



Prescription Medication: Abuse, Addiction and Complicating Factors for Attorneys

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Cindy is a 37 year old attorney, mother of two, married and working full time for a large law firm. Cindy has struggled to maintain her assumptions that she can make the billable hours towards the partnership track, meet the needs of her children in a way that her stay at home mother met hers, keep physically fit and be a supportive partner to her husband. She started taking Vicodin, prescribed by her physician, following surgery for a knee injury. Cindy noticed that she began needing more Vicodin to manage her pain than her physician was willing to prescribe. She started borrowing Vicodin from friends and family members in order to feel better because when she didn't take enough medication she began to feel physically ill. She reported the Vicodin gave her more energy and allowed her to be more productive at work, and assisted her in keeping up with the kids and her home responsibilities. She resorted to buying her Vicodin off the internet in order to have enough of the medication to feel functional. Over time, the quality of her work was slipping, the pressure and tension in her life was rising and the relationship with Vicodin as the solution was deepening. Eventually, Cindy found herself in a colleague's office crying and explaining that trying to obtain enough Vicodin had taken over her life. This task consumed her thoughts and behaviors each day and the pills no longer gave her the relief she sought. Her colleague arranged for Cindy to meet confidentially with the State Bar's Wisconsin Lawyers Assistance Program (WisLAP) Coordinator. Cindy had developed an addiction to the medication her physician had prescribed for her.

Most people take their prescription medications as prescribed. However, according to the National Center on Addiction and Substance Abuse at Columbia University, over 14 million Americans admit to abusing prescription drugs. Reportedly that number doubled between 1992 and 2003 and has tripled among teenagers. In 2006, a Madison, Wisconsin task force reported that prescription medications are making their way into the streets of Madison and surrounding communities.¹ The abuse of prescription medications, as well as dependence on these medications, is on the rise. One of the challenges for attorneys is recognizing that abuse of prescription medications can lead to addiction. Most people assume that prescribed medications are safe and cannot result in physical or psychological addiction. But if the

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directions are not followed or if the use is long term, there can be problems. Statistics cited by the American Bar Association illustrate that attorneys have twice the rate of substance dependence compared to the general population; attorneys may be more vulnerable to dependence upon prescription medications.

The National Institute on Drug Abuse states that the most commonly abused prescription medications fall into three categories; the Opioids, which are prescribed for pain, such as Vicodin, Oxycodone, Hydrocodone and OxyContin; the Central Nervous System (CNS) depressants often prescribed for anxiety or sleep problems, such as Clonazepam, Valium, Xanax and Lorazepam; and the Central Nervous System stimulants frequently prescribed for attention deficit, such as Ritalin, Adderall and Dexedrine.

Living with chronic pain or any chronic medical or mental health condition, coupled with the stress of life may motivate drug seeking behavior in a misguided attempt to improve quality of life. However, for Cindy and an increasing number of others, this often results in a reduced quality of life, as addiction to the medication can leave the person with yet another illness to treat.

Defining Addiction

Addiction is simply defined as compulsive use of a substance despite the negative consequences resulting from the use. However, in reality addiction is a complex illness that can be difficult to identify and to treat effectively. Similar to other substances of abuse, prescription medications such as the Opioids, and the CNS depressants and stimulants, activate the reward system circuitry of the brain. When this reward circuit is activated the brain notes that something important is happening. The pleasurable effect of the medication is perceived as a reward and this tells the brain to look for that feeling again. With repeated use, resulting in repeated rewards, the system looks for increased amounts of pleasure from the medication and eventually dulls the effects of naturally rewarding behaviors such as exercising, eating or sex. Thus the person takes more of the medication seeking to maintain or increase the reward, but eventually the attainment of pleasure eludes them yet the craving for pleasure continues due to the reward system within the brain. The body can become physiologically dependent upon the medication demonstrating the development of tolerance where more of the substance is needed to gain the same desired effect. When the person tries to reduce or arrest their use, they experience withdrawal and quickly learn that by returning to use or increasing their amount they can feel better simply by warding off the physiological withdrawal. This response is both physiologically and psychologically reinforcing. Psychologically the person believes that the use of the substance is helping them; this belief contributes to compulsive use. With alcohol or drug dependence the person is typically using to seek a state of “normalcy” only to find a vicious cycle of using, withdrawing and or craving, seeking, using and so forth. Hence, Cindy ended up in the circular cycle of an addiction. She was seeking relief from her troubles when in truth the proposed source of the relief was prohibiting relief from the pain while her brain reward circuitry produced intense cravings for the medication. This resulted in drug seeking behaviors and an overall decrease in her functioning. Substance dependence is defined in the scientific literature as a medical illness because the brain chemistry and functioning has been altered leaving certain functions of the brain dysregulated. Recent research postulates this dysregulation remains permanent and requires abstinence from use for stabilization.²

