STUDIES

in the Spirituality of Jesuits

Alcoholism and Jesuit Life
An Individual and Community Illness

by

Simon Peter, S.J.

Published by the American Assistancy Seminar on Jesuit Spirituality, especially for American Jesuits working out their aggiornamento in the spirit of Vatican Council II

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THE AMERICAN ASSISTANCY SEMINAR ON JESUIT SPIRITUALITY

consists of a group of Jesuits from various provinces who are listed below. The members were appointed by the Fathers Provincial of the United States.

The Purpose of the Seminar is to study topics pertaining to the spiritual doctrine and practice of Jesuits, especially American Jesuits, and to communicate the results to the members of the Assistancy. The hope is that this will lead to further discussion among all American Jesuits--in private, or in small groups, or in community meetings. All this is done in the spirit of Vatican Council II's recommendation to religious institutes to recapture the original charismatic inspiration of their founders and to adapt it to the changed circumstances of modern times. The members of the Seminar welcome reactions or comments in regard to the topics they publish.

To achieve these purposes, especially amid today's pluralistic cultures, the Seminar must focus its direct attention sharply, frankly, and specifically on the problems, interests, and opportunities of the Jesuits of the United States. However, many of these interests are common also to Jesuits of other regions, or to other priests, religious men or women, or lay men or women. Hence the studies of the Seminar, while meant especially for American Jesuits, are not exclusively for them. Others who may find them helpful are cordially welcome to read them.

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Editor's Foreword

The preparation of the present issue of *Studies* stirred the present writer's curiosity for some statistical information. He consulted several textbooks on psychology and abnormal psychology, widely used in colleges and universities of the United States, and found figures like the following. The estimates vary a little from author to author, but not significantly for present purposes.

Of the some 220,000,000 persons in the U.S., about half take some alcoholic drinks, most of them in a moderate and harmless quantity. But an estimated 12,000,000 to 15,000,000 Americans--6 to 8 in every 100--abuse the drink enough to be labeled, at least for periods, as alcoholics: persons whose drinking brings serious detriment in their health, occupational functioning, and personal relationships. They shorten their life span by an average of 12 years.

Moreover, each of these excessive drinkers is estimated to cause serious distress or inconveniences for about 4 to 6 other persons (on the average), such as husbands or wives, children, employers, and friends. The trouble spreads even more widely in society at large. Abuse of alcohol is associated with about 50% of the deaths or injuries in automobile accidents, 50% of the murders, 40% of the assaults, and some 30% of the suicides. Through absenteeism, impaired efficiency, accidents, and costs for medicine or treatment, it brings a loss of perhaps 25 billion dollars a year to the U.S. economy. It is now the nation's Number One drug problem, with about 200,000 new cases each year; and it cuts across all professions. Whether there are more male than female alcoholics is becoming doubtful. Cases have turned up even among airline pilots, surgeons, and police officers. In these circumstances, it is only natural that instances will be found among priests and religious.

Most persons first walking the lengthy path into alcoholism do not perceive that they are in danger. Instead, for them the discovery usually is that at some time pretty far in the past they became compulsive drinkers, trapped alcoholics. By now they have a disease from which they are unlikely to recover without help from others and iron determination from themselves.

But often their close friends do not know what to do or how to help.

The American Assistancy Seminar is happy to present this present paper from a Jesuit who fell into alcoholism and did, with help from God, his own efforts, and those of his friends, successfully recover. He experienced in turn a desire to help other priests or religious who are either themselves in similar danger or are trying to help others. This prompted him to share his experiences with others by offering to write the paper published here. We members of the Seminar admire with gratitude his courage in making this offer. And we respect his right to anonymity by publishing his presentation under the pen name Simon Peter.

George E. Ganss, S.J., Chairman
The American Assistancy Seminar

ALCOHOLISM AND JESUIT LIFE: AN INDIVIDUAL AND COMMUNITY ILLNESS

by

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Introduction

I am a Jesuit in my thirties. I have a "good job" in one of our corporate apostolates. I feel a personal call from the Lord to serve him and his people. And I am an alcoholic--recovering with the grace of God and the good works and fellowship of Alcoholics Anonymous.

The catalyst for my joining AA was, over several years, the sad and lingering deaths from alcoholism of three members of my Jesuit community. The decline of these three men was all the more horrible for me to watch because I saw that in two of the cases, for some reason or another, help was not insisted upon. They went falling, vomiting, collapsing, being hospitalized again and again, down the predictable chute of alcoholism while many of us said, "Isn't it a shame." When one of them wound up with "wet brain" and did not know himself from a rabbit, I resolved with the help of God's grace to get some help. AA was there to save me. My community was not.

This was not because of callousness or wickedness, mind you. It was because of ignorance, because we are not called to be our brother's admonitor, because "we all have our little foibles," because these brethren did not know what to do anyway other than to preach, to say, "Don't drink so much." By himself an alcoholic can no more not drink than a hypertense person can take the suggestion, "Stay calm." Words won't cure.

Why is an issue of *Studies in the Spirituality of Jesuits* being devoted to alcoholism? Because this disease, just like heart disease, diabetes, high blood pressure, and many other problems you can think of, is part of the lives of too many Jesuits. How many? There are currently

in the United States about one hundred million people over fifteen years of age who drink alcohol. The National Council on Alcoholism suggests that about ten percent of these are subject to the disease. Alcoholism is no respecter of education, spiritual impulse, or moral rigor, any more than diabetes is. It is an equal opportunity disease. This means that potentially in the United States the Society of Jesus may have six to seven hundred alcoholic members. Each of our ten provinces probably has them in the dozens. Some are graced with recovery, like myself. Many others still need help. Other religious institutes too are exposed to this problem, and hopefully can be helped by the accounts and reflections in the present article.

But still the question: Why have an issue of *Studies* on alcoholism? Are we to expect issues also on heart disease, hypertension, or arthritis? Probably these topics will not come up. We take up alcoholism because it is a family disease, because the warping of the alcoholic severely affects the lives of those he or she lives with. An organization has been developed for the families and friends of alcoholics, Al-Anon, which generates understanding. There is no such thing for our Jesuit family--and often nothing to bring such understanding to it, a large community.

Further, in the alcoholic and those whose lives he touches, a depressive and resentful mind-set develops that is in dead opposition to the gladness and liberation of the call of Christ. To understand and treat the alcoholic is to opt for freedom and growth.

The societal dimensions of the disease parallel the spiritual. For example, fifty percent of all fatal automobile accidents involve alcoholic drivers. The American Hospital Association declared that twenty-five to thirty percent of all adult medical-surgical patients in metropolitan hospitals, regardless of the formal diagnosis, are suffering from a drinking problem. One out of four hospital beds in our cities is taken by a person suffering from alcoholism. Some larger hospitals report that fifty percent of all fracture cases result from drunkenness. Thirty-three percent of those who commit suicide are alcoholics.

