

TREATMENT FOR THE UNINSURED AND THE POOR

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PART 1

Late stage alcoholism is that stage of the illness just prior to premature death or insanity. It is extremely easy to diagnose: continuous drinking, physical, moral, and mental deterioration, decrease of tolerance, psychomotor inhibition, despondency, feelings of hopelessness, and disaffiliation. Late stage alcoholics are “endowed with a terrible power to suffer an awful sum of pain to which no individual can be indifferent, save at the price of their own humanity.”

T. S. Eliot's Grizabella is the model for these people:

The border of her coat is torn and stained with sand,
and the corner of her eye twists — like a crooked hem.

Saying: “Touch me. It is so easy to heal me.

In the lamplight the withered leaves collect at my feet the wind begins to moan Memory.
All alone in the moonlight, I can smile at the old days: I was beautiful then.

I remember a time I knew what happiness was Let my memories live again.” These people are the poorest of the poor. They have lost jobs and financial security. They have lost families and friends. They have lost homes, automobiles, the tools of their trade, and the membership in their professional societies or unions. They have lost the respect of their fellows and their own self-respect. Often, they have even lost a sense of self-identity. They may remember a time when they knew what happiness was, but now they know no reason to hope that their memories will ever live again. They know failure so well that they identify with it. They dare not even hope that God, should such a being exist, has any plan or place for them in his heart. They live in almost total isolation from God, society, friends, family, and self. The De Paul Center was founded in October, 1977 by Steve Newton, a Holy Cross seminarian who had been dismissed from the Holy Cross Fathers for drunkenness. Steve had himself ended up on the streets of Chicago a late stage alcoholic. He had, by the grace of our loving God, found sobriety in 1975 and had begun to find himself and his faith and ideals again. In the Summer of 1977, while I was in the Rochester Guest House, Steve was making plans to return to Holy Cross. He ended up in Portland living with the Holy Cross Community and looking for a job. The plan was that after a year's reevaluation he would return to the Seminary. God's plan was somewhat different. The only job Steve could find was with a dry hotel run by the Saint Vincent de Paul Society. Shortly after he was hired, the director of the hotel, Bob Baker, son of Guest House's Art Baker, left to take a job elsewhere and ended up with Catholic Charities. Steve was left with a program that was almost bankrupt and a dream. His dream was that these men (for in those days no women were accepted into the program) who were late-stage chronic alcoholics, such as he had been, could find sobriety, just as he had. It was to be nine years before Steve was free to return to the Seminary at Notre Dame. He should be finishing his studies for ordination in the next year — but that is a whole different story.

The De Paul Center is founded on the following four principles:

1. No one is born on Skid Road. People get there as a result of having reached the late stages of their disease without earlier successful intervention and treatment.
2. Alcoholism is a treatable disease.
3. Treatment needs of the disaffiliated differ from those of the earlier stage alcoholic.
4. There is no such person as a hopeless alcoholic.

One of the discoveries that Steve and his colleagues found was that the late stage disaffiliated alcoholic did poorly in standard treatment programs because the late stage disaffiliate alcoholic was sicker than the

ordinary client that showed up in those programs. In this, I believe that Steve and Austin Ripley found the same truth: the sicker a person is, the more treatment they need. This is such a simple and self-evident fact that it has been overlooked for years. Affiliated alcoholics — those who have not yet lost all family, friends, and finances — who are able to afford treatment generally are referred back to the families and employers who intervened on their drinking in the first place. The Skid Road alcoholic has only the street to call home. Further, the Skid Road alcoholic has only begun to clear mentally from the confusion that alcohol, drugs, malnutrition, and exposure have induced when the typical 30-day program has done all that it can for him. We believe that alcoholism is a treatable disease. Since it is a treatable disease, anyone who has the disease can recover if they are given treatment appropriate to their degree of illness.

