
**REDUCING THE STIGMA: THE DEADLY EFFECT OF
UNTREATED MENTAL ILLNESS AND NEW STRATEGIES
FOR CHANGING OUTCOMES IN LAW STUDENTS**

Joan Bibelhausen, Katherine M. Bender,
and Rachael Barrett[†]

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[†] Joan Bibelhausen, JD, Executive Director, Lawyers Concerned for Lawyers, Minnesota's Lawyer Assistance Program; Katherine M. Bender, PhD, Programming Director, Dave Nee Foundation; Rachael Barrett, MBA, Executive Director, Dave Nee Foundation.

I. INTRODUCTION

Depression, alcohol use, and suicide occur at a greater frequency in the legal profession than for the rest of the population. The good news is that there are individuals and organizations addressing these problems head on. This Article will discuss how stigma discourages members of the legal profession from seeking mental health treatment and what is being done and can be done to change this. First, this Article will provide a brief description of the Dave Nee Foundation, which is dedicated to reducing that stigma. Next, this Article presents information and statistics about the prevalence of mental health issues and suicide in the legal field. Finally, this Article discusses how to overcome barriers to seeking assistance and provides resources to get help.

II. THE DAVE NEE FOUNDATION

Friends and family established the Dave Nee Foundation¹ in 2006 after the death by suicide of Dave Nee. Dave was a Fordham law student beloved by many. He was a student leader and active in moot court. To the shock of all who loved him, Dave died by suicide shortly after graduation, while he was studying for the bar exam. Dave's death was the first time his friends learned of his struggle with depression. Fueled by their grief, Dave's friends and family established a non-profit corporation whose mission is to raise awareness among law students and reduce the stigma associated with mental health treatment. The Foundation encourages help-seeking behaviors and provides safe spaces for law students to share their struggles without fear of professional consequences.

The Foundation collaborates with more than thirty law schools, as well as lawyer assistance programs and mental health professionals around the country to raise awareness about mental health concerns. Through its programming effort, *Uncommon Counsel*,² the Foundation conducted presentations at law schools and reached over 1400 students, faculty, and administrators in the 2013–14 academic year.

1. DAVE NEE FOUND., <http://www.davneefoundation.org> (last visited Nov. 30, 2014).

2. *Uncommon Counsel*, DAVE NEE FOUND., <http://www.davneefoundation.org/uncommon-counsel> (last visited Nov. 30, 2014).

III. STIGMA AND STIGMA REDUCTION

Stigma refers to a feeling of disgrace or fear, often experienced by those with a mental health condition.³ According to the Centers for Disease Control (CDC), “this stigmatized trait sets the bearer apart from the rest of society, bringing with it feelings of shame and isolation.”⁴

The isolation felt by those with mental health issues belies the prevalence of mental illness in the United States. According to the U.S. National Institute of Mental Health, in 2012, there were an estimated 43.7 million Americans (or almost one in five adults) who experienced any mental illness (AMI) in the past year.⁵ This represented 18.6% of all U.S. adults.⁶ The criteria for AMI includes adults with a “mental, behavioral, or emotional disorder (excluding developmental and substance use disorders)” diagnosable currently or within the past year and of sufficient duration to meet diagnostic criteria specified within the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*.⁷ An individual experiencing AMI may have no impairment or a mild impairment, but there is a continuum. Of those 43.7 million U.S. adults, 9.6 million, or 4.1%, live with a serious mental illness (SMI).⁸ An SMI can result in disability and represents the commonly held stereotype of what constitutes mental illness (e.g., schizophrenia, major depression, or bipolar disorder).⁹

There are two types of stigma associated with those suffering from mental health concerns: anticipated self-stigma and perceived public stigma. “Perceived public stigma refers to discrimination and devaluation by others, and anticipated self-stigma refers to internalization of negative stereotypes about people who seek

3. WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY 1788 (Jean L. McKechnie ed., 2d ed. 1983).

4. *Stigma and Illness*, CENTERS FOR DISEASE CONTROL, http://www.cdc.gov/mentalhealth/about_us/stigma-illness.htm (last visited Nov. 30, 2014).

5. *Any Mental Illness (AMI) Among Adults*, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (last visited Nov. 30, 2014).

6. *Id.*

7. *Id.*

8. *Serious Mental Illness Among U.S. Adults*, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/serious-mental-illness-smi-among-us-adults.shtml> (last visited Nov. 30, 2014).

9. *Id.*

help.”¹⁰ Most public awareness campaigns attempt to de-stigmatize public perception of mental illness.¹¹ This approach often employs contact strategies (contact with persons with mental illness) or social activism.

Researchers at the Illinois Institute of Technology (IIT) have investigated the efficacy of the three most common methods to address stigma.¹² These three methods are: (1) education to replace stereotypes with accurate information (e.g., public awareness campaigns), (2) facilitated interpersonal discussions with members of the stigmatized group, and (3) activism or protesting to call attention to those engaged in stigmatizing behaviors.¹³ IIT found that,

[o]verall, both education and contact had positive effects on reducing stigma for adults and adolescents with a mental illness. However, contact was better than education at reducing stigma for adults. For adolescents, the opposite pattern was found: education was more effective. Overall, face-to-face contact was more effective than contact by video.¹⁴

Research into understanding effective public strategies to reduce stigma is underway, but less understood are mechanisms to reduce or eliminate self-stigma. Developing methods to reduce self-stigma is critical. Achieving this understanding is crucial because while public stigma may not be a barrier to help-seeking behavior in all cases, self-stigma seems to reduce the likelihood of seeking help.¹⁵ This is not to suggest the sheer dint of continued research will eliminate public stigma. The recent death by suicide of actor Robin Williams in August of 2014 displayed the continued need to raise awareness and educate the public on the complexities of mental illness and its ability to affect individuals across the

10. Elise Pattyn et al., *Public Stigma and Self-Stigma: Differential Association with Attitudes Toward Formal and Informal Help Seeking*, 65 *PSYCHIATRIC SERVICES* 232, 234 (2014).

11. See Patrick W. Corrigan et al., *Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies*, 63 *PSYCHIATRIC SERVICES* 963, 963 (2012).

12. *Id.* at 963–64.

13. *Id.*

14. *Id.* at 963.

15. John Lally et al., *Stigma of Mental Illness and Help-Seeking Intention in University Students*, 37 *PSYCHIATRIC BULL.* 253, 253 (2013).

spectrum.¹⁶ There remains much work to be done to reduce public stigma, which may contribute to self-stigma as individuals internalize negative perceptions.

Self-stigma may also contribute to under reporting the prevalence of AMI. “Research indicates that people who are in need of help often fail to use helping resources because it represents an open admission of inadequacy.”¹⁷ If one considers the impact of self-stigma on reporting, the incidence of AMI (18.6%) may be even greater than reported.

As mentioned above, effective methods to reduce self-stigma have not been developed. Work to address this gap in understanding is currently underway at Iowa State University, which is host to the Self-Stigma Research Collaborative.¹⁸ The Collaborative reported, “According to some estimates, within a given year, only 11% of those [with] a diagnosable problem seek psychological services.”¹⁹ Only 2% of those whose issues are not diagnosable seek treatment.²⁰ Meanwhile, individuals will continue to resist help seeking even when the suffering is severe and increasing.²¹ Finally, the Collaborative noted “that individuals are less likely to ask for help from nonprofessional sources, such as friends, if they fear embarrassment or if asking for help would lead them to feel inferior or incompetent.”²²

Stigma, either public or self, influences an individual’s ability to seek help.²³ For law students, the barrier to help seeking related to self-stigma is compounded by fear of professional consequences. This is strongest with respect to the character and fitness questions on state bar applications and the ensuing investigation if the applicant reveals that he or she has sought help. The process is

16. See generally Matthew Stucker, *Robin Williams’s Death Ruled Suicide*, CNN (Nov. 11, 2014 8:18 PM), <http://www.cnn.com/2014/11/07/showbiz/robin-williams-autopsy/>.

