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Timothy J. Sweeney JD, CCJAP [a], David P. Myers MD, CAP, FASAM [a] & Joseph Molea MD, CAP, CHE [a]
[a] HealthCare Connection of Tampa, Inc
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Treatment for Attorneys with Substance Related and Co-Occurring Psychiatric Disorders: Demographics and Outcomes

Timothy J. Sweeney, JD, CCJAP
David P. Myers, MD, CAP, FASAM
Joseph Molea, MD, CAP, CHE

ABSTRACT. The following paper is the result of a retrospective study of clinical case files of legal professionals treated for substance-related and co-occurring psychiatric disorders at a recovery center specializing in the care of impaired professionals. Attorneys traditionally differ from healthcare professionals in two important ways: first, they prematurely leave treatment in greater numbers, and second, they suffer a higher incidence of co-occurring psychiatric disorders. Sixty percent of the attorneys presented with concurrent psychiatric conditions (Axis I and Axis II), compared to 46% of their healthcare colleagues. More than half of the lawyers treated had a prior history of criminal arrest. Sixty-four percent completed treatment compared to an 86% completion rate for medical professionals. The completion rate for lawyers improved significantly following institution of a dedicated impaired attorneys' program under the direction of an attorney/clinician in October of 1999. Prospective studies are needed to determine if attorneys are at greater risk of developing substance related and/or psychiatric disorders than are other professionals of similar demographic backgrounds and what specialized

Timothy J. Sweeney, David P. Myers, and Joseph Molea are affiliated with HealthCare Connection of Tampa, Inc.

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intervention, treatment, and case management services might be necessary to assure equivalent outcomes.

KEYWORDS. Attorneys, impaired professionals treatment, substance use, relapse

INTRODUCTION

In the spring of 2002, a retrospective study was conducted of 75 clinical case files of attorneys, judges and law school graduates treated at HealthCare Connection of Tampa, Inc. ("HCC") for substance-related disorders prior to the 2002 calendar year. HCC is a continuum of services treatment facility specializing in the care of impaired professionals, e.g. physicians, attorneys, nurses, pharmacists, etc., and persons with co-occurring psychiatric disorders. The treatment continuum range is designed to accommodate patients at ASAM-PPC levels other than hospital-based care, and includes halfway, three quarter, aftercare and monitoring services. Detoxification, when necessary, is managed by an addictionist on an outpatient basis at the on-site medical clinic or referred to affiliated acute care institutions. Follow-up of individual clients in this study ranged from a minimum of six months to a maximum of seven years.

The study collected and examined demographical data including median age, gender, marital status, practice type and drug of choice. The study also considered the incidence of psychiatric dual diagnosis as well as personality disorders/configurations confirmed by mental health providers skilled in the interpretation of standardized mental health testing. Finally, data was collated regarding law enforcement and state bar association complications, as well as history of prior treatments.

The outcome study considered how treatment was concluded (patients leaving treatment against medical advice versus successfully completing treatment and following aftercare recommendations) with comparison of discharge types before and after formal institution of recovering attorneys' program track in October of 1999. Where available, follow up data was collected concerning Program participants' recovery progress following treatment.

METHODS

Collection of data on select professional groups is well known.[1] The data presented in this study was collected by the clinical team, which included all authors, and was collated and analyzed by the authors. The lead author, a Florida-licensed attorney and Certified Criminal Justice Addictions Professional, represents an innovative resource in peer-to-peer treatment for attorneys. As the director of HCC's Recovering Attorneys' Program, the author attends all clinical staffings and provides input on the progress of and problem areas relative to each attorney in treatment. Such cross training provides the potential to impact the treatment process greatly; however, this variable was not addressed in isolation.