Summarizing from the Diagnostic Manual of Mental Disorders, the DSM-IV-TR:

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

- Tolerance- needing more of the substance to get the same desired effect over time or a diminished

effect with continued use of the same amount;

- Withdrawal- manifested by the presence of physical and/or psychological symptoms upon cessation of use or a reduction in use;
- The person often takes a larger amount of the substance than they intended to;
- Unsuccessful attempts to reduce or arrest the use of the substance;
- A great deal of time is spent in activities to obtain the substance;
- Important social, occupation or recreational activities are given up or reduced due to the use of the substance; and
- The person continues to use the substance despite knowledge that it is likely to cause or exacerbate physical or psychological problems.³

Co-Occurring Disorders

Prescription drug dependence, along with other substance dependence, frequently contributes to other conditions such as depression, bringing with it fatigue, problems with concentration, sleep and appetite disturbance, feelings of hopelessness and helplessness and thoughts of death or dying. When this happens it is not uncommon for the person, most often women, to seek treatment for the depression without divulging the drug seeking and using behaviors in yet another attempt to solve the problem. However, treatment for depression is most successful when the brain receptors are available to engage the medication being prescribed and when cognitively the person is not under the influence of a mood altering substance. When another substance is being abused, the brain may not be able to benefit from the antidepressant or do the process therapy (i.e., talk therapy) necessary for improved mood. Without disclosure, the treatment provider is often on a fishing expedition trying to offer relief without knowing all contributions to the disturbance. Likewise, people who suffer from clinical depression or other mental illness may self medicate with substances, such as alcohol, in order to numb the severity of the symptoms. Research demonstrates the compulsive use of an addictive substance can result in substance dependence.

According to a 2004 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) 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%).⁴ In most instances both disorders must be addressed as primary illnesses and treated as such for optimal results and stabilization.

Substance dependence and mental illness among attorneys is also correlated with disciplinary complaints and troubles. A 2001 Oregon study demonstrated that malpractice and discipline complaint rates for lawyers, before recovery, are nearly four times greater than those in recovery.⁵ An ABA study indicated that more than 50 percent of all disciplinary cases involve impaired lawyers.⁶ It isn't hard to believe that the incidence of malpractice insurance claims is significantly higher among impaired attorneys. This data lends itself to place attention on prevention of addiction or mental illness among legal professionals. One might start by assessing "how" we reduce tension in our lives. If we engage in using an addictive substance to reduce tension or solve a problem we augment the chances of imbalance and decreased well-being both personally as well as professionally.

Denial

Recognition of the core problem(s) is difficult for others to identify and understand but it typically is even more of a challenge for the attorney who is impaired. Lawyers suffering from substance dependence or mental illness often deny they have a problem. Denial is considered a significant component in the illness of addiction. Considering the involvement of the brains reward circuitry and the psychological belief that the substance is what is promoting the ability to cope and function, denial of substance use as the primary