I cannot emphasize enough that motivation is not a requirement for admission. People come to De Paul because it is cold and wet outside, because the city has begun to clean out the areas under the bridges, because the judge gave them jail as their only alternative, because they are looking for “three hots and a cot,” because they see De Paul as another social service agency to take advantage of. Very rarely does anyone come to us of their own volition. We don’t really care why people come to us. We do care that they come. We believe that it is our job to provide motivation, to convince them that it is possible to achieve lasting, quality sobriety. (For the most part, our clients’ denial is not about the fact of their addiction, but about the possibility of recovery.) The only two requirements for admission to our adult treatment center are that a person be in the late stages of addiction and that he or she be indigent: unable to obtain quality treatment elsewhere. In 1983 we started to look at recovery statistics. Of those persons we could track who had been out of treatment 90 days or more, we found that 60% had maintained continuous sobriety since discharge. Of those who had stayed in inpatient treatment (that is, Phases I and II) for eight months or longer, 75% had maintained continuous sobriety. These are persons who have traditionally been considered hopeless, beyond recovery and to whom quality treatment was denied, in any case, because of lack of funds. In any case, De Paul’s real success lies in the fact that we are able to provide access to quality treatment to persons whose only option heretofore was premature death, usually alone in a street gutter.

PART II

Who De Paul Treats Chemical dependency is commonly recognized as a progressive illness, that is, a pathological condition that has a definite origin, a continuing process of development through successive stages as it intensifies and becomes increasingly destructive to its victims: ultimately a terminal condition. In the initial stages of dependency, the use of the mood altering drug is enforced by feelings of pleasure and euphoria. As the person progresses in the disease, the drug begins to be used as a remedy to medicate the tensions, emotional upsets, sorrows and pains, conflicts and disappointments of everyday life.

Later, the illness is characterized by maintenance use: the addict uses the drug to maintain a sense of normality. The drugs are used to allow the user to function, but also to control and prevent physical withdrawal symptoms.

The Disaffiliated Public Inebriate The disaffiliated public inebriate is one who has progressed to the final stages of the disease. Here, the mood altering substance, usually alcohol, is used to maintain oblivion. Both physical and psychological dependence are operative. The addict is isolated, disaffiliated, from family, society, and even from self. The victim of the disease now experiences despair: there is no longer any hope that one’s lot can improve significantly, no longer any vestige of self-worth or self-esteem. The learned survival skills of the earlier stage addict now work against recovery — even when the victim’s physical health has deteriorated to the point that he or she can no longer tolerate the drug enough to ward off withdrawal symptoms.

At this last stage of the illness, the personality is so disorganized, the self-image is so low, the moral anxiety is so massive, the attitudes toward self and others are so negative, and the misery is so intense that self-destructive behavior is the norm. Indeed, the client at this stage of the disease does not know how to behave in a positive healthy way.

Any attempt at hard confrontation early in the treatment experience can result in the client’s leaving treatment abruptly, as there are no ties with anyone, no sense of responsibility toward oneself. In sum, the disaffiliated public inebriate in the terminal last stage of addiction is totally alone and isolated, has no sense of belonging, and is in despair.

Women

There is considered to be a 'conspiracy of silence' surrounding female chemical dependence. American culture is reluctant to recognize it as a primary illness in women; rather, it is seen as a symptom of something else. Rather than diagnosing alcoholism, for example, physicians will all too often prescribe a bottle of tranquilizers, with the consequence that at least 80% of all alcoholic women are cross addicted. Women tend to progress more rapidly into middle and late stage disease than do men. They seem more prone to high blood pressure and cirrhosis. Hormonal changes and vitamin and mineral deficiencies cause special problems.

Divorce rates for women with the disease are much higher than for men. Nonalcoholic wives are more likely to stay with their alcoholic husbands than nonalcoholic husbands are with alcoholic wives. More women than men suffer from depression associated with their alcoholism, and thus have a higher use of prescription drugs. There are certain differences in the sexual identity problems of women which need to be addressed in treatment. To varying degrees of consciousness, sexual role conflicts exist and continue to trouble until resolved. Psychosexual underdevelopment has often been acted out in ways less personally and socially acceptable (e.g.: prostitution) than is often the case with men.