17. Aphroditi Zartaloudi & Michael Madianos, *Stigma Related to Help-Seeking from a Mental Health Professional*, 4 HEALTH SCI.J. 77, 81 (2010).

18. See generally Self-Stigma Research Collaborative, *Welcome to the Self-Stigma Research Collaborative*, IOWA ST. U., <https://selfstigma.psych.iastate.edu/> (last visited Feb. 6, 2015).

19. Self-Stigma Research Collaborative, *Self-Stigma Information*, IOWA ST. U., <https://selfstigma.psych.iastate.edu/information> (last visited Jan. 19, 2015).

20. *Id.* (citation omitted).

21. See *id.* (citation omitted).

22. *Id.* (citations omitted) (see section titled “The Role of Self-Stigma”).

23. Pattyn, *supra* note 10, at 1.

typically rigorous and the difficulty and fear is compounded by the fact that questions are asked and assumptions are sometimes made by examiners who are not trained in mental health issues.

In 1994, the American Bar Association (ABA) adopted a resolution to encourage state and territorial bar examiners to revise their character and fitness standards in the area of mental health.²⁴ Specifically, the resolution called on states and territories to “tailor questions concerning mental health and treatment narrowly in order to elicit information about current fitness to practice law, and take steps to ensure that their processes do not discourage those who would benefit from seeking professional assistance with personal problems and issues of mental health from doing so.”²⁵

Character and fitness tests are designed to safeguard and strengthen the credibility of the profession as well as to protect clients and the public from any misdeeds that might be attributed to an attorney’s mental health status.²⁶ While these are legitimate goals, the unintended consequences have a chilling effect for law students and attorneys with mental health issues. Gaining acceptance into and maintaining one’s status in the bar weighs heavily upon students and attorneys who are struggling with depression or other mental illnesses.

Since 1994, there has been uneven progress among bar examiners to tailor questions as suggested by the ABA.²⁷ Anecdotal evidence suggests that the character and fitness standards continue to discourage law students from sharing their histories and seeking and obtaining care. Specifically, the Dave Nee Foundation found that sixty-four percent of attendees of its Uncommon Counsel presentations who completed feedback forms agreed or strongly agreed that most law students do not get help when needed for fear of the professional consequences.²⁸

24. Henry R. Turnbull III et al., *American Bar Association Bar Admissions Resolution: Narrow Limits Recommended for Questions Related to the Mental Health and Treatment of Bar Applicants*, 18 MENTAL PHYSICAL DISABILITY L. REP. 597, 597 (1994).

25. *Id.* at 598.

26. Laura Rothstein, *Law Students and Lawyers with Mental Health and Substance Abuse Problems: Protecting the Public and the Individual*, 69 U. PITT. L. REV. 531, 533 (2008) (providing a comprehensive review of the context for character and fitness rules).

27. *Starr Initiative on Character and Fitness*, DAVE NEE FOUND., <http://www.daveneefoundation.org/programs/starr-initiative-on-character-and-fitness/> (last visited Jan. 19, 2015).

28. *Id.*

Concerned about the use of mental health questions in the bar exam, the Vermont Human Rights Commission sought clarification from the Civil Rights Division of the U.S. Department of Justice (DOJ).²⁹ In the ten-page response, dated January 21, 2014, the DOJ identified the need to ensure that individuals admitted into practice are “competent to practice law and worthy of the trust and confidence clients place in their attorneys.”³⁰ The DOJ acknowledged that “questions and inquiries based on an applicant’s *status* as a person with a mental health diagnosis do not serve the worthy goal of identifying unfit applicants, are in fact counterproductive to ensuring that attorneys are fit to practice, and violate the standards of applicable civil rights laws.”³¹ Finally, the letter made clear the need to protect an individual’s privacy should his or her mental health records be required to determine fitness to practice:

[G]iven the liberty interest that courts have recognized in the privacy of highly personal medical information, an applicant’s medical records, or information about her diagnosis, treatment history, or prognosis, should not be disclosed or otherwise become part of the public record. Among other harms, exposing this information to the public creates a chilling effect that could deter individuals with disabilities from pursuing the legal profession or seeking treatment, and reduces employment opportunities available to lawyers with disabilities by allowing their prospective employers to access information about their disability to which employers would not otherwise be entitled.³²

The last sentence speaks most clearly to the detrimental effects of intrusive questions into one’s mental health status.

A letter dated February 5, 2014, from the DOJ followed the letter to the Vermont Human Rights Commission.³³ This letter was

29. *See generally* Letter from Jocelyn Samuels, Acting Assistant Att’y Gen., to Karen L. Richards, Exec. Dir. Vt. Human Rights Comm’n (Jan. 21, 2014), <http://psychrights.org/2014/140121USDoJLtr2VtHumanRightsCommn.pdf>.

30. *Id.* at 1.

31. *Id.*

32. *Id.* at 9 (citation omitted) (citing *Whalen v. Roe*, 429 U.S. 589, 600 (1977)).

33. Letter from Jocelyn Samuels, Acting Assistant Att’y Gen., to Bernette J. Johnson, Chief Justice, La. Supreme Court, Elizabeth S. Schell, Exec. Dir. La.

released after an investigation into possible violations of the Americans with Disabilities Act (ADA) prompted by a complaint filed by the Bazelon Center for Mental Health Law on behalf of two Louisiana attorneys.³⁴ The letter identified the Louisiana Supreme Court's need to ensure that licensed attorneys are competent, but called into question whether or not "questions based on an applicant's *status* as a person with a mental health diagnosis . . . serve[d] the Court's worthy goal of identifying unfit applicants."³⁵

In August 2014, the DOJ announced, as a follow up to its earlier letter to Louisiana, that it entered into a settlement agreement with the Louisiana Supreme Court. For the DOJ, the agreement "ensures the right of qualified bar applicants with mental health disabilities to have equal access to the legal profession as required by the [ADA]."³⁶

The settlement agreement is likely to put some states with practices similar to Louisiana "on notice."³⁷ Although progress made by individual state bar examiners remains mixed and uneven, law students' perceptions of the professional licensure process and their reluctance to seek help for mental health concerns suggest that whatever changes may be made in policy, the cultural attitude of the legal system—the legal system's public stigma around mental health concerns—continues unabated. Until this is addressed, including greater bar examiner awareness of mental health issues, combined with an effort to engage students and support their self-motivated help seeking, struggling law students will continue to suffer needlessly.

Supreme Court Comm. on Bar Admissions & Charles B. Plattmier, Chief Disciplinary Counsel, La. Att'y Disciplinary Bd. (Feb. 5, 2014), <http://www.ada.gov/louisiana-bar-lof.pdf>.

34. *Id.* at 2–3.

35. *Id.* at 1.

36. Press Release, U.S. Dep't of Justice, Department of Justice Reaches Agreement with the Louisiana Supreme Court to Protect Bar Candidates with Disabilities (Aug. 15, 2014), <http://www.justice.gov/opa/pr/departement-justice-reaches-agreement-louisiana-supreme-court-protect-bar-candidates>; *see also* Settlement Agreement Between the United States of America and the Louisiana Supreme Court Under the Americans with Disabilities Act (Aug. 14, 2014), http://www.ada.gov/louisiana-supreme-court_sa.htm.

37. Press Release, Judge David L. Bazelon Ctr. for Mental Health Law, Bazelon Center's Complaints Result in Agreement Ending Discrimination Against Bar Applicants Based on Mental Health Conditions (Aug. 15, 2014), <http://www.bazelon.org/News-Publications/Press-Releases/8-15-14-LA-Bar-Applicant-Complaints-Settlement.aspx>.

In 2014, the ABA Commission on Lawyer Assistance Programs, with support from the ABA Law Student Division; Solo, Small Firm, and General Practice Division; Young Lawyers Division; the Commission on Disability Rights; and the Dave Nee Foundation, sponsored the 2014 Survey of Law Student Well-Being.³⁸ In this survey, students from fifteen law schools were asked about their alcohol and drug use, mental health, and help-seeking attitudes.³⁹ The study launched in the spring of 2014.⁴⁰ The survey asked students to rate factors that would possibly discourage law students from seeing a mental health professional.⁴¹ The factors most important to the scope of this Article include threat to job or academic status (48.3%), social stigma (46.6%), potential threat to admission to the bar (45%), and concern about privacy (29.6%).⁴²

It is important to understand the extent of mental health issues within the legal field. To that end, the next section of this Article will provide an overview of mental health, including general and specific descriptions of depression, anxiety, and addiction, as well as how these manifest in lawyers and law students.