problem seems inevitable. If the problem is acknowledged then the person may have to face physiological withdrawal and intense fear of exposure which they often believe threatens their job, reputation and competence in their role as a mother, father, lawyer, community leader and so forth. In addition, shame is a powerful emotion that feeds denial as a self-protective mechanism. Attorneys are particularly noted for their intellectual ability to win an argument with all of their skills to deny, defend, articulate reason and justify cause. When they apply those same skills to justifying the use of a substance as necessary for survival their sophisticated denial system quickly deflects typical intervention strategies. Couple this with the culture of practicing law, a profession which doesn't readily lend itself to the identification of an impaired attorney and problems multiply. Lawyers are in the helping profession, they are to be in the position of providing expertise and fixing other people's problems. There is little room within their role for identification of themselves or others as impaired professionals. Ironically, there is little room for identification of themselves as human beings who require balance in order to function optimally. A close look at the curriculum and grading practices of the law schools should amply demonstrated this point. Striving for perfection, achievement and winning is inherent in the law school culture and documented as part of the typical attorney personality.^{7,8,9} This culture and way of doing life can continue into their professional career and may contribute to imbalance and dysfunction.

Contributions to imbalance

Some attorneys may push themselves beyond their capabilities; some question whether this drive contributes to the higher rate of substance dependence and mental illness among attorneys. Attorneys are human beings first. Self determination theory (STD) proposes that human beings have three primary psychological needs: the need for competence, autonomy and relatedness.¹⁰ For attorneys this might translate to: what I do I do well, I have control over what I do and I don't work or live in a vacuum as I have quality interpersonal relationships. According to SDT when these needs are met in a balanced way the result is increased motivation for doing life along with enhanced mental health and well-being. In reverse, when these needs are diminished the person becomes less motivated, is more prone to imbalance such as mental health or substance use problems and significantly decreased well-being. SDT defines two types of motivation. *Intrinsic motivation* is defined by Ryan and Deci as "engagement in an activity for the purpose of gaining inherent satisfaction from the activity itself or to further a goal which is central to one's belief system. In simpler terms: I do it because I like to do it, it makes sense to do it and when I do it I want to do more of it. SDT states that intrinsically motivated behavior feeds us and increases our motivation to continue the behavior. In contrast, *extrinsic motivation* is defined by Ryan and Deci as "behavioral choices made primarily to gain a later reward, please or impress other people or relieve a sense of guilt or fear". Simpler definition: I do it because I believe I have to even though I don't want to. SDT proposes that extrinsically motivated behavior can depreciate motivation particularly if the reasons for engaging in the behavior do not make sense or the person doesn't agree with them.

SDT postulates that social-contextual conditions surrounding a person, such as dynamics within the culture or environment, can be a major factor contributing to motivation and to effectively getting psychological needs met for competence, autonomy and relatedness. In the life of an attorney this could play out like this: if the attorney works and lives within an environment that fosters autonomy with support, self initiative is acknowledged and encouraged, there is an understanding of extrinsic motivators and the environment fosters interconnectedness between others there is a greater likelihood of psychological well-being. Does that sound like the environment within a law firm or that of a solo practitioner? According to SDT environments that depreciate motivation are those that are controlling and demanding (required billable hours) denies self-initiative (take whatever cases come your way), decreases the sense of competence (will I ever make partner or be financially stable) and fosters isolation (competition with peers or not enough time

with loved ones).

One might be astute to state that the culture of practicing law, coupled with the typical personality traits of an attorney, attenuates attorney well-being; possibly contributing to mental illness or substance dependence. This could be mitigated if the attorney is calculative about working towards balance on a daily basis to provide for engagement in activities and relationships that will foster competence, autonomy and relatedness; along with tempering their drive for perfection, achievement and meeting the bottom line.

Change

Attorneys need to go towards the parts of this challenge that they can impact as there is so much in life which is beyond our control. As Albert Einstein put it “insanity is doing the same thing over and over again and expecting different results”. Whether you have developed an addiction or your life is out of balance in some other quadrant you may need to engage in change. A change in life style, work patterns, assumptions and expectations may be required. Change can be hard; possibly because change requires us to take a risk and realign our thoughts and behaviors and this feels unfamiliar. Unfamiliar can feel wrong and often we quickly acclimate back to the same thoughts and behaviors that feel familiar which prevents improvement and stabilization. Within this framework change requires tolerating an uncomfortable feeling without reverting back to our typical cognitive, emotional and behavioral routines. Change requires suffering and suffering is hard, therefore the task becomes how to “do hard” in a functional way and long enough so change becomes possible and long term rewards materialize.

