married during the war and we soon began to have children. When I was graduated from law school in 1951, we had three sons, and our fourth child, a daughter, was on her way. Nine years later we were to have our last child, another girl. It's been more than 45 years since our wedding. Our seventh grandchild will have been born by the time this is published.

After law school, I got a job with a prestigious Boston law firm. I was about to embark on my life-long career, and I had the world in the palm of my hand. I should have gone on to live happily ever after, but that was not to be.

### **Saved**

I will not dwell on the details of my drinking and its consequences, except to say it was progressive, compulsive, and obsessive, and led to a decline in my spiritual values. The promise of success was thwarted by alcohol, which eroded my self-esteem and self confidence. Toward the end, my marriage nearly foundered. It was saved, as was my life and sanity, when a wise and humble psychiatrist sent me to a self-help group of recovering alcoholics. I attended their meetings almost daily for 24 years and still go about three times a week.

In one way I do not purport to be an expert on anything but my own sobriety. On the other hand, I have naturally come to various conclusions about alcoholism and alcoholics after attending more than 8,000 meetings and hearing some 25,000 talks. This empirical evidence-and the scientific evidence I have read in periodicals-are the basis of my opinions.

I have never been anonymous about my alcoholism, either as a lawyer or a judge. I do not feel I am to blame for my alcoholism any more than I am to blame for the color of my eyes. After I was sober for several years, I concluded that most alcoholics, if not all, are born alcoholics. Their stories have revealed serious problems with alcohol from the outset. They do not appear to drink socially and "become" alcoholics over a long period of time.

### **A genetic disease**

I have come to believe that alcoholism is largely a genetic disease, and that most alcoholics are so constituted that it is impossible for them to drink in safety. It is rare to hear anyone at an alcoholics meeting say that he or she does not come from an alcoholic home. Alcoholism almost always runs in the family, and it is common for parents, siblings, and children to be recovering simultaneously.

In my case, a maternal uncle was alcoholic, and I have reason to believe that my mother would have had trouble with alcohol had she drunk it. I was once told that my paternal grandfather was an alcoholic, but I do not know if that is true. I do know my father and his six siblings never drank, which is almost unknown among first-generation Irishmen. Perhaps they were scared to drink from what they had observed. They were all remarkably successful in life, and I personally attribute that in part to their not drinking. I have two sisters who are recovering alcoholics, and one of my sons still suffers from the disease. My children have numerous first cousins, on both sides, who are alcoholics. Most of them, thankfully, are sober.

As a judge in a family court, I see a great deal of alcoholism. The bulk of my actual day-to-day work is in the field of domestic relations, and though I have never kept any statistics, I believe the majority of divorce cases involve alcoholism. I have tried to use my knowledge and experience to help those who appear before me. Alcoholics have a common bond and a unique understanding, often called a transmission line. I have never met a nonalcoholic, however well-schooled and intended, who has that uniqueness. Only an alcoholic can share with another the experience, strength, and hope. It is this gift that I try to use in my courtroom.

As a new judge, in a flight of ego, I was anxious to show off my knowledge of alcoholism. (Both the Judicial Nominating Committee of Massachusetts and the governor knew of my alcoholism. Since my appointment, other self-admitted alcoholics have followed my path to the judiciary, but as far as I know, I was the first.) My first case in which alcohol played a role involved a middle-aged couple from a rural suburb of Boston. They were in the process of a divorce. He accused her of being an alcoholic. In truth, she looked the part. I asked her if she drank, and she admitted she took a drink "now and then." I took her answer to be an alcoholic's euphemism for, "I get drunk about three times a week."

### **Fessing up**

She had been hostile up to, that point. I then asked her, gently, a question only a fellow alcoholic might ask. I said, "And I'll bet all of the fun's gone out of it, hasn't it?" Her

demeanor changed at once, and her head dropped as she quietly replied, "Yes, there's not much fun in it anymore." My question had no real significance except to tell her that I understood what was happening to her.

She then said of her husband, "He's an alcoholic, too." He said, "I'm no alcoholic; I haven't had a drink in three years." I asked, "Did you used to drink?" He said he did. I then said, "Well, perhaps then you are an alcoholic. Social drinkers don't stop drinking. There is no reason for them to do so. Only people having trouble with alcohol stop." I could see people in the courtroom nodding their heads as I spoke these words, as if to say, "Hey, that makes sense; I never thought of that." The case came back to me about a year later. At that time the husband was in a detoxification program in Washington, D.C. Indeed, he was an alcoholic.