There is a stronger level of denial in the dually addicted woman. She has developed a stronger sense of denial during her progression, symptomized by more antisocial, especially illegal, behaviors. Treatment needs to be geared to cultural and environmental issues for each person but must especially address, in depth, issues particular to female chemical use and abuse. Upon admission into treatment, women are assigned to gender specific groups and a female counselor. Education specific to women's progression into the disease, including education about the body systems, takes place in the group setting on a daily basis. Mother/child counseling is available, as appropriate. Assistance with childcare and fostercare during the course of treatment is available.

Women need to feel comfortable with themselves. Early in the course of treatment, many are reluctant to discuss problems in mixed groups related to their progression into their disease. Conversely, because many have never seen themselves as having meaning other than in relation to a man, many women are uncomfortable relating on a deep, personal level with other women. Thus, all-women groups, with good female role models, are essential early in recovery. Schools, parole/probation supervisors, employers — all will be part of the assessment and, as deemed appropriate, of the treatment and aftercare planning.

The desired outcome of the proposed program of treatment is that women leave treatment stabilized into a chemically free lifestyle. But abstinence is not the only goal of treatment; treatment must give women the tools to be able to interact — once again or for the first time — with life situations while arresting the disease process. If the whole woman is not treated simultaneously and in methodologies and settings as multifaceted and multicultural as the world in which she does or will live and work, relapse is inevitable. Each woman will leave treatment as a member of a positive peer group, having established relationships through treatment, AA, and NA with other recovering persons.

Court Committed Individuals

The De Paul Center provides alcohol and drug addiction treatment to those individuals listed as adult probationers convicted of class C felony and Class A misdemeanor offenses who are referred to us by or through the Court system. The treatment staff attempt to refocus these clients' attention or direction to prevent behavior of a negative nature from occurring. De Paul attempts to disrupt the patterns of behavior which are criminal in nature.

The treatment staff work to teach the client to recognize and to utilize external deterrents or to begin thinking of consequences to self prior to acting. Clients are also taught to recognize and utilize internal deterrents, which are consequences to others, prior to acting out. The De Paul staff has as much as possible integrated the philosophies of Yochelson and Samanow, authors of *The Criminal Personality*, into the philosophy of the De Paul program.

Persons with Dual Diagnosis The program is able to provide services to a variety of chronically emotionally and mentally ill clients. De Paul has accepted the broad definition of the Dual Diagnosis Task Force for dual diagnosis clients: "People with M-ED and A-D dual diagnoses are those individuals with coexisting mental or emotional disorders and alcohol and drug abuse problems." [1] Utilizing the expertise of the Center's consulting psychologist, as well as of the referring psychiatrists/psychologists, the program can assist these individuals to live a life free from active addiction. Clients must be able to participate in the treatment process.

The use of psychotropic drugs does not, in itself, bar a client from treatment at De Paul. The treatment staff will attempt to assist the medical staff to train the client to recognize the danger signals and to seek help in adjusting medication, rather than to attempt to self-medicate. The use of lithium therapy is supported in treatment, as is the use of psychotropic drugs when needed to live a normal or quasi-normal and independent life.

Treatment needs are many. Nonetheless, a simple approach is perhaps the best. De Paul is able to provide a battery of psychological tests to be interpreted by our consulting psychologist. These tests will include those that can diagnose and assess organic brain dysfunction. Clients so identified will be treated under supervision of the psychologist or referred to other more appropriate agencies, if possible. It is expected that the client's mental health case worker will participate in treatment planning and aftercare planning. Indeed, such participation is necessary for admission of a dual diagnosed client into treatment. Youth Alcohol and drug abuse among youth is a major social problem, the costs of which go far beyond the effects on the individual. Families, schools, court systems, and employers continue to share the financial and emotional burden of adolescent alcohol and drug misuse. Jeffrey Kushner, Assistant Administrator of the State of Oregon Office of Programs for Alcohol and Drug Problems, recently identified alcohol and drug abuse as the number one health problem for the adolescent population. Most recent statistics released from the State office in December, 1985, indicated that alcohol is involved in over 70 percent of adolescent traffic accidents and fatalities.