The etiology of addiction is currently under research and has been for many years. It is well documented that the development of an addiction can have a multitude of origins. Genetics, brain chemistry, stressors, life styles and using patterns can all contribute. We can all acknowledge that our jobs, families, personalities and life events can result in stress. Chronic stress results in tension in our lives. The way we reduce tension can contribute to balance or imbalance. If we use substances to reduce tension, or not as prescribed, this behavior may contribute to the development of an addiction and or mental illness. The risk increases if we are predisposed to these conditions by our family histories and genetic markers.

Conclusion

Cindy did not ask for this addiction, nor did she believe she developed it by engaging in immoral, illogical or otherwise irrational behavior. She was trying to fix a complex problem in her life, the problem of pain, the need to be functional and effective in spite of it, the fear of her life being out of control and a decreasing sense of competence. However, the way she attempted to solve the problem, by surreptitiously taking more medication than prescribed, seeking that medication outside of her prescribing physician and eventually obtaining it illegally through the internet, resulted in hurting her more than helping her. This is not an uncommon road to addiction. Alcohol and other drugs, including prescription medications are sometimes sought as a way to reduce tension resulting from the problems and events in our lives. Anyone who has experienced an addiction or mental illness will likely share with you the illness did not increase their sense of competence, their sense of control or improve their interpersonal relationships. So often addiction and mental illness, when left untreated, results in ruination of a life and of the lives of those attached to the one with the illness.

Who is at risk? Attorneys and others can ask themselves the following questions to screen for a potential problem:

- Do you ever use more of your medication than prescribed? Do you ever use more of any substance

than you intend to?

- When you stop taking your medication, or stop using a substance, do you experience any aches or pains, nausea, vomiting, tremors, fatigue, anxiety or insomnia?
- Have you had unsuccessful attempts to reduce or arrest your substance use?
- Do you ever borrow prescribed medication from a friend or family member?
- Have you ever bought prescription medication on the internet?
- Does your use of medication, or the use of any substance, ever negatively affect your ability to work, care for your family or your social life?
- Is anyone in your life concerned about your prescription medication use, or your use of any substance? Are you concerned about it?
- Do you continue to use substances even though you know they are not good for your other medical or psychological conditions?

If the answer is 'yes' to any of these questions, then seek consultation from a qualified health care professional or make a confidential call to the WisLAP Program.

Lawyer assistance programs

The first lawyer assistance programs were established in the mid 1970's and early 1980's. These programs initially focused on lawyers who were impaired due to substance abuse and dependence. Groups of lawyers, some of whom were in recovery from alcohol or drug dependence volunteered to assist their colleagues find recovery and stabilization. The dedication of these lawyers led to an invaluable resource for those in the profession of law. Lawyer assistance programs have currently expanded to address mental health concerns as well as multiple troubles a judge, lawyer or law student may experience which decreases their well being and ability to practice law.

Cindy did meet with the WisLAP Coordinator, was evaluated confidentially and then referred to an appropriate treatment program. She worked with her medical provider on pain management. A trained WisLAP attorney volunteer continued to meet with Cindy to provide support and guidance as she struggled to make needed changes in her life. Cindy also chose to attend a local support group which proved to be invaluable to her recovery.

WisLAP is a member service of the State Bar of Wisconsin which provides confidential assistance to lawyers, judges, law students and their families in coping with alcoholism or other addictions, mental illness, or other problems related to or affecting the practice of law. WisLAP has trained attorneys and judges who serve as peer assistants. WisLAP staff and volunteers are exempt from reporting misconduct under SCR 20:8.3. and SCR 60.04(3). The program is based upon lawyers helping lawyers and judges helping judges. WisLAP is designed to help legal professionals build on their strengths and provide support through the enhancement of physical, mental and emotional health. Confidential support and guidance is available 24/7 by calling 800-543-2625, or by contacting Linda Albert, the WisLAP Coordinator, at lalbert@wisbar.org or 800-444-9404 ext 6172.

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Endnotes

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