If the potential for spiritual damage does not effectively lead us to help the alcoholic, perhaps the hellish facts of sickness, death, and

destruction will.

This presentation will focus on how a Jesuit alcoholic affects his community, how he himself is affected, what happens simultaneously to the spiritual life of the individual and the community, what can be done to save him, what the hopes for his and the community's recovery are. I will share some of my story of sickness and recovery with you. For what happened to me could happen to any of us. I never dreamt in a hundred years that I would "grow up" to be an alcoholic. No one does. But it happens.

I hope that this presentation provides a broader base of understanding among the healthy so that they see what alcoholism can and may be doing to them in community. For the not-yet-recovering alcoholic, I hope it shows that hope and health are around the corner.

PART I. THE PROBLEM

A. The Alcoholic: A Problem to Others

How do Jesuits perceive drinking? Pretty much as other Americans do, as a normal part of life. We are exposed to the one-billion-dollar advertising with which the liquor industries of the United States and Canada face us. In most publications we read, we see liquor advertised as the symbol of "the good life." Our perceptions of the danger of alcohol are minimized by our continued exposure to it. We are offered a drink when we go to people's homes. And, in many of our communities, we are accustomed to a cocktail period before dinner. We celebrate with liquor. We relax better. We forget perhaps some of the strain of working and living so closely together.

Jesuits often note with amusement that many of us don't measure our drinks with a shot glass. We pour rather freely and generously. A guest is invited right up to the bar. Our novices and younger scholastics are exposed to this "normal pattern of living" from their early days in the Society. It is nothing we hide.

Once in a while we see that someone has taken a bit too much. He might be a bit more chatty than usual. Or maybe he is argumentative and

loud. Or he becomes negative and depressive. Or his speech is slurred. And we give him the benefit of the doubt. "He has had a hard day." "The drink just caught up with him." "It only happens with him once in a while." And these excuses are often the right ones. Any of these things can happen to any normal person. If they happen just once in a while, almost like an accident, they mean nothing special.

But then we might notice that this or that person is frequently "that way." Sometimes he is such a good guy, works so hard, is fine--well, most of the time--so that we do not like to say anything. Yet he can be embarrassing to be with. Maybe we plan how not to be with him at the dinner table. If there is a faculty party, we try to be on the other side of the room. Sometimes we may overhear his loud laugh and think "old Joe is in his cups again." And we might wish he weren't.

Then too we might find ourselves the butt of his rather black humor at times. An alcoholic is an angry and intolerant person. His life is running away from him and seems out of control. He blames everyone for that. And we may be faced with his irritation on "the morning after," the phenomenon of caustic comments and insulting remarks that can ruin our breakfast. We feel less open to him as an individual and as a Jesuit when we have experienced the brunt of his anger.

1. Denial

But we are pretty tolerant. We might say that this fellow seems to be in a bad mood lately. His complaints might lead us to think that anyone would be irritable that was having such a difficult time. So we go out of our way to make excuses for him, to try to be forgiving. No one is perfect. We face our own imperfections constantly. We tell ourselves to be compassionate towards him.

All along we may be thinking that "he will come out of it." It is only the annoyance of the present situation that is causing the problem. It is his heavy schedule, perhaps. "As an administrator, he has a pack of headaches, I'm sure." We hope silently that he will ask for and receive the grace "to become himself" again.

We even sometimes move a person to another community to give him a

fresh start. "The situation at St. Z school was very difficult for him," we might say. Sometimes we give the man a year off to rest and study or to work in another apostolate in order to pull himself together. But we get a bit frustrated when, after our thoughtful efforts, we can see he is still drinking heavily.

Our compassion may lead us to think that if the situation at such and such a community or school were more truly open, thoroughly charitable, not so old-fashioned, and the like, he would not have become this way. "It's really our fault, in a way," we might say. "To be assigned to that place could drive anyone to drink." So we begin to look a bit sourly at others, maybe too at ourselves, suggesting they or we are really to blame.

Or maybe he is a retired Jesuit, a man whom we respect, someone who may have been our superior at some time. "He is a lovely old guy, but he's taking out his pension in booze." This Jesuit in retirement has more time on his hands, may be bored, and has always associated relaxation with alcohol. But his body has aged and the heart, nervous system, and liver don't work the way they used to. Just because he could enjoy several martinis when he was thirty-five does not mean his system can take it when he is seventy. It is pathetic to see a Jesuit who has served the Church so well be reduced to a bumbling and chattering shadow of his former self, shaking so badly that he cannot get a glass from the table to his mouth without spilling it. We feel we owe respect to the man, but we are horrified to see what he is doing to himself. And we question whether we have left him so lonely and unappreciated in his old age that he has turned to alcohol.

2. Anger

But the time finally comes when we talk to the superior about it. It is really getting on our nerves now. "Something has to be done about Father X," so we say. And, unless the superior has been hiding his head in the sand, he knows it too. The superior may nod his head sagely, agree that something should be done, and wonder what to do. He may ask if the other thinks it is just a passing phase. He may even say that he has talked to Father X about it and X says he can stop whenever he wants to. He may

wonder, if Father X can choose to drink or not to, why does he always choose to drink? And so both the superior and the reporting subject feel that their discussion is inconclusive. The subject may be annoyed that the superior does not know what to do or how to do it. The superior may feel anger that this troublesome problem is before him when there are so many other things to do. He may feel frustrated in not knowing how to help.

So perhaps a Jesuit, bothered by his brother's problem, decides that a personal approach is the best thing. "We have always gotten on well"; or "We went all through the course together"; or "I've known him for years and really respect what he has accomplished." So he talks to this Jesuit drinking alcoholicly, apologizing in a way for mentioning it, saying that "it might be a problem." Depending on the stage the alcoholic Jesuit is in, his friend might be thanked for his concern and assured that everything is under control. He might be told to mind his own business. Or the drinking Jesuit might say honestly that he knows it has been a problem, but now he is doing his best to get it under control. From any of these responses the confronting Jesuit will end up feeling anger or frustration because the alcoholic situation will most probably continue to deteriorate. And this friendly soul will, as he sees it, have exposed himself to anger or long explanations for nothing. He will feel more uneasy than ever in the presence of the Jesuit drinking alcoholicly.

3. We Notice the Problem

Then there are those lay people who make comments about Father X who always has the lampshade on his head at the faculty party. Or Father Y falls asleep on a couch and has to be helped to his room. Or we overhear a secretary saying that a wise person would steer clear of Brother X on mornings after big feasts. We become angry. Here we are, working our tails off in the apostolate, building up a good rapport with people, setting up a really positive community of good will, and old boozy Father X throws red dye in our clear stream. If he can't behave, why doesn't he get out!

Or perhaps Brother Y is in an accident while driving drunk. Fifty percent of traffic fatalities are because of alcohol. Maybe he wrecks a car, hurts himself, hurts someone else, or even kills someone or himself.