How do you determine if someone is alcoholic? Perhaps the best way is to ask the family. A well-known speaker, noted for his humor and sober some 38 years when he died recently, used to say, "If you're wondering whether or not you're an alcoholic, ask your family-they're dying to tell you. And if you've lost your family, you have a little hint there." That, of course, is what I see in my court all the time: one spouse accusing the other of alcoholism while in the process of a divorce. In an early case illustrating this point, a wife said her husband had a drinking problem. His attorney vehemently denied his client was an alcoholic and said he would "prove" to me that he wasn't.

"He's never missed work; he's never been hospitalized; he's never lost his license or been arrested. I have his parish priest in court to tell you what a fine man he is." I said, "All that's fine, but his wife says he has a problem." About two weeks later, the attorney, who happened to be in my court on another matter, approached the bench and said, "Judge Leahy, I didn't know you knew so much about alcoholism. Do you remember the man who was here a couple of weeks ago? He's now in a de-tox."

In my judgment, if a family member says someone is an alcoholic, the overwhelming likelihood is that he or she is. In spite of the hostility that is usually found in divorces, which often leads the parties to accuse each other of all kinds of bad conduct, people do not generally accuse social drinkers of being alcoholics. I have never had a case in which an accusation of alcoholism has turned out to be false, no matter how vigorous the denial and regardless of the evidence. If the subject of alcoholism arises, you may be sure it is present.

### **The family connection**

Another indication of alcoholism is whether there are alcoholics in the family. I have found that even if a person is still in a state of denial regarding alcoholism (and alcoholism is a disease of denial), he or she will readily admit that others in the family are alcoholic. If others are, that is strong evidence that the person is an alcoholic.

It is a known fact that some nationalities have more trouble with alcohol than others. The Irish, Scandinavians, and American Indians fall into that category. If an Irish Catholic couple, married 20 years or so, with a number of children, is getting divorced, the cause is often alcohol abuse.

If a man does not appear in court when he normally should, such as when an order for child support is sought, there is a good chance he is alcoholic. He will talk bravely to his wife and claim he'll "never pay her a dime." He sometimes leaves the courthouse just minutes before the case is called. Alcoholics are filled with fears, and want no part of courts, judges, and lawyers. They hope the problem will go away if they do not face it.



In dozens of cases in which there has been no prior mention of alcoholism, I have asked a wife if her husband is having trouble with alcohol. She will invariably say that he is. When I ask her how I would know that fact, she will say, in a puzzled manner, that she doesn't know. I tell her it's because he is not in court, and explain to her the fears of the alcoholic.

### **Three absolutes**

I have spoken at length with hundreds of alcoholics in my court, and usually disclose that I myself am an alcoholic. That admission is usually unnecessary, because the person to whom I am speaking will know it from the things I say and how I say them. The unique understanding and transmission line are always present. If a person seems to be listening to me with a reasonably open mind, I will give him or her three absolute guarantees. I will say: "If you are an alcoholic and continue to drink, things will get worse. Your sickness will get worse, and your troubles will get worse. It is a progressive disease. Whatever level you're at now is the best you'll ever be from now on."

Secondly, "If you attend 30 meetings in 30 days and don't drink during that time, no harm will come to you from staying sober. The door swings both ways, and you can always leave if you wish to." The person usually smiles slightly at this bit of obvious wisdom. I hope, of course, that after 30 meetings a person will identify him-or herself as an alcoholic and decide sobriety is better. In any case, the meetings will spoil the drinking, and a seed will be planted that might later bloom, even if the person decides to drink again.

Finally, I say, "If you are an alcoholic and continue to drink, some day, somewhere, some time, you will look back and say: "That judge knew what he was talking about; I should have taken his advice." Sooner or later, every alcoholic will have a moment of truth about drinking and, filled with remorse, will realize the devastation it has caused in his or her life.

I have no idea how many alcoholics I may have helped in my 11-plus years on the bench. I have seen some of them at meetings; I have heard good reports about others. A lawyer I once spoke with in my lobby five or six years ago gives me a big smile and a thumbs-up sign when I see him. I am afraid, however, that most of what I say falls on deaf ears. Most alcoholics are not ready to listen. I cannot get anyone sober, keep him or her sober, or make that person willing or eager to stop drinking. I can only carry the message.