The data was obtained from the attorney/patients' clinical charts. Treatment was based on levels of care as presented in the American Society of Addiction Medicine's Adult Patient Placement Criteria (ASAM PPC-II),[2] and was executed by licensed and certified mental health providers with experience treating impaired professionals. Consistency of information and measures to control for misclassification were enhanced by the fact that each patient was evaluated by the same Addictionist upon admission and by a consulting psychologist and psychiatrist within the first week of treatment. Each biopsychosocial interview and history was conducted by a licensed and/or certified clinician and was executed pursuant to a standardized format. All Axis II personality data was derived from the Millon Clinical Multiaxial Inventory-III (MCMI-III) instrument,[3] a self-report assessment instrument designed to help the clinician assess DSM-IV-related personality disorders and clinical syndromes. The instrument is useful in assessing Axis I and Axis II disorders based on the DSM-IV[4] classification system, identifying the personality disorders that underlie a patient's presenting symptoms, and designing appropriate and efficient treatment protocols.

Post-treatment, follow up data was obtained, when possible, through lawyer assistance program monitoring agencies, culling of public records, recovery support systems, and, as a last resort, through uncorroborated self-reports and available anecdotal evidence.

RESULTS

Patient Profile

Seventy-five clinical case records were examined for attorney/patients treated from 1994 through January 2002. Forty-one of the sev-

enty-five (54.66%) were treated following creation of the specialized track, the Recovering Attorneys' Program, in October of 1999. Of the seventy-five, sixty-five were men (86.7%) and ten were women (13.3%). The age of the male attorneys ranged from 27 to 65, with a median age of 43.9 years. The median age for female attorneys was slightly younger at 41.9. Thirty-eight of the lawyer/patients were married, twenty divorced and seventeen single. Nearly all reported significant marital or relationship difficulties. Forty-four (58.6%) were litigators, eight (10.6%) were transactional attorneys (tax, real estate, probate law), seven (9.3%) were law school students or graduates awaiting admission to the bar, three (4%) were judges, four (5.3%) were disbarred[5] and nine (12%) fit some other category.

The drug of choice for the seventy-five lawyers treated was as follows:

Drug of choice	Number	Percentage (Rounded)
Alcohol	43	57
Cocaine	19	25
Opiates	6	8
Benzodiazapenes	2	3
GHB	2	3
Methamphetamine	2	3
Marijuana	1	1

Most engaged in polysubstance use/abuse. Forty-four of the lawyers (58.6%) had prior treatment. Of these, nineteen had one prior treatment, five had two previous experiences, and twenty had three or more, with the most being one lawyer with eight prior treatments.

Thirty-eight, or just over half of the lawyers treated, reported a history of criminal arrests. The most common offense was driving under the influence (18), followed by drug possession (12), domestic violence (10), trafficking (3), and assault and battery (3). (Note: some lawyers reported multiple offenses.) Thirty-four of the lawyers had bar complaints or other problems. These included nine suspensions and four disbarments.

Psychiatric Data and Personality Testing

Forty-five of the attorneys (60%) presented to treatment with a co-occurring psychiatric disorder (dual diagnosis). This percentage is higher than that for health care professionals at HCC (46%), and significantly higher than the non-professional treatment population at HCC (28%). Of the forty-five attorneys, twenty-four (32%) were diagnosed with Major Depression, eleven (14.6%) with Bipolar Disorders and ten (13.4%) with Anxiety Disorders.

The MCMI-III personality testing scores were revealing. Of a total of 119 personality configurations identified among the lawyers tested (some had more than one), the Antisocial Personality Classification (disorder, trait or feature), occurred most, with twenty-one lawyers (17.6%) testing as Antisocial. Predictable also were the high number of attorneys (14) with a Narcissistic Personality configuration. Three results, however, seem quite surprising. The second most frequent personality configuration identified was the Dependent Personality, with twenty lawyers (16.8%) so classified. The DSM-IV defines Dependent Personality Disorder as "a pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears." This would seem a curious configuration in a care-giving profession where attorneys are expected to be solvers of other peoples' problems. High frequency was also found in the Schizoid (10.9%) and Avoidant (10%) Personality Classifications. The DSM-IV defines Schizoid Personality Disorder as "a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings." Avoidant Personality Disorder is defined as "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation." These personality configurations are likely problematic for attorneys, who are expected to be socially engaging and often verbally combative. Certainly, trial lawyers (who comprise a majority of the treatment patients) would be significantly hindered by these types of personality configurations. And yet most of the lawyers entering treatment reported having very successful and lucrative practices, and these reports are confirmed by collateral contacts.