There is a strong correlation between alcohol and drug misuse and abuse and the commission of criminal activities. According to a NASADAD report in September, 1985, ". . . of major crimes committed in the U.S., one-third are the acts of people under 20 years of age, many . . . with extensive alcohol misuse problems." A recent study released by the Federal Bureau of Justice Statistics reported that more than half of jail inmates convicted of violent crimes had been drinking before committing the crime. For all crimes, 48 percent of the convicted individuals had been using alcohol and 26 percent had been under the influence of one or more drugs before committing the offense. This same study reported that 68 percent of those convicted of manslaughter, 62 percent of those convicted for assault, and 49 percent of those convicted for murder or attempted murder were alcohol or drug involved prior to committing the offense.

Local statistics from the Portland Police Bureau's Juvenile Unit underscore the correlation between alcohol and drug abuse and juvenile delinquency. In the past year, 25 percent of the 4,075 youth arrested by this unit were arrested for alcohol related offenses (1,006 youth) and another 3 percent (122 youth) were arrested for drug related offenses. An informal survey in 1984 of county law enforcement officials indicated that 75 percent of youth taken into police custody in Multnomah County are alcohol and drug involved. (Survey results reported by Mainstream Youth Program Director, Helen Richardson.)

Often, youth delinquency is a symptom of chemical dependency. Law enforcement officials, school administrators, parents, and others involved with youth recognize that many antisocial behaviors and criminal acts committed by youth result directly from alcohol and drug abuse.

Based on prevalence estimates supplied by the State Alcohol and Drug Program Office, there are approximately 2,800 youth ages 13 to 17 in Multnomah County with severe alcohol and drug abuse problems. According to a recent survey of Portland Public School students, 28 percent of high school juniors use alcohol frequently (weekly or daily) and 22 percent use marijuana frequently (weekly or daily). When compared to national surveys of high school students, Portland's juniors show a slightly lower level of frequent use of alcohol and substantially higher usage levels of marijuana. Given that nearly one-third of the Portland juniors reported frequent use of alcohol, however, the statistics for Portland youth remain alarming.

The Regional Drug Initiative Task Force has estimated that there are 500 homeless youth on the streets of Portland on any given night. The Task also estimates that all of these young people are drug and alcohol affected. There are serious consequences for chemically dependent youth who do not receive treatment. Almost half (49 percent) of youth committed to juvenile correction facilities in Oregon have histories of alcohol and drug abuse. Fifty-four percent of youth placed in Children's Services Division funded group homes have significant alcohol and drug abuse problems. Alcohol and drug related accidents are the leading cause of death among individuals 17 to 24 years of age. (Source: 1984 Multnomah County Alcohol and Drug Services Plan.) DePaul treats adolescents at a different facility than the adults. Presently we have 24 beds for adolescents and approximately 25 youth in day treatment and another 40 in outpatient treatment.

PART III

Treatment At admission and later at the first counselor assessment, particular attention is paid to the client problem survey for the disaffiliated client. Our clients have a tendency to be loners in groups, to be disinclined or unable to share the self. These clients are also apt to leave treatment at any opportunity without any apparent worry. This client believes that he or she has no need of anybody to survive: the past years of living on the street would seem to provide proof. De Paul's goal is to include the client in all phases of the program not to allow isolation. Self-disclosure is encouraged in the safety of the group. Attendance at 12-Step meetings is mandatory: here clients can meet with others like themselves who have changed and are living healthy and productive lives. Hope is restored. Bonding is encouraged, isolation is broken down. This happens slowly and in small increments. One-on-one counseling is used to encourage and stimulate the client to remain in the program despite the pain encountered. Group therapy is used to assist the client in that introspection which results from self-disclosure. Trust is re-established and bonding with the group occurs. De Paul is prepared to follow our clients through all three phases of its program to assist the disaffiliate client back into affiliation with society and a productive, healthy life.

At our adult center we have 64 beds: about half of them are assigned to Phase I clients and the other half to Phase II clients. Phase III is our outpatient program, and we presently have 55 funded outpatient slots. We actually have around eighty outpatients, some of them on our waiting list.