I know a priest, now dead of alcoholism, who served a sentence in the state penitentiary because he killed someone in an automobile accident while he was under the influence. Since we know that this can happen, we worry about the implications of this Jesuit's driving. What is the community's responsibility for policing his use of a car? What about the uncomfortable position of a community member finding himself in the car with a Jesuit driving who has had too much to drink? What does he say? Does he insist on driving? Or does he pray the *Memorare* more fervently than usual? "Why did I sign up with this guy?" he might think. "I should have known. Never again." He may never ride with the alcoholic again, but probably the alcoholic is still driving.

Or there is the man in the community who sometimes collapses in the dining room, hallway, or in his bedroom. Crash, clatter, bang, as he knocks things over. Then we probably have to call an ambulance. The driver and hospital people know that Father X is dead drunk. How nice for the community's image. What an end to a heavy day in the classroom.

Sometimes we have to "engineer" situations for our drinking brother. If there is a teachers' party, someone is delegated to keep Father X busy somehow so that he gets to the party late. We hope he won't get so looped.

Or several are "elected" to fill the table where Father Y is seated so that the lay teachers don't have to sit with him. These elect have to listen to the drunken chatter, the demeaning gossip, the negative comments, the insistent opinions--and maybe haul him off to bed as well. On the one hand, the members of the community would like to get up and walk away. On the other, he will just embarrass them in front of their lay colleagues. So they have to listen to him--or else. And they get mad because they feel boxed in and manipulated.

So the Jesuit drinking alcoholicly annoys us. We know that whatever he touches will be affected for the worse. Even if he doesn't do anything untoward, we may be embarrassed by his being known as someone who can drink anybody else under the table. When we know we can usually find him near the bar or clinking ice cubes alone in his room, we begin to lose sight of his accomplishments and his potential. We wish something could be done for him. We wish he weren't around. We don't know what to do with

him or for him. We give up on him. And we probably avoid him.

B. The Alcoholic: A Problem to Himself

For an alcoholic, the "morning after" is terrible. Not only does your head ache, but your mouth feels like it has swallowed a sand storm, and your eyes are painfully aware of the morning's brightness. Worst of all, you wonder what you did or said the night before. I remember wondering whether others realized I had had too much to drink. How did that reflect on my school, my priesthood? Did I look and act foolishly? Had I offended anyone?

Given the style of our lives, we can often hide the effects of a bit too much indulgence. Our lives are private enough that, if we can get to our rooms with some dignity after dinner, no one is the wiser. If we cannot get up as early as we want to in the morning, no one is there to check on us. As long as we do our work and carry on our lives in community with reasonable geniality, we are esteemed a "good monk."

1. Blackouts

But there are times when you do not remember what happened the night before. These phenomena are called blackouts, periods of amnesia. They can last minutes, hours, or days. The person acts in a seemingly normal way, but the day after he has no recollection at all of what happened. You are afraid to ask anyone for that would be to confess your problem. And you do not want to admit that to yourself, let alone to another. But you are also afraid that you may have done something wrong, made some commitment--and you do not recall anything.

I once drank too much in an afternoon and spent the evening in a blackout. I knew I was to meet a friend's fiancé and go out with them for dinner. Yet the next morning I had no recollection of this, of driving home, of going to bed. My clothing was all neatly hung up; my towel was still damp from the shower I must have taken. I went to check and the car was in its right place and the keys returned. But I remembered nothing. And it scared the life out of me. Later on when I told this newly married couple of my joining AA, they recalled that I had acted entirely normally that evening, had eaten dinner in a restaurant with them, and had driven off

in a seemingly safe fashion. They had no inkling that I was in a blackout. My accustomed responses had saved the night.

These blackouts are an experience many alcoholics have. They signal, among other things, brain damage. And they are one sure, though not necessary or exclusive, sign of the disease.

And so, after bouts like this, the alcoholic swears off drinking. You feel wretched anyway and so it is no problem. But a few days later, when the body pulls itself together again, there you are, back at the bar. Clearly the alcoholic does not learn easily. But it is not a matter of learning. You just have no control. No alcoholic does.

2. Obsession

I know from my own experience, and from hearing the experiences of others in AA meetings, that an alcoholic spends a good part of the day thinking about alcohol. Instead of my first waking thoughts being on the Lord, as St. Ignatius suggests, I first thought of how much I would drink that day. I knew what commitments I had ahead of me that day and the following. I would plan to have only one before dinner because I had an early class the next day. But then again, it might be a hard day today, I'd reason. Two wouldn't matter. But the problem was that two often became three or four--big ones. I never thought much about measuring.

Then after dinner I'd dutifully, heroically, go back to my office and shuffle papers. I really could not focus on any ideas. If I spoke on the phone, I tended to be very long-winded. And my community often did not witness this effect of too much drinking because I was not with them.

The alcoholic swears off drinking innumerable times. He sometimes proudly announces that he is "on the wagon." I purposely did not drink during retreats to show myself my mortification and control. I figured that if I stopped for eight days, I could not possibly be an alcoholic. I also made extensive plans on how to control my drinking. I tried wine for a while, then beer. But the alcoholic content of one normal glass of wine or one can of beer is equal to that of a shot of hard liquor. It just takes longer to drink--and more volume to achieve the desired effect.

3. Embarrassment

I always wondered if people knew it when I had too much to drink. I felt very chatty when I drank. Maybe too chatty, I thought. So I had to think out in my befogged brain just how to allow my geniality its scope and not to betray its lubricant.

I became terribly sensitive to anyone talking about those who drank too much. "Was that an oblique reference to me?" I wondered. Better not to sit with so-and-so for a while so it won't come to his mind again, I resolved.

When one good friend, in honest annoyance, said to me at the dinner table in our small theologate community, "There you are, sloshed again," I was mortified. I denied it. I was angry because he had said it in front of a group. But it scared me. Since he was a man I liked and respected, I knew he did not say it out of spite or cruelty. He had just had his fill of me and was confronting me. I suppose that it might have been better if he had followed that up with a private discussion when I was sober, but perhaps he was embarrassed at his outburst and felt out of his depth in such a discussion. It took eight years of further drinking for his comment to take root in my priorities. But I never forgot it. It was the kindest thing he could have said to me. For I knew that others were noticing my drinking, just as I was. And I was afraid.

An alcoholic solves the problems of the normal loneliness and pain of living by drinking. But then the liquor creates problems all its own. For instance, like many people, I felt sometimes uncomfortable with visits home. Somehow I had expectations that my family did not measure up to. So I drank at their homes to relieve the tedium and, so I thought, make myself jollier. But this drinking worried my family, even though they were reluctant to bring it up to me, the priest. One relative would make special comments whenever there was some public person, an actor or politician, who got in trouble because of drinking. I knew she said this out of concern for me, but I resented it enormously. When my father, an ever-quiet man who was always a source of encouragement, spoke once in worried tones, I was angry, but politely assured him that all was under control. But their worries--and the problem that I wouldn't and seemingly

couldn't face--hung over my head. And I felt added remorse that I, a priest, should cause concern because of my involvement with the bottle.