IV. MENTAL HEALTH

It is beyond the scope of this Article to define and describe all mental health conditions; however, an overview will provide context for understanding stigma and perhaps recognizing that help is needed. Of pertinence are mood, anxiety, and substance use disorders. Accordingly, this Part will explain the general characteristics of each based on the *Diagnostics and Statistical Manual of Mental Disorders (DSM-V)*.⁴³

38. Katherine Bender, 2014 Survey of Law Student Well-Being (2014) (unpublished survey) (on file with Dave Nee Foundation). The survey included 3400 respondents. *Id.* Contact Katherine Bender of the Dave Nee Foundation at kbender@daveneefoundation.org for more information on the survey and results.

39. *Id.*

40. *Id.* The study was launched and principally investigated by David Jaffe, assistant dean of students at American University Washington College of Law, and Jerry M. Organ, law professor at the University of St. Thomas School of Law (Minnesota). *Id.* Mr. Jaffe and Mr. Organ, along with the programming director of the Dave Nee Foundation, have presented the findings at conferences, including the 2014 ABA Commission on Lawyers Assistance Programs conference in Nashville.

41. *Id.*

42. *Id.*

43. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL

Mood disorders, as implied by the title and as defined in the *DSM-IV*, encompass the emotional state of an individual for a length of time.⁴⁴ While the *DSM-IV* used the term “mood disorders” to describe both depressive disorders and bipolar disorders,⁴⁵ the *DSM-V* makes a distinction between “bipolar and related disorders” and “depressive disorders.”⁴⁶ Although we may often hear friends or colleagues refer to “bipolar” or depression, it is important to clarify what in fact those diagnoses entail.

Throughout any given day, people without depressive disorders and without a bipolar or related disorder, may experience states of happiness, sadness, or anger. Someone with a depressive disorder, by contrast, tends to experience primarily sadness.⁴⁷ For depressive disorders, this means a person would experience emotional states of primarily sadness, emptiness, loneliness, tiredness, or irritability, for a period of at least two weeks.⁴⁸ In addition to an overall emotional state of sadness for at least two weeks, other symptoms such as changes in sleep patterns, food intake, or concentration levels must be present.⁴⁹ When determining whether a person has a depressive disorder, it is important to rule out any medical conditions, such as thyroid disorders, that may cause similar symptoms.⁵⁰

Some depressive disorders include major depressive disorder, persistent depressive disorder (dysthymia), premenstrual dysphoric

DISORDERS (5th ed. 2013) [hereinafter *DSM-V*].

44. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 324–428 (4th ed. 2000) [hereinafter *DSM-IV*].

45. See *id.*

46. See *DSM-V*, *supra* note 43, at 123, 155; see also Matthew R. Buckley, *DSM-5: Exploring New Clinical Perspectives*, NBCC Foundation Webinar Series: Innovations in Counseling Part 3 (Jan. 23, 2015) (unpublished webinar presentation) (on file with author). For more information on the NBCC Foundation's webinar series, *Innovations in Counseling*, visit www.nbccf.org/Webinars/Innovations.

47. See generally Konstantinos N. Fountoulakis, *The Emerging Modern Face of Mood Disorders: A Didactic Editorial with a Detailed Presentation of Data and Definitions*, *ANNALS GEN. PSYCHIATRY* (April 12, 2010), <http://www.annals-general-psychiatry.com/content/pdf/1744-859X-9-14.pdf>.

48. *DSM-V*, *supra* note 43, at 160–61.

49. Rudolf Uher et al., *Major Depressive Disorder in DSM-5: Implications for Clinical Practice and Research of Changes from DSM-IV*, 31 *DEPRESSION ANXIETY* 459, 461 (2014).

50. See, e.g., *DSM-V*, *supra* note 43, at 155.

disorder, and other specified or unspecified depressive disorders.⁵¹ Distinctions between these types of depressive disorders depend on the severity of the symptoms and the length of time and number of days one feels depressed.⁵² Persistent depressive disorder or dysthymic disorder is defined as “[d]epressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years,”⁵³ while major depressive disorder may be described as more severe depressive symptoms with periods of reprieve from the depressed episodes.⁵⁴ One mnemonic devised for use to determine depressive episodes is SIGECAPS, which refers to problems with sleep, interest, guilt, energy, concentration, appetite changes, psychomotor agitation, and suicidality that are experienced by people with depression.⁵⁵

The distinction between depressive disorders and bipolar disorders is important to understand. When someone is diagnosed with a bipolar disorder it means that in addition to experiencing severe depressive episodes, the person also experiences states of mania or hypomania.⁵⁶ In a manic state or episode, one would experience symptoms of “abnormally, persistently elevated . . . mood and persistently increased activity or energy.”⁵⁷ The person would also experience three of the following symptoms or behaviors paraphrased from the *DSM-V* for the purposes of this Article: very talkative, no need for sleep, reckless behavior, inflated sense of self, racing thoughts or increased distractibility.⁵⁸ It is again important to rule out any thyroid or medical condition that could cause similar symptoms.⁵⁹ Similarly, it is important to make sure that these episodes cannot be accounted for by substance use.⁶⁰

In addition to depressive and bipolar and related disorders, it is important to review anxiety disorders. Anxiety, like sadness, is a feeling that most people experience. However, anxiety in and of itself is not a disorder. Anxiety can be a disorder when it becomes

51. *Id.*

52. *See id.*

53. *Id.* at 168.

54. *See id.* at 165.

55. Amy Cheung et al., *Is Your Young Patient Suffering in Silence?*, 58 J. FAM. PRAC. 187, 189 (2009).

56. *See DSM-V, supra* note 43, at 123.

57. *Id.* at 127.

58. *See id.* at 124 (providing a complete list of criteria).

59. *See id.* at 135.

60. *See id.*

excessive, or when anxiety escalates into a phobia or intense fear of something real or imagined and is not limited to a fleeting emotion.⁶¹ Examples of anxiety disorders include generalized anxiety, panic, social anxiety, and phobias.⁶² The recently published *DSM-V* removed obsessive-compulsive and posttraumatic stress disorder (PTSD) from the anxiety disorder classification.⁶³ Obsessive-compulsive disorder and PTSD immediately follow anxiety disorders in the *DSM-V*,⁶⁴ indicating the similarities across the disorders. Again, it is beyond the scope of this Article to detail each of the symptoms for each unique disorder. It is more appropriate to list some of the symptoms that people with anxiety disorders experience, such as heart palpitations, breathlessness, feelings of being choked, persistent fear, and difficulty concentrating.⁶⁵ Not every person with an anxiety disorder will experience every one of these symptoms. It is important to distinguish anxiety that arises from certain life circumstances, such as stage fright or a natural worry about a test, from anxiety that interferes with an individual's daily functions.⁶⁶

Substance use disorders cover criteria such as dependency on, intoxication by, and withdrawal from, various substances, including, but not limited to, alcohol, sedatives, opioids, marijuana, inhalants, and nicotine.⁶⁷ Other key features in determining the extent of the disorder—from mild to severe—include the level of impairment in meeting work or other obligations, as well as continued use of the substance, despite other consequences related to one's work or personal life.⁶⁸

61. 27 AM. JUR. PROOF OF FACTS 3D *Generalized Anxiety Disorders* § 9 (1994) (“The essential feature of generalized anxiety disorder is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least six months, about a number of events of activities . . .”).

62. *DSM-V*, *supra* note 43, at 189–90.

63. *Id.* at 811–12.

64. *See generally id.* at 189–290.