I will continue to try to help nevertheless. You never know when a person may be ready. I am sure all who hear me know that I am trying to be of help, and that I am never being critical or talking down to them. Who am I to criticize a fellow alcoholic who still suffers from this terrible disease?

In looking back over my career as a judge, I think my alcoholism has been a positive factor in dealing with those who have appeared before me, both alcoholics and non-alcoholics. I have tried to comfort and advise the nonalcoholic spouse who has been ridiculed and made to feel like the guilty party. Of one thing I am certain. Even if I have helped no one, I have helped myself stay sober for another day each time I reach out to another human being who is still sick and suffering. That alone makes it all worthwhile.

## MODULE 10 – CASE CITATIONS ON JUDICIAL DISCIPLINE AND SANCTIONS

- 1) In Re Gilbert 668 NW2nd 892 (Mich. 2003)  
Serious public misconduct as a result of judge's alcoholism warrants removal.
  - 2) In Re Doggett 874 So2nd 805 (La 2004)  
Removal warranted where alcoholism impaired judge's ability to perform duties.
  - 3) In Re Wilson 750 So2nd 631 (Fla 1999)  
Case of theft and dishonesty resulting from alcoholism warrants removal.
  - 4) In Re Krake 942 So2nd 18 (La 2006)  
Lack of mechanism to identify and treat alcoholism worsened judicial misconduct
- In Re Krake 976 So2nd 162 (2008)  
Judge suspended due to failure to follow probation terms imposed in 2006 proceeding –Judge had been referred to LA LAP for compliance with urine and attendance at AA or Lawyer meetings
- 5) In Re Timberg 674 A2nd 1221 (Pa 1996)  
Alcoholism may constitute mitigating factor but does not excuse misconduct thus sanction imposed suspension without pay for six months and not removal and referred to PA-LAP for monitoring
  - 6) Matter of Collester 599 A2nd 1275 (Nb 1992)  
Admission and treatment of alcoholism mitigating factor precluding removal
  - 7) In Re Cope 848 So2nd 301 (Fla 2003)  
Finding of guilt of public intoxication and inappropriate conduct of an intimate nature resulted in a public censure due to judge's admissions and sincere remorse.
  - 8) Matter of Crivello 564 NW2nd 785 (Wis 1997)  
Gross personal conduct; spousal abuse. Circuit judge publicly reprimanded (judge defeated for re-election)
  - 9) In Re Norris 581 So2nd 578 (Fla 1991)  
Remorse and good faith effort at rehabilitation are mitigating factors in determining sanctions. Judge received a public reprimand by publication of the opinion.
  - 10) In Re Hanley 867 NE2nd 157 (Ind 2007)  
The Court issued a Public Reprimand after the Commission and the judge filed a conditional agreement stipulating that the judge operated a vehicle while intoxicated.

- 11) In Re Kneifl 351 NW2nd 693 (Neb 1984)  
Judge suspended without pay for 3 months based on 2 isolated incidents involving cursing & threatening
- 12) In Re Cruz 851 NE2nd 960 (Ind 2006)  
Judicial Discipline of a public reprimand was imposed after charges of driving while impaired were brought against judge although the charges were dropped by the prosecutor.
- 13) Matter of Conner 589 A2nd 1347 (Nv 1991)  
Sanctions including removal for criminal violations including driving while impaired.
- 14) In Re Noecker 691 NW2nd 440 (Mich 2005)  
Deceptive and untrue testimony concerning arrest for drunk driving warrants removal.
- 15) Matter of Koch 890 P2nd 1137 (Az 1995)  
Removal appropriate sanction for misconduct rejecting argument that alcoholism is a temporary disability
- 16) Matter of Thomas 494 NW2nd 458 (Mich 1992)  
Assaults, obscene phone calls warrant removal, alcoholism can be mitigating factor
- 17) In Re Downey, 937 So.2d 643 (Fla. 2006)  
Habitual viewing of pornography from courthouse computer; failure to disclose a juror's written communication; improper contact & communication with female attorneys. Public reprimand given judge's sincere apologies & long-standing history of judicial service. Court accepted judge's stipulation to charges, thus assuring he would no longer serve after 1/07. Judge voluntarily sought psychological counseling.