And what was happening to my priestly character, my spiritual life? I had worked hard all those years to complete the course, tried my best in prayer and on retreats, got myself ordained in the general good graces of everyone. But what, I thought, if I kept having trouble with the bottle? Would my little secret be whispered abroad in the school and everyone know and watch the young priest go down the tubes? Or would my brother Jesuits know it and just watch me ruin myself, as we had watched and let those other Jesuits in my community kill themselves? I came in a way to be an observer of myself and my problem, a watcher of my own disintegration, a helpless other person faced with a fate that seemed inescapable.

One time I knew I had an eight o'clock evening Mass to say, but could not control my drinking before or at dinner. It was too late to get a substitute without admitting "my problem." So, very carefully, very deliberately, very worriedly, I celebrated Mass as scheduled. I hoped I would meet no one afterwards, but, as luck would have it, one person was there who talked for a bit while I held on to a rail for support. And then she said something about drinking. It hit me like a sledgehammer. I had been so careful. Had she noted my drinking anyway? What will she think of me, of the priesthood, of the Jesuits? Not so good for a person's priestly image. In these ways is the alcoholic continually tormented with remorse and guilt.

4. <u>Alcohol: The Disease</u>

When normal drinking degenerates into compulsive drinking, when the threshold of control is crossed, the alcoholic is in trouble and afraid. My experience is that it is hard to face and admit lack of control. For, in one way or another, I had always been in control. I had always worked hard at my studies and had been able to "control" the subject matter. The apostolic experiences of my regency were a success, for I had been able to organize my talks and relate well to my co-workers and Jesuit community. I spent a good deal of time on homilies and prepared each liturgy carefully. I had been blessed with a number of successes and people had sincerely complimented me.

It is a commonplace in literature on alcoholism that the professional person--physician, dentist, lawyer, judge, educator, clergyman, businessman--has the hardest time facing his or her problem. These people are used to being in control, to making decisions on priorities. But here the alcoholic Jesuit is--yes, here I was--in a runaway situation that preoccupies much of his attention. He keeps telling himself that it won't happen again and dreading in his heart that it will. To the question "Is my life unmanageable?" he has to begin to admit that the answer is "yes."

Alcoholism is a chronic and progressive disease. Once you have got it, that's it. It never goes away. It can be arrested by not drinking, but it can't be cured. Untreated it leads to one of two things--insanity or death. To these, the only alternative is abstinence.

Alcoholism is a disease. Some may want to question this. Perhaps they think it is just a matter of will power. But it is a disease. The American Medical Association, the American Hospital Association, the World Health Organization, the American Bar Association, the United States and Canadian governments, plus any number of national and international medical associations, all say so. As a disease, it is the third most successful killer. Only cancer and heart disease do it better.

5. The Quantity of Alcohol

As with any progressive and chronic disease, it only gets worse. "Worse" for an alcoholic, for me, other Jesuits, anyone--is always that he drinks more. The system does become more tolerant. The liver works harder at detoxifying the blood. The alcoholic finds that he needs to drink more to get the same effect one or two drinks produced just a few years before. And the physical effect this has on the system is ruinous.

I was a gulper. Many alcoholics are. While the normal person is drinking one drink, I needed two. If I had to wait for a second round in a restaurant while the others nursed their drinks, I nervously twirled the ice cubes around in my glass. I never much liked drinking in restaurants because they made only one-shot drinks. Even two drinks did not get me to where I wanted to be. To order a third was expensive and might betray my problem to the other people. To drink at home, where no one was counting,

no one was measuring, was much better. I began to prefer to be home rather than out with friends. Drinking forced me to shut off a healthy side of life and to confine myself to friends according to the drinking opportunities they afforded.

And then I always minded the cost of a drink in a restaurant, sometimes two dollars for a small one. At home I could drink up to eight or ten ounces for free. My need contributed to the twenty-five billion a year Americans spend on liquor. I never gave a thought to the cost to my community. It was a need of mine. I was working so hard that I deserved it. I had so many difficult people to put up with that I owed it to my nervous system to relax. The world was wrong. I was being put upon. Small price, a couple of drinks, to make life tolerable.

The funny thing was that more and more things began to make life intolerable. I complained bitterly. And I became afraid of an occasion when there would be no liquor around to lighten my burden. I was in a hospital once for an eye infection. The only liquor they gave out was a small glass of wine at lunch. I got a friend to bring me a bottle which I hid in a drawer. I told him I was having trouble sleeping. He suggested that I ask for a pill from the nurse. I replied that I never liked to take drugs if I could help it. The reply did not strike me, or him apparently, as ludicrous, even though I was already addicted to the drug alcohol.

6. How to Get a Drink

The time comes for every alcoholic when he becomes a sponger. He has spent all he has on drink, but he still craves more. Whether he is a panhandler on the street, already drunk, but still asking for money so he can buy some cheap wine, or the more elegant and refined Jesuit alcoholic who needs it just as badly, there is always the problem of supply. To ask for too much pocket money may cause suspicion. The house bar, however, may not be open as often as is necessary. There are always good friends who can be counted on at birthdays and at Christmas (lovely Christmas with all its cheer), or the understanding ones who give you a bottle as you leave their home. One Jesuit of our community was usually totally drunk when his hosts used to pour him home, but, as a parting gesture, they

thoughtfully put a bottle in his overcoat pocket. That fine man is dead now from alcoholism.

Some houses (blessed relief) have an open-bar policy. This is fine for unaddicted people. After all, there is sugar on the table and ice cream for dessert, diabetics in the community notwithstanding. This open bar saves untold worry for the alcoholic. He can be the head bartender for the house, making sure all the supplies are stocked, sampling them liberally to check their quality. He justifies his continued presence at the bar by his service to the community. Or, if he is a closet drinker, he can easily purloin a bottle of his favorite potion and take it to his room. The excuses for all of these actions would be rich in their confection, if that person were asked to supply some. But he is probably not asked. And the Jesuits of his community may know well what is going on, but not know what to do about it.

7. Work and the Alcoholic

For an alcoholic, work is a real problem. First of all, you often do not feel well. To be at that class or office on time and for a full day is really draining. Secondly, there is always someone, student or colleague, who has some imaginative new plan for something or other. You admit that it is a good idea, but it means more work. You don't know how you can fit it in, giving due priority to the time you know your drinking takes. Or there are those cheery types who want your help or attention just as you are trying to get through a hangover. What is worse, you have to hide your problem and be the open and loving type you tell yourself you want to be and still are. But you dread any appointments, any projects, any new ideas that may change your automatic programmed responses.