65. *DSM-IV*, *supra* note 44, at 430, 472; *see also Symptoms, ANXIETY & DEPRESSION ASS'N AM.*, <http://www.adaa.org/understanding-anxiety/panic-disorder-agoraphobia/symptoms> (last visited Nov. 30, 2014).

66. For more specifics about mood or anxiety disorders, see *DSM-V*, *supra* note 43, at 123–234.

67. *Id.* at 481.

68. *See id.* at 492.

Knowing some of the basic criteria for mood, anxiety, and substance related disorders, it is critical to understand how prevalent these conditions are within the field of law.

V. STRESS AND THE LEGAL PROFESSION

Walk into any law school's orientation, and you will hear that the legal profession is stressful.⁶⁹ Stress management, wellness, and self-care resources abound. To comprehend why stress is an issue in the legal profession and what makes those resources most useful, one must begin with a basic understanding of stress.

What is stress? Stress is a series of physiological responses and adaptations to a real or imagined threat or demand.⁷⁰ Stress can occur when individuals perceive that the pressures they are experiencing exceed their capacity to deal with them, especially in a situation where they perceive coping as important.⁷¹ Some stress

69. See Connie J.A. Beck et al., *Lawyer Distress: Alcohol-Related Problems and Other Psychological Concerns Among a Sample of Practicing Lawyers*, 10 J.L. & HEALTH 1, 2-3 (1996).

70. CYNDIE KOOPSEN & CAROLINE YOUNG, *INTEGRATIVE HEALTH: A HOLISTIC APPROACH FOR HEALTH PROFESSIONALS* 3 (2009).

71. Robert Sanders, *Researchers Find Out Why Some Stress Is Good for You*, UC BERKELEY NEWS CENTER (Apr. 16, 2013), <https://newscenter.berkeley.edu/2013/04/16/researchers-find-out-why-some-stress-is-good-for-you/> ("Some amounts of stress are good to push you just to the level of optimal alertness, behavioral and cognitive performance."). See generally Elizabeth D. Kirby et al., *Acute Stress Enhances Adult Rat Hippocampal Neurogenesis and Activation of Newborn Neurons via Secreted Astrocytic FGF2*, *ELIFE* (Apr. 16, 2013), <http://dx.doi.org/10.7554/eLife.00362>. The Yerkes-Dodson Law offers an inverted U model to explain low levels of performance at a below normal arousal or stress level, optimal performance with an appropriate amount of arousal (stress), and over-arousal (stress), where performance deteriorates and creativity, comprehension, and concentration also diminish. See David M. Diamond, *Cognitive, Endocrine and Mechanistic Perspectives on Non-Linear Relationships Between Arousal and Brain Function*, 3 *NONLINEARITY BIOLOGY TOXICOLOGY MED.* 1, 1-2 (2005). See generally Robert M. Yerkes & John D. Dodson, *The Relation of Strength of Stimulus to Rapidity of Habit-Formation*, 18 *J. COMP. NEUROLOGY PSYCHOL.* 459 (1908) (describing the relation of strength of stimulus to rapidity of habit formation). Various resources have been developed to assist in identifying and maintaining the optimal level of stress. See, e.g., Dan Goleman, *The Sweet Spot for Achievement*, *PSYCHOL. TODAY* (Mar. 29, 2012), <http://www.psychologytoday.com/blog/the-brain-and-emotional-intelligence/201203/the-sweet-spot-achievement>; *The Inverted-U Model*, *MIND TOOLS*, <http://www.mindtools.com/pages/article/inverted-u.htm> (last visited Nov. 30, 2014). Chronic or intense stress is dangerous to our health. See *Chronic Stress Puts Your Health at Risk*, *MAYO CLINIC*, <http://www.mayoclinic.org/healthy-living/stress-management/in>

helps us perform more effectively, but maintaining that optimum level is, of course, a challenge.

Eustress is a term coined to identify a subgroup of stress that promotes well-being⁷² and is beneficial to us. It charges us up and allows us to meet challenges head on. The athlete looks forward to a marathon while it may seem overwhelming to someone who is not inspired by such a challenge. The same level of satisfaction and fulfillment can come to a litigator who relishes preparing for the fight. It can exist for the litigator who enjoys entering the fray even when the odds are against her or for the dealmaker who pours himself into drafting the finest contract and negotiating for the best deal. The dealmaker may abhor the idea of doing the litigator's job and vice versa. Regardless of how beneficial stress may be, human bodies react. The heart beats faster, pupils dilate, digestive and immune systems shut down, and the hormones adrenaline and cortisol are released.⁷³ In the short term, this works in our favor. Once the "danger (or deadline)" has passed, our system should return to a baseline level of functioning, with periods of less stress. But when we are exposed to unending waves of these biological transformations, a normal stress response can cause serious problems. Over time, the chronic presence of these changes can result in problems such as high blood pressure, frequent illness, and the development of coping mechanisms that are reactions, not solutions.⁷⁴

The thriving and fulfillment that exist can become negative with fatigue or other factors that change the hormonal response to stress, therefore causing eustress to become distress. Distress is the "chronic feeling of being overwhelmed, oppressed, and behind in [one's] tasks."⁷⁵ It can trigger feelings of anger, guilt, and fear.⁷⁶

-depth/stress/art-20046037 (last visited Nov. 30, 2014).

72. Debra L. Nelson & Bret L. Simmons, *Eustress: An Elusive Construct, An Engaging Pursuit*, in 3 *EMOTIONAL AND PHYSIOLOGICAL PROCESSES AND POSITIVE INTERVENTION STRATEGIES* 265, 266 (Pamela L. Perrewé & Daniel C. Ganster eds., 2003).

73. BRIAN LUKE SEAWARD, *MANAGING STRESS: PRINCIPLES AND STRATEGIES FOR HEALTH AND WELL-BEING* 37-38 (5th ed. 2006); *see also* AMIRAM ELWORK, *STRESS MANAGEMENT FOR LAWYERS: HOW TO INCREASE PERSONAL & PROFESSIONAL SATISFACTION IN THE LAW* 46 (3d ed. 2007).

74. *See Stress and Anxiety*, N.Y. TIMES, <http://www.nytimes.com/health/guides/symptoms/stress-and-anxiety/possible-complications.html> (last visited Nov. 30, 2014).

75. *Stress*, CAL POLY HEALTH & COUNSELING SERVICES, <http://www.hcs.calpoly>

There is a sense that life is controlling lawyers and they see little hope for relief, both of which can have unhealthy results.

VI. SOURCES OF STRESS FOR LAWYERS

The legal profession presents many opportunities to take on someone else's problems, and it presents unique sources of stress. Stress is a constant reality in the everyday practice of a lawyer, regardless of his or her area of focus or workplace.

A. *Rule-Based Morality*

Lawyers help people—and make a difference for their clients—by finding a way to fit a set of circumstances to a set of rules. Lawyers apply the law to the facts and rely on precedent to guide the way.⁷⁷ From that can come a tendency to see everything in terms of how they believe it should fit into the world as they understand it. Moreover, lawyers will use their finely tuned persuasive and argumentative skills to insist on that interpretation. This often occurs when they advocate for a client or cause, but it can enter their personal lives as well. In *Lawyer Know Thyself*, “rights orientation” is presented as a common element of the lawyer’s personality.⁷⁸ The lawyer is more likely to focus on rights and obligations rather than relationships, emotions, and interpersonal harmony.⁷⁹ Interestingly, this concept is noted in the *Model Rules of Professional Conduct* when addressing the lawyer as an advisor.⁸⁰ Comment two to Rule 2.1 states,

Advice couched in narrow legal terms may be of little value to a client, especially where practical considerations, such as cost or effects on other people, are predominant. Purely technical legal advice, therefore, can sometimes be inadequate. It is proper for a lawyer to refer to relevant

.edu/content/counseling/stress (last visited Nov. 30, 2014).

76. See ELWORK, *supra* note 73, at 47.

77. See generally HARVEY HYMAN, *THE UPWARD SPIRAL: GETTING LAWYERS FROM DAILY MISERY TO LIFETIME WELLBEING* 18–20 (2010) (expounding on the formulaic nature of lawyers’ thoughts and the problems that follow therefrom).