Our treatment is, as I have mentioned, offered in three distinct phases. In the first phase of treatment, our goal is to give the clients time and education. Time to recover from the gross effects of alcohol and drug intoxication. Time to recover from the physical disabilities brought about by late stage addiction and the life styles that late stage addiction imposes. We also use this time to offer the clients intensive education through lectures, films, and discussions as well as through intensive group therapy sessions. We attempt to break down the clients' denial systems so that they can accept the possibility of health and so be motivated to change attitudes and behaviors. In essence, we assist the clients to take the first two steps of the twelve-step program of Alcoholics Anonymous.

In Phase II of our program, we assist the client in making the longer-term lifestyle changes that are necessary for continued recovery. In this phase of treatment, we ask that the client find a job. We start charging the clients \$50.00 per week for their treatment at this time, in an attempt to help them to learn that they must be responsible for themselves: many of them have allowed others, and society, to take care of them for a long time. They must learn to be responsible for themselves. This is also a self-esteem issue. Many of our clients need to learn how to interview for a job, how to write a resume, how to deal with not getting the job after the interview. This is a time to learn or relearn many basic social skills that the rest of us take for granted. They are the lost skills (or perhaps the never learned skills) that, if not recovered, will certainly lead to failure and relapse. State-dependent learning plays a real factor in this process: many of our clients are now attempting to do things that previously were easy for them. Now, performing those same tasks without drugs is a new and fearful experience.

Finally, we do have an outpatient program for those clients who need aftercare with De Paul after they have moved out of the building and are on their own. By this time, however, the client will have established a viable support group in AA or NA and have a sponsor. There may be related issues, however, that need to be dealt with: post-traumatic stress syndrome, ACOA issues, incest and other abuse issues, and so forth.

PART IV

Why De Paul? Now is perhaps the time to share some of what I have learned in the past ten years since I left Guest House and became associated with De Paul, at first tentatively and peripherally, and then as board member, Chairman of the Board, counselor, treatment director and presently as President and Chief Executive Officer. Father Leo Booth claims that another name for our disease is isolation. I believe him. I know how lonely and isolated I was when I first walked through the doors of recovery in Rochester. I am sure that many of you can remember the feelings of loneliness, of being desperately alone. Some of you may even be able to identify with one of De Paul's clients who told me one day of his loneliness, a terrible sense of isolation from all that he knew. He decided that it was literally unbearable, intolerable, and that the only solution was to die. The next thing that he remembers is coming to in the emergency room of a nearby hospital. He had tubes stuck wherever a tube could be put. He was strapped down in bed. And he was filled with anger and a sense of desolation that he cannot to this day describe adequately. He said that going through his head were the

words, "See, not even God wants you!"

His disease had stripped from him his family and friends. It had separated him from job and bank account. It had robbed him of the regard of his peers and any shred of self-respect he might have had. It had isolated himself from his own sense of self-identity ("See, not even God wants you instead of me!") and even from his God. But that cry, awful as it is, was nonetheless the start of his recovery. That cry is the cry of the alcoholic in the depths of despair, at the last moment of his bleak and sorry attempt to control the world, to exert power over his environment. It is the cry that identifies him with Jesus on the Cross, crying out in His humanity, "Eloi, Eloi lama sabachthani! — My God, My God, why have you forsaken me!" It is De Paul's task, a task in which I have the awesome privilege of sharing, to meet men and women at this crisis point in their lives. I am reminded of the story of Lazarus who died and was buried before Jesus came to him. He went out to the tomb and grieved and requested that the tomb be opened. His disciples, Lazarus' friends and family, did not want to open the tomb; indeed Lazarus' own sister objected, "Lord, by now he will smell, it is the fourth day." Yet Jesus persisted, and the disciples and friends took the risk and opened the tomb. And Jesus called out to Lazarus, "Lazarus, come forth!" And Lazarus did. And Jesus told his friends, "Untie him, let him go free." And they did. And Lazarus lived again free of the shroud and bindings of death. That is my privilege at De Paul, that is my ministry: to participate in the risk of rolling away the stone. We assist clients to discover the dreadful things of their past — and to find that they are bad odors that can be blown away by the winds of recovery. We do not call clients forth from death, Another does that. We do assist in the process of untying them and setting them free.