Or you need some drinks first thing in the morning to stop the shakes or at noon to get you through the day. But then these might leave you sleepy or unable to concentrate on your work. You may have to keep a bottle in your office and keep filling the coffee mug on your desk with its power. Or you may carry a flask in your briefcase and nip into the teachers' room or men's room between classes--or even in the middle of a class--for a bracer. While these settle the nerves of the alcoholic, they

don't much help his attention span.

A lot of people think of the alcoholic as the down-and-outer, the Skid Row habitué, the drunk sleeping in the gutter. Actually only about three percent of alcoholics call the street their home. The "average" alcoholic is about forty years old, has a good job, and has a high school education or more. In the AA meetings I attend, the people are from every walk of life, judge and policeman, nuns and priests, men and women who have only become alcoholic after their spouses have died, young people who are addicted to drugs and drink, little old ladies with blue-rinsed hair, and teenagers. For this last group, there are often meetings solely of young people in their age group, where they can talk about sobriety and recovery in terms of their own problems. There are several alcoholic rehabilitation centers in the United States for those under twelve years of age with the problem. And I had thought that I was too young to be an alcoholic!

8. Signs of Alcoholism

It is common for the alcoholic to be a most resentful person. The emotions and perceptions of reality go haywire under the strain of so much alcohol. Oh, sometimes they are most convivial, but the pervading emotion is anger. In my case, if there was something amiss in the world, the Church, my school, my community, I was articulate in exposing the apparent wrong. If you did not see it quite so strongly as I, you were either of ill will or too dull to notice.

It is hard to live with a guy whose only interest is what goes wrong, who always knows the right way for things to be done. He becomes too self-righteous for anyone to put up with. So people steer clear of him. And the alcoholic, knowing this reaction and afraid to stir up people's just anger at himself, is careful not to be with the same person too often. He withdraws more and more. And the loneliness of an isolation induced by his fear of being discovered, even though he may live in a large community, leads him to compensate by more drinking.

Yet the alcoholic Jesuit, the alcoholic anyone, realizes that he is isolating himself, but does not know what to do about it. Where he may

have been a quiet and compassionate person, he finds he harbors a growing irascibility. Where he could previously laugh at himself and with others, now he is hypersensitive about anything said relating to himself. Is it a veiled insult? Is it a threat? He does laugh at others--at their foibles. He must bring people down to his level, knock them off their pedestals, make another or all the community so angry at his behavior and their own ability to deal with their own emotions about him that they lash out in anger; or maybe in dissatisfaction at the problems he so insistently points up. Then he has got them where he wants them. He can see their bitterness, their annoyance, their going out of control. They are a bit like he is now. Their dislike of him, their anger at him goes to reinforce his own perceptions of himself. His illness has helped to create an illness in them. They, whose actions may be the supposed excuse for the alcoholic Jesuit's drinking, become afflicted with anger, intolerance, and dissatisfaction in the way he is.

C. The Alcoholic: The Problem in Common

In marriages, this is the time when separation and divorce take place. In our Jesuit communities, the situation usually just continues. The disease that is progressive in the alcoholic Jesuit can become progressive in a parallel way in his community. The members of his community become, just like a spouse, co-alcoholics, tied to the swings of the disease's rampages. They are no longer free people, acting healthily and creatively with one another. They are Jesuits in reaction to a diseased focal point. (The extent of this reaction, of course, depends on the size of the community and on the extent to which the members allow themselves to be touched by others' lives.) Whether their reaction is anger, disappointment, embarrassment, or frustration, their lives are more and more to be considered in relation to and focused upon the alcoholic. The more sick he becomes, the more outrageous his behavior, the more sickened they become by his presence.

The community becomes discouraged. "If we can't heal our own, how can we help to heal others? If our ministrations and concern in our own community don't work, how are we going to be effective in our outside

apostolates? If the superior cannot deal with this Jesuit whose life is screaming out for notice and help, how will the superior be able to help the normal person in his times of sickness and need?"

The spiritual self-doubt that now affects the community is mirrored in the alcoholic Jesuit. Every bit of the Society's history and spiritual tradition stand there to judge him. He prays about the Two Standards, the Call of Christ, the Three Classes of Men. Better not to think about it. He comes out on the wrong side, unhearing, low man in any such considerations. What can he tell Christ about the priest, the Jesuit, he has become? He feels a spiritual emptiness in himself. The only thought that fills him is the promise of drinks that day.

PART II. TOWARD SOME SOLUTIONS

A. The Situation

1. Reflections on the Disease

Our reactions as Jesuits to an alcoholic in the community are different from our reactions to others who may be ill. We know that Father X has diabetes, Father Y has heart problems, and Brother Z uses a walker. We are compassionate, recognize the unpleasantness of the problem for the man himself, and try to help him out as we can. Their problems are more or less publicly known and considered to be part of the community scene. The alcoholic's problem is probably known, but it is usually not publicly acknowledged. We do not refer to it with the alcoholic individual. We do not normally extend our compassion and concern. We do not usually say, "How is your alcoholism doing?" although to the others we do say, "How are you feeling with your pacemaker?" or "Is the new diabetes medicine helping?"

The situation parallels to some extent the fighting in Viet Nam. The soldiers were getting killed in a "battle situation" that was not technically declared a war. So with the alcoholic Jesuit, we are facing a disease situation that is not publicly acknowledged and accepted. The community has to put up with all the anger and antisocial behavior of the

alcoholic Jesuit. But the members cannot publicly, communally, discuss the problem. The community is, in a way, powerless before the disease and its effects. And usually, at one level or another, its members are angry for having to put up with a situation that has not been publicly declared.

While it may sound strange, the alcoholic is often the last to know of his illness. It may sound stranger still for this to happen to some Jesuit who has had years of schooling and is reasonably bright. But it is true. I could not see what was happening to me or understand what I was doing to my community. My whole preoccupation was with drinking and how I could fit my apostolate in around it. At first drinking interfered with my work; then work came to interfere with my drinking. But I never had the time for any objective diagnoses, and never the courage to face what I might find.

A person in the throes of alcoholism is obsessive-compulsive. He is obsessed with the thought of drinking. His body compulsively craves it. This total preoccupation precludes an understanding of and represses an openness to what is happening to him. If someone had asked how my digestion was, I would have said, "Just fine." And I would have been annoyed at the presumption of their questioning. If I were to have been asked about my drinking, I would have said just the same thing, knowing in my heart that I was daily trying my best to exert my customary control over it. To me, alcoholism was a drinking problem that a person could not deal with. I was *trying* to deal with it. Just because I failed didn't mean I was an alcoholic. It just meant that I wasn't trying hard enough. To my mind then, it was a question of moral resolve.