78. See generally SUSAN SWAIM DAICOFF, AM. PSYCHOLOGICAL ASS’N, *LAWYER, KNOW THYSELF: A PSYCHOLOGICAL ANALYSIS OF PERSONALITY STRENGTHS AND WEAKNESSES* 38–39 (Bruce D. Sales et al. eds., 2004).

79. *Id.*

80. See MODEL RULES OF PROF’L CONDUCT R. 2.1 (2013).

moral and ethical considerations in giving advice. Although a lawyer is not a moral advisor as such, moral and ethical considerations impinge upon most legal questions and may decisively influence how the law will be applied.⁸¹

Despite the lawyer's focus on rule-based formulas and rights, he or she must also be aware of the impact legal action has on a client's life outside of the lawyer-client context.

B. Perfectionism

Lawyers are told from the beginning of law school that mistakes will cost them. From the potential for humiliation with the Socratic method when students are not prepared (or even if they are) to missed deadlines and important details resulting in professional discipline, lawyers learn that they must not fail. When law students and lawyers learn perfectionism, it is not limited to their work life. Any possible failure becomes an opportunity for intense self-scrutiny and every move lawyers make can become defined by winning or losing.⁸² A compromise or settlement may be seen as a failure because they did not get everything they asked for when they reached for the sky.

C. Pessimism

Law may be the only profession that succeeds because its practitioners anticipate the worst that might happen. The best lawsuit anticipates every potential damage and the best contract anticipates every possible breach. In one study, those law students who were identified as holding more pessimistic attitudes experienced greater academic success.⁸³ The pessimist not only sees what can go wrong, but also is more likely to view bad things as permanent and unchangeable.⁸⁴ This negativity also arises from disparaging comments about lawyers from society and the ways lawyers talk to and about each other.⁸⁵ Comments and views from the outside may be a tool that is deliberately used by others to

81. *Id.* R. 2.1 cmt. 2.

82. See Elwork, *supra* note 73, at 22–23 (discussing the trait of perfectionism in lawyers and the resultant predisposition to stress).

83. DAICOFF, *supra* note 78, at 63.

84. *Id.*

85. HYMAN, *supra* note 77, at 17.

belittle the profession and diminish the impact of the work of lawyers, but that does not change the impact it can have upon an individual. Unfortunately in a profession where any weakness is exploited to further a lawyer's cause, lawyers strive to not be seen as showing any vulnerability. All of this negativity coupled with a fear of demonstrating any weakness can trigger mental health issues.⁸⁶

D. Vicarious Trauma

Vicarious trauma may be a lawyer's greatest risk. Lawyers are not the immediate first responders to the worst things that happen, but they often spend more time with the details and people who experience the direct trauma than anyone else. Yet a lawyer's need to be perfect (a "don't let them see you sweat" attitude) and pessimistic tendencies can make lawyers even more vulnerable to the effects of this trauma. They do not show weakness, they do not process stress, and they hold it inside until they burnout.

The Canadian Bar Association has created the Legal Profession Assistance Conference (LPAC), which provides support to various lawyer assistance programs across Canada.⁸⁷ LPAC's resources include a desk manual on vicarious trauma.⁸⁸ It describes "secondary traumatic stress" as experienced by "those who come into continued close contact with trauma survivors and their stories, including their oral and visual evidence."⁸⁹ Symptoms are similar to those of posttraumatic stress disorder and can include intrusive thoughts, avoidance of reminders or additional exposure, and physiological arousal.⁹⁰ The terms "vicarious trauma" and "secondary trauma" are often used interchangeably and refer to the impact of continued exposure to the traumatic experiences of others.⁹¹ Vicarious traumatic stress was particularly noted to occur among those working in the areas of criminal justice and family law, but attorneys in any practice area may be impacted by what happens to their clients.⁹²

86. See DAICOFF, *supra* note 78, at 63.

87. See *Legal Profession Assistance Conference (LPAC) of the Canadian Bar Association*, LPAC, <http://www.lpac.ca/main> (last visited Mar. 20, 2015).

88. *The Cost of Justice: A Desk Manual on Vicarious Trauma*, LPAC, <http://www.lpac.ca/main/main/traumamaterial.aspx> (last visited Mar. 20, 2015).

89. *Id.*

90. *Id.*

91. See generally *id.*

92. Donald C. Murray & Johnette M. Royer, *Vicarious Traumatization: The*

In one of LPAC's resources, the authors note that lawyers experience negative mental health and career consequences both because of the impact of the exposure and because of a lack of self-care practices that often is more common among those in other helping professions.⁹³ A later study compared attorneys and mental health workers, both of whom worked with clients who had been traumatized.⁹⁴ Not only did the study show that attorneys were significantly impacted by burnout and secondary trauma, but that this occurred to a greater degree than for the mental health professionals.⁹⁵ A study of public defenders in Wisconsin demonstrates the impact of this trauma on attorneys as well as support staff.⁹⁶ The study also shows that simply talking about what one experienced, even and especially secondarily, can reduce the effects of the trauma.⁹⁷ The LPAC study authors stress the importance of the "transformation of th[e] meaning [of the vicarious traumatization] into something positive."⁹⁸ For the attorney, this may be difficult when the legal problems facing the client are the tip of the iceberg. The lawyer may not truly feel that he or she is making a difference for the client. As pessimists, unless lawyers really look for the good they may be doing, they may not see it. Yet, lawyers can provide the client with someone who listens to him or her, and who makes sure the system works, as it should.

E. Isolation

In law, a student and lawyer's isolation is physical, mental, and professional. Law students and lawyers spend their time in carrels or small offices interacting with computers and phones. Taking time for socializing cuts into study time or billable hours and may

Corrosive Consequences of Law Practice for Criminal Justice and Family Law Practitioners, LPAC, http://www.lpac.ca/main/main/vicarious_trauma.aspx (last visited Mar. 20, 2015).

93. *Id.*

94. Andrew P. Levin & Scott Greisberg, *Vicarious Trauma in Attorneys*, 24 PACE L. REV. 245, 250 (2003) (summarizing the outcomes of studies comparing secondary trauma in attorneys and mental health professionals).

95. *Id.*

96. See Andrew Levin et al., *Secondary Traumatic Stress in Attorneys and Their Administrative Support Staff Working with Trauma-Exposed Clients*, 199 J. NERVOUS MENTAL DISEASE 946, 948 (2011) (noting that attorneys were generally more negatively impacted than their support staff).

97. See generally *id.*

98. See Murray & Royer, *supra* note 92.

be directly or tacitly discouraged. The adversarial system may lead to students and lawyers not personally sharing because it may be seen as a sign of weakness. Client connections are often fleeting because the matter the lawyer is assisting the client with eventually comes to an end. Also, the relationship between the client and lawyer is often complicated because the client likely does not want to have the issue that brought her to the lawyer.⁹⁹ While there is connection with clients, those clients often change.

F. Grandiosity

There are four ways in which grandiosity manifests in lawyers.¹⁰⁰ “[Lawyers] either identify with grandiosity or [they] repress it and project it onto others.”¹⁰¹ First, lawyers may display grandiosity through posturing and pretension and may even come to believe they are above the law.¹⁰² Second, lawyers work longer and harder because they believe they are the only ones who can achieve their desired result.¹⁰³ This is one way in which workaholism develops. Third, lawyers push away their emotions because emotions do not matter to achieve the “right” result.¹⁰⁴ Fourth, lawyers perceive themselves as victims by believing that their own feelings are paramount to those of others and that they do not receive the recognition or payoff they deserve.¹⁰⁵ Both depression and anxiety are a likely result of grandiosity.¹⁰⁶

G. Analytical Thinking vs. Emotional Processing

The role of counselor is addressed in the *Model Rules of Professional Conduct*. Rule 2.1, discussing the lawyer’s role as an Advisor, states, “In representing a client, a lawyer shall exercise independent professional judgment and render candid advice. In rendering advice, a lawyer may refer not only to law but to other

99. HYMAN, *supra* note 77, at 7.

100. DON CARROLL, *A LAWYER’S GUIDE TO HEALING: SOLUTIONS FOR ADDICTION AND DEPRESSION* 72–74 (2006).

101. *Id.* at 72.