The Axis II personality data breaks down as follows:

Type	Number	Percentage	DSM Prevalence
Antisocial	21	17.6	3% to 30%
Dependent	20	16.8	high

Narcissistic	14	11.7	2% to 16%
Schizoid	13	10.9	uncommon
Avoidant	12	10	10%
Borderline	9	7.6	10%
Obsessive-Compulsive	9	7.6	3% to 10%
Paranoid	7	5.8	2% to 10%
Depressed	6	5	n/a
Histrionic	4	3.4	10% to 15%
Sadistic	3	2.5	n/a
Passive-Aggressive	1	.8	n/a

Outcome

The average length of stay in treatment was 10.6 weeks, with a range from one day to nine months. Of the seventy-five patients, forty-eight (64%) successfully completed treatment and twenty-seven (36%) left AMA. (For the purposes of this study, the term "against medical advice" is given a broader meaning than is typical in the therapy setting, and includes all patients other than those who entirely accepted clinical recommendations for treatment, length of stay, and aftercare. For instance, a lawyer who came seeking and was admitted for one week of treatment, and who successfully completed that week, is herein nevertheless designated "AMA" if, at the end of the week he declined a recommendation for continued care.) Of the twenty-seven AMAs, eighteen occurred prior to institution of the formal Recovering Attorneys' Program; thus, 79% of the lawyers in the Recovering Attorneys' Program successfully completed treatment and followed aftercare recommendations, versus 47% successful completions pre-Recovering Attorneys' Program.

Four clients were re-treated at a later date; one was re-treated twice. Three of the re-treated patients had no further relapses. No follow up information was available relating to nine of the AMAs. Three are believed to be sober, per the monitoring agency. Eight have either self-reported or are reported to be in relapse since treatment. Four had periods of or are currently incarcerated, three have been subsequently disbarred and two suffered substance abuse-related deaths.

Of the forty-eight successful completions, forty-one (85.4%) are reported sober, evidenced by compliance under monitoring contracts, or having successfully completed a contract. Four are believed to be in relapse and no information was obtainable on the other three. Four of the successful completions currently have five or more years of documented sobriety; five have four plus years documented, one has three plus, five have at least two years sober; twelve have over one year sober, eight have six months or more and six are in their first six months of sobriety. Of the forty-one currently sober, twenty-nine report no relapse following treatment, while twelve report one or more relapses following treatment prior to achieving their current sobriety. These recovery figures, while much improved in comparison to the pre-Recovering Attorneys' Program data, nevertheless fall a little short of the success rates demonstrated for recovering medical professionals under five year monitoring contracts.[6] This may be due to the fact that health care professionals are typically more easily compelled to submit to treatment, and for lesser offenses, than their lawyer counterparts. Medical boards usually have broader and more stringent powers at their disposal to protect the public, and, collaterally, to require licensees under their purview to become rehabilitated. By comparison, state bar associations are lagging behind in this respect and, as a result, lawyers typically end up in treatment much later, only after progression of the alcoholism/addiction has produced catastrophic consequences.

DISCUSSION

Profile

Based on the foregoing, the typical attorney entering treatment is a male trial lawyer in his early forties, with a polysubstance addiction (often alcohol and cocaine), and who has a co-occurring mood disorder as well as a personality disorder complicating treatment. He is a veteran of multiple prior treatments, is often successful at work but rarely enjoys a satisfying home life.

The rate of psychological dysfunction and personality disorders were higher than one might expect, given the strenuous screening process inherent in becoming a member of the legal profession, although the occurrence of characterologic disorders in professionals has been documented elsewhere.[7] With respect to the personality testing, lawyers not surprisingly tested high on the antisocial and narcissistic scales. This is

consistent with the lawyer stereotype that includes notoriety for rationalizing behavior, forcing comprimise, and being unaffected by public opinion to the point of appearing egotistical. Such characteristics in measured doses can define a successful attorney. When unchecked, however, these personality configurations may become fixed. This may explain why these configurations appear with such frequency in the attorney population suffering from substance use disorders.