2. The Stigma

If a person thinks that maybe he is a diabetic and recalls that several of his family are or were diabetic, he mentions it to a doctor and is tested. There is no stigma. He need not go on about how he loves bonbons. You either have the sickness or you don't. If you do, medicine is prescribed and you have to live by a diet. But it does not reflect on your moral caliber, your religious convictions, your priesthood. It's

an illness, pure and simple.

The alcoholic, or person knowing he is out of control and wondering what on God's earth to do about it, does not have these stigma-free options--or so he thinks. If he asks a doctor, he fears that the doctor might look at him in a funny way. Asking a member of the community is no good. What would he know? We never covered anything like this in studies. So often the alcoholic lives, or rather drinks, with his problem, afraid of the stigma of asking, afraid of the day when he will be confronted and exposed.

Even less is the alcoholic Jesuit likely to mention his problem in a manifestation of conscience to his local or provincial superior. He may talk about the problems of his work and even of his life, but, on the topic of drinking, he remains silent. First of all, he cannot admit it to himself. Secondly, despite all the earnest comments in province alcoholic rehabilitation statements (see Appendix IV for an example of one province's statement), he knows that treatment involves his stopping drinking. And he just does not know how life would go on without liquor.

3. To Hit Bottom

All common wisdom had it that you had to let an alcoholic hit bottom before he would see the light and get help. This point of view has its merits: A lot of people are dead or insane before hitting that proverbial bottom and so there are fewer problem-people to deal with. But it is an immense waste--those years, guilt-ridden and mired in anger. These years of destructive drinking waste the past too, all those years of preparation that led nowhere.

For the person to hit bottom usually takes ten to fifteen years. It is a long time to watch a good person ruining himself. It is like being faced with a leprous person before medicines were discovered. He just falls apart before you. That is what happens to the life, ambitions, hopes, productivity, and spiritual life of the alcoholic; they fall apart. And the community is privy to the ruin and--if it doesn't do something--party to the destruction.

4. To Admit the Problem

To go back to my own story once more, I got sick of what was happening to me and afraid of what I saw happening to the three Jesuits whom I mentioned in the introduction to this article. And so I went to see, with all the secrecy of confession, one Jesuit of my community who is in AA. We had a frank discussion. He expressed amazement that I had the problem. Here it was, getting to the disaster stage for me, so much so that I was even willing to talk about it with someone; and he had not even noticed it. Such is the problem in large communities where you are usually not with one another often enough to notice what is happening. I was delighted that he did not confirm my suspicions immediately. Obviously I had not made a public nuisance of myself so far. Perhaps I was making mountains out of molehills.

This recovering alcoholic Jesuit told me to be sure of my addiction before joining AA. Since I professed that I was definitely unsure, he suggested that I set a limit for drinking that I thought was reasonable and normal. I would resolve never to drink beyond that, no matter what the occasion. If I could not stick to that, I was most probably an alcoholic.

I went and thought on that one. If I proposed too large a limit, the whole test would be meaningless and I would never know if I was an alcoholic or not. And I might end up killing myself in the course of my testing. If I proposed too low a limit, I was possibly cheating myself of a good time and the possibility of normal drinking. It is a measure of the extent of my disease to note what I determined as the amount never to be exceeded: three doubles, poured liberally by hand, before dinner, a half bottle of wine with dinner, and two after-dinner drinks when these were offered on feasts or at people's homes. If this does not strike you as a lot, you maybe have a problem. If you find it a great amount indeed, you will be interested to know that it is relatively modest in comparison with the consumption of those who progress further in the disease (like a friend of mine now in AA who drank six half gallons of bourbon in five days and had to be taken to the hospital for emergency detoxification).

But I could not stick to my liberal drinking limit. True, I failed it just once in a while. But the occasions were frequent enough. Yet it took me another seventeen months before I could approach that Jesuit again and tell him of my failure. He sent me to a doctor, himself a recovering alcoholic, to talk it over. The doctor handed me the test printed here:

ARE YOU AN ALCOHOLIC?

To answer this question, ask yourself the following questions and answer them as honestly as you can:

	Yes	No
Do you lose time from work due to drinking?	___	___
Is drinking making your home life unhappy?	___	___
Do you drink because you are shy with other people?	___	___
Is drinking affecting your reputation?	___	___
Have you ever felt remorse after drinking?	___	___
Have you ever gotten into financial difficulties as a result of drinking?	___	___
Do you turn to lower companions and an inferior environment when drinking?	___	___
Does your drinking make you careless of your family's welfare?	___	___
Has your ambition decreased since drinking?	___	___
Do you crave a drink at a definite time daily?	___	___
Do you want a drink the next morning?	___	___
Does drinking cause you to have diffculty in sleeping?	___	___
Has your efficiency decreased since drinking?	___	___

	Yes	No
Is drinking jeopardizing your job or business?	___	___
Do you drink to escape from worries or trouble?	___	___
Do you drink alone?	___	___
Have you ever had a complete loss of memory as a result of drinking?	___	___
Has your physician ever treated you for drinking?	___	___
Do you drink to build up your self-confidence?	___	___
Have you ever been to a hospital or institution on account of drinking?	___	___

If you have answered YES to any one of the questions, there is a definite warning that *you may be* an alcoholic.

If you have answered YES to any two, the chances are that *you are* an alcoholic.

If you have answered YES to three or more, *you are definitely* an alcoholic.

(The above test questions are used by Johns Hopkins University Hospital, Baltimore, Maryland, in deciding whether or not a patient is alcoholic.)

I failed the test, marking a *yes* at five entries. The doctor told me to tell my superiors and ask to go to Guest House. I was afraid to tell them. So I went to an AA meeting with the Jesuit from my community. I have been going to meetings ever since. If I had it to do over again, I would take the doctor's advice. It would have streamlined the path to sobriety. But I made it in AA. I found it to be a spiritual program that harmonizes altogether well with Jesuit spirituality. That is perhaps because a Jesuit, Father Edward Dowling, S.J., was influential in the formative years of the program. In AA a Jesuit will feel at home with the program. In Appendix II below on page 54, a passage entitled

"How It Works" is reprinted from chapter 5 of *Alcoholics Anonymous*, the "Big Book" of AA. This section includes AA's twelve steps for recovery. They can help anyone's *metanoia*. Through the grace of God offered to me in the AA program, I started back on the path to God that was opened to me on the first day of my novitiate.

5. A Community Response

One of the greatest charities you can offer your brother Jesuit who is drinking too much is to face him with your concern. Do it when you know he will be sober. Just say, "This is how I see it." Don't moralize; don't try to convince him. Just go to him as a friend, as a brother. He may say, "I know that it is probably not easy for you to come in and say this." But whether he is gracious or not, whether he does anything about it right then or not, you are facing him with reality, the way you, and probably others, see him. That is at least a start. The honesty of the members of his community will play an important part in his recognizing and accepting his problem.