102. *Id.*

103. *Id.* at 73.

104. *Id.*

105. *Id.*

106. *Id.*

considerations such as moral, economic, social and political factors that may be relevant to the client's situation."¹⁰⁷

During the Foundation's Uncommon Counsel presentations, the term "counselor" is discussed with law students. The point is made that mental health professionals and lawyers can technically both be called "counselors." Unlike a mental health professional, a lawyer has not been taught or trained how to properly process emotions; and, in fact, their training involves removing emotions and thinking analytically.¹⁰⁸ Thus, while the public looks to attorneys to be both legal and emotional counselors, lawyers are not equipped to be emotional counselors.

VII. HOW DO LAWYERS AND LAW STUDENTS KNOW WHEN THEY ARE OVER-STRESSED?

If we look for them, there are many cues, which will help us recognize that we are not dealing effectively with our stress. They manifest physically, emotionally, and behaviorally. Physical cues include throbbing in the chest, indigestion, breathlessness, tiredness and fatigue, aches and pains, frequent infections, headaches, and high blood pressure.¹⁰⁹ Emotional cues include mood swings, lack of enthusiasm, guilt, lack of concentration, anxiety, lack of confidence, and loss of self-esteem.¹¹⁰ Behavioral cues include accident proneness; increased smoking, drinking, and drug consumption; appetite changes; irritability; change in sleeping patterns; change in working patterns; chronic lateness or procrastination; poor hygiene; and clumsiness.¹¹¹

Another way to look at this is to consider competence and diligence. If lawyers feel they are not handling a matter as well as they would like, are competence and diligence called into question? Rule 1.1 of the *Model Rules of Professional Conduct* addresses competence in a straightforward manner: "A lawyer shall

107. MODEL RULES OF PROF'L CONDUCT R. 2.1 (2013).

108. One law review article discusses the danger of suppressing emotions for judges, but it is applicable to lawyers too. See Terry A. Maroney, *Emotional Regulation and Judicial Behavior*, 99 CALIF. L. REV. 1485, 1536-54 (2011).

109. See *Adult Stress—Frequently Asked Questions: How It Affects Your Health and What You Can Do About It*, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/stress/index.shtml> (last visited Nov. 30, 2014) [hereinafter *Adult Stress*].

110. See *id.*

111. See *id.*; see also ELWORK, *supra* note 73, at 27-28.

provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.”¹¹² Thus, if lawyers do not feel they were as thorough or as prepared as they could have been, because of stress or any other reason, does competence become an issue? The *Model Rules* suggest that it does. Rule 1.3, concerning diligence, simply states, “A lawyer shall act with reasonable diligence and promptness in representing a client.”¹¹³ The comments to Rule 1.3 could be viewed as directly addressing stress management in the legal profession: “A lawyer’s work load must be controlled so that each matter can be handled competently.”¹¹⁴ It would appear that the *Model Rules* suggest that the lawyer who is overwhelmed is thus able to handle less—whether because of a mental health issue or any other reason—and must do something about that stress in order to remain competent. Arguably, this should be the case regardless of whether that same workload would not be a problem for another lawyer.

If we extend this line of discussion to the lawyer’s employer or colleagues in the case of a partnership, it is also appropriate for the employer or partner to take steps if it is evident that the lawyer is compromised in some way. Model Rule 5.1 provides, in part:

(a) A partner in a law firm, and a lawyer who . . . possesses comparable managerial authority in a law firm, shall make reasonable efforts to ensure that the firm has in effect measures giving reasonable assurance that all lawyers in the firm conform to the Rules of Professional Conduct.

(b) A lawyer having direct supervisory authority over another lawyer shall make reasonable efforts to ensure that the other lawyer conforms to the Rules of Professional Conduct.¹¹⁵

Further, the colleague who can be held to have some level of authority over the lawyer who is struggling may herself be found to be in violation of the rules if no steps are taken to assist that lawyer and misconduct occurs.¹¹⁶

112. MODEL RULES OF PROF’L CONDUCT R. 1.1.

113. *Id.* R. 1.3.

114. *Id.* R. 1.3 cmt. 2.

115. *Id.* R. 5.1.

116. *Id.*

VIII. LAWYERS' AND LAW STUDENTS' RESPONSES TO STRESS

Many students and lawyers try to cope with stress by turning to tobacco, alcohol, caffeine, herbal remedies, and legal or illegal drugs, as well as diversions like gambling, internet shopping, games, pornography, or compulsive eating.¹¹⁷ These substances and processes may mask some of the symptoms of stress and provide temporary relief, but they do not help in the development of effective stress-management techniques.¹¹⁸ Further, these techniques can harm physical health, weaken resistance to stress to a greater degree, and cause additional stressful complications in life.¹¹⁹

IX. PSYCHOLOGICAL DISTRESS AND LAW SCHOOL

Psychological distress is a significant issue for many law students.

[A]lthough not present prior to law school, a variety of forms of psychological distress become evident at clinically significant levels within the first few months of law school attendance. These symptoms increased as the law students progressed through the three years of the program and did not significantly decrease during the first two years of practice.¹²⁰

The results of the 2014 Survey of Law Student Well-Being, mentioned above, indicate that of the students who reported an anxiety disorder, 30% were diagnosed after the start of law school.¹²¹ Similarly, of the students who reported depression, almost 18% reported that the diagnosis was made after the start of law school.¹²² Further, 41.7% of respondents thought they needed help for emotional or mental health problems in the past year.¹²³

117. See generally *Adult Stress*, *supra* note 109.

118. See *id.*

119. See generally CARROLL, *supra* note 100, at 53–55 (discussing the impacts of utilizing alcohol as a coping technique).

120. Beck et al., *supra* note 69, at 44–45 (citing G. Andrew H. Benjamin et al., *The Role of Legal Education in Producing Psychological Distress Among Law Students and Lawyers*, 11 AM. B. FOUND. RES. J. 225, 240–41 (1986)).

121. Bender, *supra* note 38.

122. *Id.*

123. *Id.*

X. MENTAL HEALTH AND SUBSTANCE USE ISSUES AMONG LAWYERS

A study of lawyer distress, which looked at issues of alcohol and other psychological factors, asked attorneys to self-report psychological distress symptoms.¹²⁴ These results were then compared to results from general studies of wider populations and other studies of the general population.¹²⁵ In the population as a whole, 8.5% of men and 14.1% of women reported experiencing an affective disorder, which includes depression.¹²⁶ For lawyers, nearly 21% of men and 16% of women experienced significant symptoms of depression or related affective disorders.¹²⁷ The numbers for anxiety were even higher.¹²⁸ While 4% of men and women in the population at large met the criteria for anxiety, 30% of male lawyers and almost 20% of women lawyers experienced these symptoms.¹²⁹

In an earlier study, lawyers from the State of Washington were surveyed.¹³⁰ In this study, 19% of the respondents reported that they experienced significant depression.¹³¹ Some reported feeling regularly or occasionally suicidal.¹³² A 1990 study by researchers from the Department of Mental Hygiene, School of Hygiene and Public Health at Johns Hopkins University reviewed depression in twenty-eight professions.¹³³ Attorneys were found to experience depression at 3.6 times the rate of the general adult population.¹³⁴ Attorneys also had the highest rate of depression for all selected professions.¹³⁵

Lawyers have also been found to have a greater incidence of substance use issues. Recent research by the Substance Abuse and Mental Health Services Administration shows that 8.2% of the

124. Beck et al., *supra* note 69, at 12.

125. *Id.* at 4.

126. *Id.* at 50.

127. *Id.*

128. *Id.*

129. *Id.*

130. G. Andrew H. Benjamin et al., *The Prevalence of Depression, Alcohol Abuse, and Cocaine Abuse Among United States Lawyers*, 13 INT'L J.L. & PSYCHIATRY 233, 236 (1990).