# WELLNESS ISSUES

## A GUIDE FOR CHIEF JUDGES OF THE NINTH CIRCUIT COURTS



## A MESSAGE FROM THE CHIEF CIRCUIT JUDGE

This guide was developed by our circuit's Wellness Committee to assist chief judges in learning how and when to intervene in situations where the judicial performance of a colleague may be compromised. It provides a framework for offering assistance to judges who need to reduce or terminate their participation in cases, and to facilitate judges' access to professional services.



*Chief Judge,  
Alex Kozinski*

The Ninth Circuit is committed to the fair administration of justice. It is of critical importance that judges perform their official duties unimpaired by physical or mental distress or disability. Please review the valuable information in the pages that follow. I am confident that upon doing so you will find yourself better prepared to deal with these sensitive matters when they arise among your colleagues. Thank you.

Alex Kozinski  
Chief Judge  
U.S. Court of Appeals  
for the Ninth Circuit

July 2009

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# I INTRODUCTION

Chief Judges share a unique responsibility and opportunity to promote the wellness of their colleagues. Indeed, your ability to address issues of judicial disability is an important factor in preserving the independence of the judiciary and public confidence in our courts.



*Judge Philip Pro, Chair  
Wellness Committee*

As human beings, we are all subject to health problems, loss of mental acuity and physical stamina, grief, depression, substance abuse, and other conditions which may impair our ability as judges. Unfortunately, most judges are no better equipped than anyone else to deal with such difficult and individualized issues. We should make an effort to understand when and how to react when it appears a colleague may be struggling with such issues.

In an effort to assist you and to promote the overall wellness of the judiciary, the Ninth Circuit Wellness Committee has developed this manual in the hope that it will afford some guidance to chief judges to help identify and more effectively address disability and wellness issues which may arise. The Committee hopes you will find the manual useful and that you will offer your suggestions for its improvement.

Philip Pro  
District Judge, Nevada  
Chair, Wellness Committee



Wellness issues often reveal themselves in altered behavior, observed most frequently by those closest to the individual.

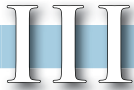
### **A. Is there a problem?**

1. Early warning signs include: tardiness, uncharacteristic behavior, unexplained absences, excessive forgetfulness; sleeping on the bench; failure of judicial temperament; unusual difficulty reaching decisions.
2. Expressions of concern and information can come from colleagues, secretaries, law clerks, lawyers, family members.

### **B. What are the possible causes?**

1. Physical, mental, or emotional impairment. These are bound to be interrelated in effect but may have a predominant origin. The origin, in turn, may suggest different remedial actions. For example, the warning signs of addiction and encroaching senility may look similar to the concerned observer but the available remedies are likely to be very different.
2. Have simple explanations been explored? For example, has the judge changed medications recently? Has the judge experienced some recent trauma, e.g., death of a spouse or child; a life-threatening event?





Upon receiving information or an inquiry about a judge's inability to perform his or her duties, the chief judge's first step should be to evaluate the behavior which prompted the complaint and the source of the information.

### **A. The Behavior**

Is the behavior out of character for the judge in question? One observer's assessment of "irascibility" may be another observer's "proof of mental illness." Does the behavior at issue require immediate intervention? Does the behavior at issue justify only a heightened awareness and observation to determine if it is merely an aberration rather than a symptom of a continuing problem that will need to be addressed if confirmed?

### **B. The Source**

The universe of persons in a position to observe a judge's behavior is limited: colleague, secretary, law clerk, lawyer, litigant, friend, family member. Reporting questionable conduct by a judge to any person in a position to act on the information is a sensitive issue. It requires taking affirmative action outside of normal channels. Reports from litigants and lawyers may be prompted by dissatisfaction with how the judge has handled a particular case. Virtually everyone in a position to make a credible report will have personal loyalties to the judge which work against disclosure and open evaluation. Although colleagues, friends and family members rarely sit in on court proceedings, any behavior they observe that is sufficient to raise a question is likely to have a component that comes out on the bench.

## C. Marshaling Resources

1. Call Richard Carlton of the Ninth Circuit's Private Assistance Line Service (1-866-ASK PALS) for assistance in evaluating the information. PALS is a confidential telephone hotline to assist judges, their families and their staffs with questions relating to a judge's physical and mental well-being. Mr. Carlton is available 24 hours a day, seven days a week. An email address, [pals@ce9.uscourts.gov](mailto:pals@ce9.uscourts.gov), has also been established for those judges who wish to communicate by email rather than by (or in addition to) telephone. The email message is a direct link to Richard Carlton at PALS.
2. Take steps to verify the reported information.
3. Decide who to involve in the initial evaluation process. Confidentiality is imperative. Restrict information to those with "a need to know" only.
4. If the verified information warrants further action, decide who should conduct further investigation and potential intervention.