And then pray for his healing. If you think you have problems with the compulsions in your life, know that this brother of yours, if he is an alcoholic, is an addict. His compulsiveness is total, uncontrollable. By himself he can do nothing. Pray that the Lord will give him the grace of sobriety.

But what about the Jesuit who does not find AA or ask for the help of Guest House or some other rehabilitation facility? His Jesuit brothers have to face him with the reality of what is happening to him. "Live and let live" is death for him. "Live and help live" is his only hope.

How is that done? It involves the superior making an appointment with the person, probably for the morning when he will be more or less sober. This Jesuit comes to find the superior and several others who can clearly describe the evidences that give them cause for concern. When the drinking Jesuit sees them, his heart drops. He is angry, afraid, ready to walk out. Someone tells him first of the positive things in his life, of the successes he may have had, of the potential and quality they see in him. There is no reason to be flowery here, but just make some comments

that are honest and sincere. This Jesuit probably has not heard or thought anything positive about himself for some time. He will not quite believe it all, but it will be healthy for him to look back on.

Then someone, probably the superior, tells him that they all feel he has a problem with drinking. This should come as no news to him. The matter should have been brought up to him repeatedly before in a concerned fashion by both his peers and that superior. But he probably will not take much pleasure in their effort. He might again simply deny that it is a problem. Or he will minimize its seriousness. He might start blaming others for the problems in his life that lead to drinking. He might say that anyone would drink a bit if he had to live in a house with such suspicious people. One alcoholic counselor told me that he considers it an easy session if he is only told once to go to hell. So the confrontation can be a rather difficult interview.

But the superior and the others present should not allow themselves to be affected by the drinking Jesuit's anger. They are facing him with what terrifies him. Nor should they get involved in any discussion of the rationalizations he puts out. Rather they should individually mention specific instances of his behavior when drinking. Recount chapter and verse of just what has happened. These are not opinions; they are facts.

There may still be argument. The drinking Jesuit may say that he does not drink as much as he used to, that he has cut down significantly, that he has even been off liquor for a time now. All these efforts, even if they are true, only point to his personal attempts to deal with a problem that he knows is getting out of hand. It is not these off-and-on efforts that are significant. It is the consequences of this drinking, what it does to his life and the lives of those he works and lives with, that point out the need for professional help.

The superior then says that, because of the continued nature of these behavioral patterns, because the quality of life and service has been impaired by the drinking as has been detailed, he has decided that professional treatment is an urgent priority. Since the superior and those then with him are in no position to diagnose the problem professionally, they do not have to call it alcoholism. It can simply be named

problem drinking. The Jesuit should be assured of confidentiality in regard to the meeting just held and the rehabilitation and diagnostic program. It is the superior's job at that point to help find another for the man's work, if this is at all possible. But what is most important is that the man be told that the appointment with the rehabilitation facility has been made. It will begin tomorrow. The tickets are on the table. Someone is going with him. The time of departure is set down.

What if he says no? Then the superior orders him into treatment. If he resists, he is told that he is removed from his work until he gets treatment, though he will be most welcome to return after his recovery. If he still refuses, he must be dealt with as anyone who refuses to obey the legitimate command of his superior. If these seem like draconian measures, you have to realize that an alcoholic is one of the best manipulators there are. He is an expert at denial. He is killing himself and harming his community and apostolate by his denial. The only way to help him is by being firm. (For excellent articles on confrontation, please see the Bibliography below, after Appendix IV.)

Are there any parallels for this treatment? Experts in alcoholic rehabilitation tell those in business to do this with their employees, to offer them rehabilitation time and a promise of a welcome back. But then they say, if necessary, "No rehabilitation program, no job. You either get help or get fired." In marriage there is a parallel pressure from the words, "Either get help or the kids and I are leaving." By this intervention, we are precipitating a crisis, not waiting for it to happen when the alcoholic Jesuit is practically dead from overindulgence. (A good example of decisiveness is the 1974 New Orleans Province policy on Alcohol Abuse, found below as Appendix IV. A number of the provinces have something similar.)

Perhaps the superior knows in a given instance that the frontal attack is not necessary, that the Jesuit will go if he just tells him. But I don't know. I think it might be nice to look back on several of my brethren really plotting and getting into a sweat out of their concern for me.

That Jesuit, when he recovers, will be so grateful to be living free

again that the confronters will be glad they took courage. It is a rich experience, when you look back on it, to have saved someone's life. You have not told the man your disappointment, your anger; you have not made moral judgments on his drinking. His situation has been simply described by his brothers, and then defined by a third person, a rehabilitation clinician from the outside. It is a trial for the disease, not the man. He is the injured party, not the defendant.

But do Guest House and other rehabilitation programs work? They do. Not every time, but for a very high percentage of those who take the treatment there is a new and healthy life awaiting them, provided they continue their frequent meetings with AA. Are they happy to be recovering alcoholics? Compared with the alternatives, insanity or death, it's terrific.

I have heard it said that Father X is too old to be helped. Who has the right to give up hope on a person? Everyone is worth a try. When the "golden years" turn into a personal disaster for a Jesuit because of drinking, he is surely owed the consideration of our most effective support.

6. The Recovery

When Father X returns from treatment, he is no fragile egg. Just like anyone else who has been recovering from a sickness, the returning, now recovering, alcoholic has to fit, as far as he can, into the mainstream of community life. He will try to be sober, not just dry. To be sober is to have a positive plan of growth and recovery ahead of you; it is staying sober one day at a time through hope in the Lord. On the other hand, a dry drunk is an alcoholic who is simply not drinking, and this is a Pelagian effort. Pulling yourself up by the bootstraps, not drinking through sheer willpower, can make life a hard and tedious thing. Through the Twelve Steps of AA a person is called to the fullness of sobriety.

A Jesuit newly returned from a rehabilitation program will probably go to many AA meetings. The more, the better, especially in the beginning. He will be experiencing himself in society once again, now with a clear mind. Since this facing reality is something of a new experience

for him, he will need the special support other recovering alcoholics can give him. Some members of the community may feel that he is substituting one addiction, AA meetings, for the liquid addiction he had. Give him a chance. These meetings help cleanse the alcoholic of his hang-ups, his anxieties; they reinforce his determination to try one day at a time to stay sober.

Some wonder when they hear the alcoholic say that he is staying sober just for today. I could always stop drinking for a day. For example, in my piety, I never drank on Ash Wednesday or Good Friday. I don't know that I can stay sober forever. But I can do it today. And tomorrow I can decide the same thing with God's help. And this daily decision and this daily gift of God to me of sobriety can go on for the rest of my life, for the rest of the life of any alcoholic.

One thing is very clear: The alcoholic who slips back into drinking is probably the person who did not go to enough AA meetings. AA is not the only way to keep sober, but it is the best way found so far. There are over a million of us recovering alcoholics worldwide who say so.