131. *Id.* at 240.

132. *Id.* at 240–41.

133. William W. Eaton et al., *Occupations and the Prevalence of Major Depressive Disorder*, 32 J. OCCUPATIONAL MED. 1079, 1085 (1990).

134. *Id.* at 1083.

135. *Id.* at 1085.

population surveyed had a substance use disorder (including alcohol and drugs) in 2013.¹³⁶ While studies in the legal profession are older, all of them show that law students and attorneys misuse alcohol approximately twice as frequently as other adults¹³⁷

XI. SUICIDE, SUICIDAL IDEATION, AND ITS PREVALENCE IN THE LEGAL FIELD

Uncommon Counsel, a program of the Dave Nee Foundation, tries to raise awareness of depression, which Dave Nee suffered with in silence. Only after Dave's death did friends and loved ones learn of his depression; it appears Dave masked it and perhaps turned to alcohol to cope with the depression. In many ways, Dave's death—while tragic—is too common an outcome when people with depression or other mental health concerns do not get effective treatment. The legal profession sees higher rates of substance use¹³⁸ and suicide attempts.¹³⁹

According to the CDC's National Center for Injury Prevention and Control, suicide was the tenth leading cause of death in 2010

136. SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2013 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS 7 (2014), available at <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>.

137. Rick B. Allan, *Alcoholism, Drug Abuse and Lawyers: Are We Ready to Address the Denial?*, 31 CREIGHTON L. REV. 265, 265–66 (1997). As of the publication date of this Article, the ABA has partnered with the Hazelden Betty Ford Foundation's Legal Professionals Program to "conduct a research project on the rates of depression, substance abuse and anxiety among licensed lawyers" in the United States, which will provide updated statistics in this area. Martha Neil, *ABA to Partner with Treatment Center in Study of Attorney Depression, Substance Abuse and Anxiety*, A.B.A. J. (Aug. 20, 2014, 7:58 PM), http://www.abajournal.com/news/article/aba_to_partner_with_treatment_center_in_study_of_attorney_depression_substa.

138. *Depression Health Center*, WEBMD, <http://www.webmd.com/depression/guide/untreated-depression-effects> (last visited Nov. 30, 2014) ("Untreated depression increases the chance of risky behaviors such as drug or alcohol addiction.")

139. Erkki Isometsä, *Suicidal Behaviour in Mood Disorders—Who, When, and Why?*, 59 CAN. J. PSYCHIATRY 120, 121 (2014) ("Suicide is a complex phenomenon, with multiple domains of risk factors, and valid perspectives for both scientific explanation and prevention. For psychiatry, however, a central fact is that, according to numerous psychological autopsy studies, almost all subjects (about 90%) have suffered from some—usually multiple—mental disorders at time of death." (citation omitted)).

across all age groups, the third leading cause of death for those ages fifteen through twenty-four, and the second leading cause of death for those ages twenty-five through thirty-four.¹⁴⁰ CNN reported that suicide by occupation (as calculated by the CDC) lists lawyers in the top five.¹⁴¹ Experts in the field noted “3.7 percent of the adult U.S. population reported having suicidal thoughts in the last year.”¹⁴² The 2014 Law Student Well-Being Survey found that 20.4% of respondents have thought seriously about suicide sometime in their life and 6.3% have thought seriously about suicide in the last 12 months.¹⁴³ In comparison to the CDC findings, that is nearly double the rate of the general population.

Statistics alone, however, do not really help people to understand suicide. Suicide is not a topic about which many are willing to engage. In fact, law schools have often turned down the opportunity to host a free presentation by the staff of the Dave Nee Foundation at their campus because they do not want to “depress” the law students or “scare” them by talking about suicide.¹⁴⁴ Perhaps staff at these law schools believe the myth that talking about suicide will plant the idea of suicide in someone’s mind. To be clear, that is a myth.¹⁴⁵ Discussing suicide and its warning signs do not cause emotional distress for students.¹⁴⁶ In fact, the website for the American Foundation for Suicide Prevention suggests that talking about suicide helps to protect those contemplating suicide and can

140. OFFICE OF STATISTICS & PROGRAMMING, CTRS. FOR DISEASE CONTROL & PREVENTION, 10 LEADING CAUSES OF DEATH BY AGE GROUP, UNITED STATES—2010 (2010), available at http://www.cdc.gov/injury/wisqars/pdf/10lcid_all_deaths_by_age_group_2010-a.pdf.

141. Rosa Flores & Rose Marie Arce, *Why Are Lawyers Killing Themselves?*, CNN (Jan. 20, 2014, 2:42 PM), <http://www.cnn.com/2014/01/19/us/lawyer-suicides/>.

142. Alex E. Crosby et al., *Suicidal Thoughts and Behaviors Among Adults Aged ≥ 18 Years—2008–2009*, MORBIDITY & MORTALITY WKLY. REP., Oct. 21, 2011, at 1, 5, available at <http://www.cdc.gov/mmwr/pdf/ss/ss6013.pdf>.

143. Bender, *supra* note 38.

144. This is based on personal communications with law school administrators and the Foundation’s staff.

145. See generally Madelyn S. Gould et al., *Evaluating Iatrogenic Risk of Youth Suicide Screening Programs: A Randomized Controlled Trial*, 293 JAMA 1635 (2005).

146. See generally M. David Rudd et al., *The Emotional Impact and Ease of Recall of Warning Signs for Suicide: A Controlled Study*, 36 SUICIDE LIFE-THREATENING BEHAV. 288 (2006); Kathy L. Silbert & Gordon L. Berry, *Psychological Effects of a Suicide Prevention Unit on Adolescents’ Levels of Stress, Anxiety and Hopelessness: Implications for Counselling Psychologists*, 4 COUNSELLING PSYCHOL. Q. 45 (1991).

reduce the stigma and shame so often associated with suicide and mental health concerns.¹⁴⁷

Suicidal thoughts can be symptoms of other mental illness, specifically depressive disorders or bipolar disorders.¹⁴⁸ Research indicates correlations between anxiety disorders, posttraumatic stress, and even eating disorders with suicidality.¹⁴⁹

Because more and more attention is being paid to suicide, its causes, and ways to prevent it, there is hope that the problem will be eliminated. However, as long as there are societal and cultural beliefs about suicide that, in and of themselves, may prevent people from seeking help, we will have a long road ahead of us. But, that does not mean we idly sit by.

Ninety-five percent of attendees of the Dave Nee Foundation's Uncommon Counsel presentations report that they are able to recognize three warning signs of suicide because of the presentation.¹⁵⁰ This is similar to most prevention programs that include an awareness component and for which posttests show statistically significant increases in knowledge about suicide.¹⁵¹ A key element to suicide prevention training programs is to recognize when someone is in distress and refer that person to the proper

147. See *Understanding Suicide: Myth vs. Fact*, AM. FOUND. FOR SUICIDE PREVENTION (Sept. 6, 2013), <https://www.afsp.org/news-events/in-the-news/understanding-suicide-myth-vs.-fact>. The American Foundation for Suicide Prevention is an organization with sixty-seven nationwide chapters that "fund[s] research, create[s] educational programs, advocate[s] for public policy, and support[s] survivors of suicide loss." See *About AFSP*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/about-afsp> (last visited Nov. 30, 2014).

147. *Suicide Prevention*, DEPRESSION & BIPOLAR SUPPORT ALLIANCE, http://www.dbsalliance.org/site/PageServer?pagename=urgent_crisis_suicide_prevention (last visited Nov. 30, 2014).

148. *Id.*

149. See generally Erin Fink et al., *The Joint Influence of Disordered Eating and Anxiety Sensitivity on the Acquired Capability for Suicide*, 37 COGNITIVE THERAPY RES. 934 (2013); Edward A. Selby et al., *Habitual Starvation and Provocation Behaviors: Two Potential Routes to Extreme Suicidal Behavior in Anorexia Nervosa*, 48 BEHAV. RES. THERAPY 634 (2010).

150. *Uncommon Counsel*, *supra* note 2.