The chief judge may choose to delegate some or all of these responsibilities to a response person or team chosen from among his or her judicial colleagues. Depending on the peculiarities of the district, there may be a standby group, person or a committee which regularly handles wellness education, and wellness response. More likely, the chief judge's response will depend on the particularities of the individual case.

# IV RESPONSE

In planning how to respond to the problem, take into account all those who will be involved and affected, personally and professionally, during the process and by its outcome.

## A. Recognition of the players

1. Chief Judge – the person responsible for organizing a response to the problem.
2. Impaired Judge – The judge about whom a question has been raised may or may not be open to communication about his or her behavior. The judge may have explanations that would change any preliminary “diagnosis” made by concerned observers.
3. The Judge’s Family – The judge’s family can be a valuable source of information and an important ally in fashioning an appropriate response. The judge’s spouse, in particular, will have observed the judge’s behavior in non court-related situations. He or she will probably be aware of any medical or situational explanations for unusual and unacceptable behavior. Involving the judge’s family is a sensitive matter. Outside the public arena, impairment and health issues generally are viewed as extremely private concerns. The judge’s spouse may be reluctant to be involved in any discussion that appears disloyal. The judge’s spouse may refuse to recognize the existence of any problem.

A colleague who is a family friend may have the best chance of opening a dialogue and providing some reassurance. The goal is to help, not hurt the judge.

4. Judicial Colleagues – When an impairment issue requires relieving a judge of some or all of his or her caseload, the burden will fall directly on his or her judicial colleagues. Redistribution of cases raises numerous administrative decisions and legal questions which should be addressed with the Clerk of Court.

Second guessing a colleague's behavior or performance is a very personal issue which may threaten the collegial atmosphere of the court. Early and continuing recognition of and education about wellness and impairment issues may help judges recognize that no one is immune to the problems posed by advancing age or impaired health.

5. Judicial Employees – A judge's secretary, judicial assistant and law clerks may be among the first to observe behavior that raises concern about the judge's ability to perform. Given their roles as personal support staff and their natural loyalties, members of the judicial staff may be reluctant to discuss their concerns with the judge or with anyone outside of chambers. They may have concerns about their own futures as well if the judge does not continue to carry a full caseload.

6. Clerk's Office – Talk to the Clerk of Court and ask for information and possible rumors that may be circulating regarding the judge in question. Reorganization or dispersal of a judge's caseload will have some impact on virtually all of the Clerk's staff and impose extra work on their already busy workloads. Those clerks who work directly with the affected judge's cases are likely to have the most

anxiety over their futures. See Section VI on p.11 on Communications and Public Relations.

7. The Legal Community – Any questionable behavior in court or at court-related functions is likely to be of grave concern to the legal community as well as to the court. The necessity to take control of communications is discussed in Section VI on Communications and Public Relations.

## **B. Developing a plan of action**

1. If the evaluation process warrants further action, the chief judge must decide how to proceed. Who will participate in the decisions involving intervention and case management? Is there a trusted colleague or confidant who can assist in approaching the affected judge? Is there someone in another court who has dealt with the same problem and can offer advice? Should a professional advisor be present? Will notes be kept? If so, by whom and for what purpose? The nature of the problem will affect how the intervention should proceed. See Section VII on p.13 on Substance Abuse and *Depression* and Section VIII on p.15 on *Aging*.

2. Interveners need to be cautioned about being sensitive to, among other things:

(i) preserving the dignity of the impaired judge;

(ii) assisting the impaired judge to recognize that his or her behavior has raised the issue;

(iii) eliciting, if possible, the cooperation of the impaired judge in finding an effective response to the concerns raised (e.g., leave of absence, retirement, reduction in caseload); and,

(iv) protecting the confidentiality of personal information as much as possible.





Understanding the severity of a judge's problem is necessary to determine the best strategy for caseload management.

### **A. Estimating the length and type of potential disability of a judge**

- Partial or complete, i.e., part time availability or full time absence.
- Mental or physical - even if the judge is capable of part time work, should he or she be permitted to do so?
- If there is a suggestion of mental disability or substance abuse, should that judge be handling any cases, or signing orders on matters previously argued and now under advisement?
- If a matter is under advisement when reassigned to another judge, should it be re-argued? Is it sufficient to obtain the transcript of oral argument? A transcript probably is inadequate if credibility issues are involved.