The high percentage of attorneys entering treatment who tested high on dependent, avoidant, and schizoid scales was startling. As described above, these are personality configurations one would anticipate hindering the successful practice of law. But such was not the case. It appears these individuals compensated for their personality proclivities by acting in a fashion contrary to their nature through classic psychological defense mechanisms such as sublimation of aggression, projection of internal conflicts, and denial of emotions aided by self-medication with alcohol or drugs of abuse. In some cases this balancing act lasted for years until overtaken by the consequences of uncontrolled substance use and the lawyer sought (or, more often, was compelled to seek) treatment. Many of these dysfunctional characteristics can aid a successful attorney in the short run. In the study population, however, these personality configurations exist in patients with substance-related disorders. This raises a philosophical question: does the profession itself demand coping mechanisms that compel individuals with normative personality structures to adopt pathological structures which in turn cause stress and subsequent self-medication, or, do certain dysfunctional personality types gravitate to an environment that allows them to exhibit personality pathology while masquerading as functional attorneys? We leave such questions for the personality theorists to ponder.

Suffice it to say that the large percentage of co-occurring Axis I and Axis II pathology in a professional population is alarming and may explain the higher relapse rate seen in attorneys when compared to healthcare professionals suffering from substance-related disorders.

Outcome

Treatment outcomes improved significantly following institution of the Recovering Attorneys' Program in the Fall of 1999. It is believed that the basis for this improvement may be found in the framework of the Program:

- impaired professional treatment with additional, lawyer-specific overlay services;
- Program oversight by director with both legal and clinical background;
- proactively addressing work, Bar and criminal (if any) issues.

The Program and treatment community are well-served by keeping lawyer-patients extra busy. Boredom and ennui are counterproductive in any treatment population; with attorneys too much downtime is often a recipe for clinical problems (e.g., revocations of consents, threats of lawsuit, AMAs). Lawyers in the Recovering Attorneys' Program have three extra group activities, an additional five hours, per week.

A program director or case manager with both legal and clinical experience is most helpful and is the centerpiece of the program. Lawyers typically enter treatment with practice issues that must be addressed. Often, the lawyer/patient will advise the clinical staff that every lawsuit/legal file left behind requires immediate attention, and that there exist myriad reasons to cut short, postpone or forego treatment altogether (with sometimes devastating consequences to the attorney's career should such argument prevail). Or, if the lawyer does acquiesce to treatment but fails to obtain any resolution of the law practice issues, he may never engage in the recovery process, being so preoccupied focusing on these external issues. On the other hand, there often are real problems that must be addressed, in order to avoid new or additional Bar grievances for client neglect. The key is to accurately discern between problems that need immediate attention, versus issues that are the product of the ever-present denial, rationalization and justification utilized by the substance use disorder patient. The typical clinician can not be expected to know the true state of a lawyer's practice: which trials really are going forward on the next docket, which real estate closings can no longer be continued and so on and so forth. And even if a therapist was able to discern crises from non-crises, what to do? The truth is, judges, mediators, opposing counsel, and even clients are usually accommodating if approached in the right way. This is why having dual disciplines is effective: the legal background aids in deciding which matters are urgent and who needs to be contacted, and the clinical background is helpful in convincing of the paramount importance and need for prioritization of treatment.

Further studies of a prospective nature are needed in order to identify the causal relationship between chemical dependency/mental health problems and the legal profession. However, both ethics and compas-

sion dictate that aggressive intervention cannot be withheld, but rather must be initiated immediately, given the large number of lawyers that may be suffering from either active or occult dependency or other mental disorders. This intervention should be initiated by state bar associations, which need to adopt a more active and confrontational role relating to its members' substance abuse and mental health issues. The intervention should then take the form of comprehensive chemical dependency and mental health assessment followed by, when dictated, lawyer specific primary and extended care treatment, and aftercare monitored by the state's lawyers' assistance program.

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