151. See generally Gretchen Bean & Kristine M. Baber, *Connect: An Effective Community-Based Youth Suicide Prevention Program*, 41 SUICIDE LIFE-THREATENING BEHAV. 87 (2011); Gwendolyn Portzky & Kees van Heeringen, *Suicide Prevention in Adolescents: A Controlled Study of the Effectiveness of a School-Based Psycho-Educational Program*, 47 J. CHILD PSYCHOL. & PSYCHIATRY 910 (2006).

place for help.¹⁵² There are, however, often barriers to getting help.¹⁵³

The Dave Nee Foundation hopes that administrators at law schools hosting the Uncommon Counsel program will be seen as more approachable by students. The good news is that 81.2% of respondents from the 2014 Law Student Well-Being Study reported that they would be somewhat likely or very likely to use a health professional if they thought they had a mental health problem.¹⁵⁴ The less promising news is that only 24.6% of law students reported they actually received counseling from a health professional and only 15.4% reported they would be somewhat likely or very likely to seek help from a dean of students.¹⁵⁵

XII. INTERVENTIONS AND RESOURCES

The questions mental health professionals often hear after a death by suicide are “How could I have known?” and “What could I have done?” It is not the intention or purpose of this Article to impose guilt or blame on institutions, cultures, families, or individuals who have lost someone to suicide. This Article does not propose that readers become psychologists, psychiatrists, or other mental health professionals. However, it is a myth that only mental health professionals can help a person in crisis.

Often people who are suicidal or who die by suicide have been contemplating death for a while and will have shown warning signs.¹⁵⁶ Temporary states of crisis often feel very permanent and pervasive, and people in such a state may not be able to see a path other than death. It is in these moments that people may start to make arrangements for death; they may indicate their motives with a verbal or behavioral cue. While it is beyond the scope of this

152. See, e.g., Bean & Baber, *supra* note 151, at 87; Portzky & Heeringen, *supra* note 151, at 910.

153. See generally INT’L ASS’N FOR SUICIDE PREVENTION, STIGMA: A MAJOR BARRIER TO SUICIDE PREVENTION (2013), available at https://www.iasp.info/wspd/pdf/2013/2013_wspd_brochure.pdf.

154. Bender, *supra* note 38.

155. *Id.*

156. See generally M. David Rudd et al., *Warning Signs for Suicide: Theory, Research, and Clinical Applications*, 36 SUICIDE LIFE-THREATENING BEHAV. 255 (2006); *Suicide Warning Signs*, AM. FOUND. FOR SUICIDE PREVENTION, <http://www.afsp.org/understanding-suicide/suicide-warning-signs> (last visited Nov. 30, 2014).

Article to discuss all of the theories of why people die by suicide, resources are available for those who wish to look further.¹⁵⁷

Common warning signs include statements about hopelessness, expressions of purposelessness, talking about death, giving away items, engaging in reckless behaviors, increase in substance use, withdrawal in normal social behavior, mood change, and/or acquiring the means to die by suicide (drugs, weapons, etc.).¹⁵⁸

Individuals should take action by following the subsequent suggested best practices and resources. If the person is in immediate and imminent danger, contact 9-1-1 or take him/her to an emergency room. People are also encouraged to call the suicide prevention help line at 1-800-273-TALK. For law students, many law campuses have resources that are campus specific in case of a mental health emergency. The idea, however, is to encourage law students and lawyers to seek the help they need before they escalate into a crisis or suicidal state. There are resources available to help prevent these crises.

Nearly every state and province has a lawyer assistance program (LAP), and most serve law students as well as lawyers.¹⁵⁹ Programs are generally confidential and can offer immediate and supportive assistance. LAPs are staffed by attorneys and clinicians who understand the legal profession, law school, and the stresses that accompany both. Peer support and the opportunity to talk with someone who has been there are the cornerstones of many of these programs. Services are free and some have twenty-four-hour

157. See generally THOMAS E. JOINER, WHY PEOPLE DIE BY SUICIDE (2005). For more information on suicide risk assessment, see Darcy Haag Granello, *The Process of Suicide Risk Assessment: Twelve Core Principles*, 88 J. COUNSELING DEV. 363 (2010).

158. *Know the Warning Signs of Suicide*, AM. ASS'N SUICIDOLOGY, <http://www.suicidology.org/resources/warning-signs> (last visited Jan. 9, 2015).

159. See, e.g., *Directory of Lawyer Assistance Programs*, A.B.A., http://www.americanbar.org/groups/lawyer_assistance/resources/lap_programs_by_state.html (last visited Nov. 30, 2014). The ABA Commission on Lawyer Assistance Programs provides many other resources that are specific to mental health and substance use issues in the profession. See *Commission on Lawyer Assistance Programs*, A.B.A., <http://www.americanbar.org/colap> (last visited Nov. 30, 2014) (“The ABA Commission on Lawyer Assistance Programs has the mandate to educate the legal profession concerning alcoholism, chemical dependencies, stress, depression and other emotional health issues, and assist and support all bar associations and lawyer assistance programs in developing and maintaining methods of providing effective solutions for recovery.”).

hotlines. Students can also ask for help if they are concerned about a classmate. The services range from coaching on how to be supportive, to providing resources, to managing a crisis response.

LAPs typically also have websites that provide basic information on conditions and resources.¹⁶⁰ This information is helpful for readers who have a concern about themselves or others. Dan Lukasik, a New York lawyer, created a website and blog that provides comprehensive information about depression and related disorders.¹⁶¹ *LawLifeline*, created by the Dave Nee Foundation in partnership with the Jed Foundation, is a mental health resource specifically for law students.¹⁶² It provides information on helping others or oneself, assessment tools, and connections to specific resources at individual law schools.¹⁶³

Law schools have resources as well. Deans of students often have connections with counselors who have worked with other law students, either through campus counseling centers or in the community. Some law schools have peer support and mentor programs. Students may avoid accessing these resources because of the fear of academic or bar admission consequences. Law schools do not see asking for help as demonstrating weakness and those requests are handled confidentially.

XIII. HOPE FOR THE LEGAL COMMUNITY

This Article has highlighted the mental health concerns faced by many law students and lawyers. Perhaps more problematic than those mental health concerns, however, is the reluctance that those in the legal profession demonstrate towards seeking help. This Article has also used empirical data to demonstrate that social

160. See *Directory of Lawyer Assistance Programs*, *supra* note 159.

161. LAW. WITH DEPRESSION, www.lawyerswithdepression.com (last visited Nov. 30, 2014); see also *Why I Created This Website*, LAW. WITH DEPRESSION, <http://www.lawyerswithdepression.com/why-i-created-this-website/> (last visited Nov. 30, 2014) (“[This] is a site specifically devoted to those in the legal profession struggling with mental health concerns and who search for a deeper meaning in life and the law.”).

162. See LAWLIFELINE, <http://www.lawlifeline.org> (last visited Nov. 30, 2014). *Lawlifeline* was a joint product of the Dave Nee Foundation and the Jed Foundation, and it was inspired by the Jed Foundation’s website, www.Ulifeline.org.

163. See *id.*

stigma and professional stigma prevent those with mental health concerns from getting help. However, there is hope.

Articles like this, LAPs, law school initiatives, and other efforts that openly address these issues show a willingness and readiness for a cultural shift. The Dave Nee Foundation was born from a tragic loss; however, the work of the Foundation instills hope. Inspired by the loss of one, it is the Foundation's goal, working with school and community resources, to save the lives of many. Lives have been changed because of Dave's legacy. Dave's death prompted his friends and family to action. They learned about and came to understand the scope and depth of the problem facing law students with untreated mental health concerns. Based on their research, they then sought to create pathways to educate, raise awareness, and conduct empirical research with the ultimate goal of eliminating the stigma among law students and within the legal community in the area of mental health and mental illness. Every day in this work, we see more law professors, students, administrators, and practicing attorneys joining the call to act, to help, and to share their experiences. We need more voices to join in, share their experience, and promote help seeking to accelerate our movement toward the goal of preventing suicide. Together we can make a difference and save lives.