### **B. Redistribution of cases**

- Permanent reassignment of case(s) in accordance with the random method used in the district. Also, consider using visiting judges.
- Temporary "caretaking" of cases by other members of the Court.

## Redistribution of cases cont.

- Signing a non-routine order requires taking ownership of the subject of the order. One cannot hide behind “Signed by Judge X for Judge Y.”
- Is the case now proceeding under the original judge’s scheduling order or that of the caretaker judge, or a magistrate judge who presided at the Rule 16 scheduling conference or to whom the case has been referred for continuing case management purposes?
- If the caretaker judge presides over a dispositive motion or trial, should the case first be permanently reassigned, and if so, to the caretaker judge, or in accordance with the district’s random assignment procedure?
- Check local rules. In some districts, the local rule requires that random draw be used for even temporary reassignment.
- Be aware that the conflict checking program will not be running on a case not permanently assigned to the “caretaker” judge.



# VI

## COMMUNICATIONS AND PUBLIC RELATIONS

The absence of a judge from the bench will be noted by colleagues, court staff and at least some members of the bar. Be prepared to respond to inquiries.

- When should judicial colleagues be told and what should they be told?
- What are counsel for litigants told by the “caretaker” judge and staff? There will inevitably be inquiries: “Why is this judge handling my case?” “When will the original judge return?” “Why is that judge out?” “Which judge will preside at trial?”
- Get the story right and keep it straight. Remember, if a judge’s cases are redistributed among several other judges, the same lawyer may be asking these questions of different judges. It reflects poorly on the district when the lawyer is told by Judge A that Judge Y is on sabbatical; and Judge B answers the inquiry by saying Judge Y is on medical leave.
- Rumor Control. There is little that can be done to quell rumors in the legal community, but recognizing the importance of candid, coordinated responses to inquiries will help reduce the chances of causing more rumors than might otherwise arise.
- Candid communications with the court family, as necessary, will also minimize the explosion of rumors and will assist ensuring that the Court does not add to the problem by disseminating conflicting information.

- Be conscious of potential morale issues. Non-judicial employees are limited in their allowable time-off. While judges are not subject to the same limitations, staff may resent extra workload they acquire by virtue of the prolonged absence of a judge. In other words, should the Clerk of the Court consider requiring the disabled judge's staff to cover hearings and trials even if another judge is presiding? Likewise, judicial colleagues may come to resent the extra workload they assume.



# VII

## SUBSTANCE ABUSE AND DEPRESSION

Behavioral changes may be indicative of substance abuse, depression or other physical or emotional problems. Identifying the underlying problem is an emotionally charged process.

- Occasional alcohol abuse is typically after hours, and is unlikely to be observed in the courthouse. Alcohol and other substance dependence is a progressive disease of the brain that typically leads to declining attentiveness and a reduction in work productivity. More progressed cases exhibit pronounced changes in behavior and appearance.
- In this population, the most common substance problem is prescription drug abuse. The consequences of overuse or misuse are rarely obvious to the user of the substance. In order to self-justify using prescription drugs in the face of adverse consequences, individuals develop an amazing capacity for self-deception (commonly referred to as “denial”).
- Both substance abuse and depression often are exhibited in the workplace as dramatic changes in mood, behavior, and/or energy level, both on and off the bench.
- The same set of symptoms that might be suggestive of depression or substance abuse can also be indicative of other physical or emotional problems. It is best to avoid attempting to diagnose the problem and leave that step to a physician or mental health professional.
- These are emotionally charged and highly sensitive issues to address, especially with someone accustomed to freedom from close scrutiny from colleagues.

- It is best when these subtle, and sometimes not so subtle changes are brought to the judge's attention by a trusted colleague or confidant. When possible, family members should be brought into the process as important allies. In the courthouse, a judge can try to hide impaired abilities or emotional problems behind the formality of the judicial robe; at home, there is nothing to hide behind. On the other hand, spouses are often just as frightened and threatened, and in just as much denial as the judge.
- In more extreme cases, or when the judge is in denial, a group intervention is likely to be more effective. Even for skilled debaters, denial or deflection is more difficult to accomplish when opposing a group.
- Focusing on reduced work productivity as the primary courthouse concern can sometimes make these discussions less emotionally charged.