Called from the tomb of isolation, we invite them to rediscover their real selves. Through arduous and often painful work, we assist them in discovering the essential worth of that gift which is them, the invaluable gift of God which they are. We help them to come to believe that they can find health and sobriety, because they are worth it. Ann Belford Ulanov, Professor of Psychiatry and Religion at Union Theological Seminary, has recently written of depth psychology something that is true also of our recovery process: that its ". . . work is to unshackle us, . . . to help us to find the secret life hiding away in the bits of madness that we suffer. But when it comes to embracing that life and living on into it, psychology must be transcended. We enter into the space of a relationship between our experience of illness and the transcendent Other . . . how do we house this greater subject which takes up residence in us, radically altering the center from which we live?"[2]

This I believe is Step Two: we come to believe that a power greater than ourselves can restore us to sanity. In other words, we come to realize that we are contingent and finite. We come to know experientially that we cannot do anything of ourselves, but that we depend on the awesome grace of God. This morning I believe that the key to recovery is first to begin to know who I am: a gift, contingent and finite, but immeasurably valuable when one considers the Giver.

Let us examine, for a moment, what I have just said. I am a gift, freely given. There is no necessity in me. I am not owed to me. I am contingent. I need not have been. There is no earthly reason for me to be. I am not necessary — and, apart from God's promises, there is no metaphysical reason for me to continue in being. My being, my existence is contingent not on any metaphysical imperative, not on my own willing it, not on any imperative that I can discover in creation, but on God and his promises. I am finite: I have all too many proofs of my finitude. I have limits, I am not all powerful. As I examine all my own limits, my finiteness, my powerlessness, I come to understand who I am and what graces I have been given. I begin to break free from the sin of Adam and the sin of Lucifer. I begin to realize what a marvelous gift to me I am. Knowing the gift, I can come to know the Giver who is what I am not and is the source of what I am. Knowing the Giver, I can come to know others — themselves gifts of that same Giver; and so my recovery enters into its final phase: what we call Step 12 in AA.

We recognize that our disease, our sin, if you will, is self-centeredness run riot and we turn then to Step Three of that marvelous program of living, Alcoholics Anonymous. We turn our will and our lives to the care of God. Having assisted our clients thus far on the thrilling path to recovery we find that our recovery, our growth in grace, has been enhanced. I find that, in Ulanov's words, "having found this One who is like me and yet opens on to God, Jesus, the concrete person who is the Christ, the self-giving, the self-suffering love of God,"[3] I am able to relate not only to my higher power, but to my peers. And "henceforth we do not do good works or act helpful, but rather live, one with another, in the presence of this live center that holds us all together and in being."[4]

The 12th step, the step which is ministry, becomes a reality in our lives. Isolation becomes a painful

memory of what once was and a ghastly warning of what may yet be, should I lose focus of my true center, Jesus the Christ. More importantly, I have the courage to continue to help open tombs and to rip away the shrouds of death. I begin to live out the life of God's Son who shared mine so completely, even to the total isolation of the cross where he was abandoned by friends, even by the Father. I dare to say that I now understand Gerard Manley Hopkins' words in the poem, *That Nature Is A Heraclitean Fire*:

Across my floundering deckshone
A beacon, an eternal beam, Flesh-fade,
and mortal trash
Fall to the residuary worm; world's wildfire,
leave but ash;
In a flash, at a trumpet crash I am all at once what Christ is,
since he was what I am, and this
jack, joke, poor potsherd,
patch, matchwood,
Is immortal diamond.

And I am the richest of men, since I work daily with diamonds discovering their own worth and beauty.[5]

I must thank Guest House for its part in untying my shroud and introducing me to a twelve-step program which set me free to find my diamond. I must thank you, too, my brothers and sisters, for your patience this morning. Let us pray for one another and especially for those still shut up in the awful isolation of addiction.

[1] Dual Diagnosis Task Force Report, March, 1988: p. 3.

[2] Ulanov, Ann Belford: "The God You Touch," *Parabola*, vol. xxii, no. 3, 1987, p. 31.

[3] *idem*.

[4] *idem*, p. 32.

[5] *cfr.* Hanvey, James: "Aids and Arc: Examining the Church's Ministry," *International Christian Digest*, vol. 1, no. 7, 1987, pp. 41-42.

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