# VIII AGING

Problems associated with aging are the most difficult to address, often requiring help from family and trusted colleagues.

- The most common problems are increasing forgetfulness and declining mental acuity. On the bench, this is often manifest in an inability to track or retain details and repeat requests for information that has already been presented. This can lead to a dramatic slowdown in the time to reach decisions.
- Staff are often the first to notice these problems. In the beginning, staff may likely try to compensate for and cover-up the problem. They can also become allies in addressing or managing the problem.
- No subject is more difficult to talk about than aging issues because of the permanency of the problems. Unlike depression and substance abuse, declining productivity related to aging is often not treatable or reversible. Involving the family is vitally important whenever possible. Again, involving a trusted colleague or confidant in the process or discussion is also very important.
- Confusion and reduced mental acuity can also be symptoms of a treatable physical problem. A complete physical examination by a physician and sometimes a neurological work-up are recommended.

## Aging

*The 36-Hour Day: A Family Guide to Caring for Persons With Alzheimer Disease, Related Dementing Illnesses, and Memory Loss in Later Life*, by Nancy L. Mace and Peter V. Rabins

*Living in the Labyrinth: A Personal Journey Through the Maze of Alzheimer's*, by Diana Friel McGowin

## Alcohol and Substance Addiction

*Alcohol and the Addictive Brain*, by Kenneth Blum, Ph.D.

*Drug, Brains, and Behavior: The Science of Addiction*, National Institute on Drug Abuse. <http://www.drugabuse.gov/scienceofaddiction>

- Robert J. Seerden, a retired justice of the Texas Court of Appeals. (Alcohol addiction)
- Sheila M. Murphy, a retired Cook County, Illinois, circuit court judge (Alcohol addiction).

## Wellness, General

- Wellness Web Site: <http://www.circ9.dcn/wellness>
- American Bar Association  
<http://www.abanet.org/legal services/colap>
- ABA Commission on Lawyers Assistance Programs  
Richard A. Soden, chair (Goodwin Procter LLP, Boston)
- American Judicature Society (AJS) Working Group on Impaired Judges  
Dr. Diane Cowdrey, Director, Utah Judicial Institute  
Robert P. Cummins, Cummins & Cronin, LLC, Chicago  
Gordon L. Doerfer, Associate Justice, Massachusetts Appeals Court  
Larry Hammond, Osborn Maledon, Phoenix  
John K. Konenkamp, Associate Justice, Supreme Court of South Dakota  
Hunter H. Patrick, Wyoming District Court  
Steven Scheckman, Special Counsel, Judiciary Commission of Louisiana

## **Wellness, General cont.**

- AJS Working Group on Impaired Judges, cont.  
Annette J. Scieszinski, Judge, Monroe County Courthouse, Albia, Iowa  
David J. Waxse, Magistrate Judge, Kansas City, Kansas  
Seana Willing, Executive Director, Texas State Commission on Judicial Conduct  
Warren Wolfson, Justice, State of Illinois Appellate Court

*Depression: Feeling Good: The New Mood Therapy*, by David D. Burns, MD

- Richard P. Carlton, MPH  
Education, Research and Development  
Lawyer Assistance Program  
State Bar of California  
(415) 538-2355  
pals@ce9.uscourts.gov

*A Time to Heal*, by Timmen Cermak, MD

*Lawyer, Know Thyself*, by Susan Swaim Diacoff

*Bi-Polar Disorder: An Unquiet Mind*, by Kay R. Jamison, MD

*The Judge's Journal*, A Quarterly of the Judicial Division, American Bar Association, Fall 2006, Vol. 45, No. 4 quarterly publication.

*Judicature*, The Journal of the American Judicature Society, July-August 2006, Vol. 90, No. 1 bimonthly publication

- Programs by State:

Arizona Member Assistance Program ("MAP")

<http://www.myazbar.org>

Member Assistance Program can be found under "Member Resources"

California Lawyer Assistance Program

<http://www.calbar.ca.gov>

Lawyer Assistant Program can be found under "Attorney Resources"

Hawaii Attorneys and Judges Assistance Program

<http://www.hawaiiiaap.com>



**Wellness, General cont.**

-Programs by State, cont.

Oregon Attorney Assistance Program (OAAP)

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

*Why Zebras Don't Get Ulcers (An Updated Guide to Stress, Stress-Related Diseases, and Coping)*, by Robert M. Sapolsky

- Wellness Committee 2008-2010

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Revised July 2009



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