Most probably the Jesuit should go back to his former work, unless there is some great block there. In that case, he should discuss with his provincial where he can best serve. His former schedule might have to be curtailed a bit to allow for the AA meetings he needs. But he will probably find, as I did, that the regular work goes much more quickly and easily because he feels well and his mind is in working order.

The rehabilitation program may suggest follow-up treatment that he should be involved in. Counseling may be suggested. Whatever it is, the time and price are cheap in terms of a life saved, an apostolate served, or just in comparison to the liquor that person would have drunk up.

A Jesuit newly in AA may feel uncomfortable at the evening cocktail hour. If this is the main time and place for community recreation, other Jesuits in the community can offer him their companionship to go to the movies, on a walk, to the museum, or the like. I decided, as do some others, to be at the cocktail hour regularly. I was worried that people would note that I was drinking a soft drink instead of my usual potion. I found that people at a bar are single-minded in their interest to get

themselves a drink. They never paid the slightest attention to what I was drinking. Some alcoholics are uncomfortable with others who are drinking. Everyone is different. Everyone finds sobriety on his own terms. Some, like me, feel ill at ease in a social situation only when others are drinking heavily. Many avoid stand-up cocktail hours where one can never get a decent conversation. When there is no conversation to hold your attention, and liquor seems to be the binding force of the gathering, the party can be a temptation. If these situations are not a problem for a recovering alcoholic, they are at least an unpleasant reminder of the worst of his past.

It takes a long time after sustained drinking to get one's mental health back. Depending on the duration of the problem and its seriousness, it may take several years, some say three to five. The body usually comes back more quickly with the person's renewed appetite and some vitamins. The fog over the mind that develops when one is drinking alcoholicly begins to lift and you begin to see the real world again. It seems that, to have this fog lift, it takes about a month for each year of heavy drinking. It took me about ten months to see just how sick I was. It is curious to look back and see that I was at one time unsure I was an alcoholic. It is a frightening thing to look back and see where the disease had taken me. I still recall from time to time some incident that proves again the extent of my problem. This is a common experience among alcoholics. If you are tempted, if a drink looks as if it might be good again, if you wonder if you can ever drink like a normal person, just remember one of your real benders. It helps to sober up your thinking in a hurry.

My experience after several years in AA is typical, as I hear it from others in meetings. I feel like a person who was very sick who is getting better day by day with God's help. My sense of humor is returning and I can enjoy life the way I ought to. My health is fine and I feel the energy, the hopes, the determination that someone my age ought to feel.

7. Healing and Acceptance

For the first year and a half or so in AA, I experienced, off and on, some depression. To think of having to go to AA meetings the rest of my

life, to think of the time and opportunities I had wasted, to think of the scandal I might have given--all this depressed me. I knew I was getting better. I thanked the Lord for it. But this dark cloud of my past was still facing me.

I had admitted that I was an alcoholic, but I had not accepted it. That extraordinary grace came to me in my last retreat, in a kind of revelation of the love of the Father, to know that the Lord redeemed me from my disease because he loves me and walks with me in my recovery to my apostolate. That alcoholic past is no longer fearful because that is where the Lord went out to meet me, to find me, to touch me with his healing hand. He does not say, "I love you, my son, (and I shall kindly overlook your peccadillos)." But he loved me *in* my sickness, redeemed me from a certain ruin, and he rejoices with me now as a father who watches his child--that child who, once crippled, now grows.

The Lord graced me with the vision to see that the disease was not just a sad experience, but a school of suffering where I have learned and still learn to accept the crosses and the crossed in life. This acceptance of my past and my future in the Lord is the key to my continued sobriety, to my growth in prayer, to my service in the Church.

The impoverishment I experienced when I was drinking left me open to find that Jesus is Lord of my life. When I was lord of my life, it was a mess. In giving Him all that I had, I was not giving much. But it was me--and He accepted me. My total dependence on Him now for sobriety and life itself is the basis for my becoming what I can be, what He wants me to be.

There is a serenity now that there never was before. Yes, I still get annoyed over things, but somehow I can let God do his job. I ask for the wisdom each day to do what I can and to know how not to get upset over the things that I can't change.

Best of all, I have come to a new relationship with the Lord. I trust him each day to keep me sober. When I go to bed sober at night, I thank him for being so trustworthy. I have so many things, so many people, to thank the Lord for, now that I can see again.

These graces, while specially given to me, are what every recovering alcoholic asks for. The proof of the Lord's having heard us is that we are sober to thank him.

8. The Community's Acceptance

It may not be just like old times for the recovering alcoholic in community. Depending on the length and extent of his disease, people's perceptions of him have changed. Perhaps they have unwittingly come to be patronizing. Or they have avoided him. And so we must face also the need for healing that the community of the alcoholic presents.

In a normal rehabilitation program, the family of the alcoholic is involved. With members of other families they work out their anger and frustration; they share with and receive support from those who have suffered and do suffer as they do. One special help for this process is Al-Anon, an organization for the families of alcoholics.

I suppose that it is impractical in our larger communities for everyone to be involved with this rehabilitation effort. Depending on the size of the community, the individuals will perceive themselves as having been affected to a greater or lesser extent. And yet the sickness of the alcoholic will have, sometimes imperceptibly, lowered the community's expectations and hopes. His activity will have been at odds with a union of minds and hearts. So the community needs healing in order that it can grow outward and more compassionate from this experience. The fear is that the individuals will grow more inward, more private, less giving. To pretend there was no hurt there, that there is nothing we cannot ignore in the problems of community, is to live a charade.

There may be some "elder brother" feeling in some members of the community. "So the prodigal son has gone off, had a twelve week vacation for his rehabilitation, cost us a lot of money; and all this after making a disgrace of himself proving an embarrassment to us! Now all is supposed to be forgiven and forgotten. Not by a long shot!" If Jesuits in community have this feeling (and it would not be surprising), they do not understand that alcoholism is a disease that touched them as well as the Jesuit who drank. Al-Anon can help them.

With the healing grace of the Lord, the members of the community can grow in compassion and hear the words of the father of the prodigal son: "But we had to celebrate and rejoice! This brother of yours was dead, and has come back to life. He was lost, and is found." To accept and

interiorize this lesson, really to rejoice in the saving power of the Lord again shown in our very community, is a great grace for any Jesuit.

9. Practical Matters

I suppose that a good number of Jesuits may recoil from the idea of going to an Al-Anon meeting in order to deal with the healing they need after someone else's bout with the bottle. We are sometimes so private, so slow to ask for help. That same attitude, if you find it in yourself, is what makes it hard for the Jesuit drinking alcoholicly to ask for help.

But even if (you can tell yourself this story) it is not for your own sake, go to some Al-Anon meetings, some open AA meetings, for the sake of the apostolate. Given the number of alcoholics in the United States, given the number of lives they touch, you probably frequently encounter someone touched by the disease. For example, on a retreat I recently preached to twenty-five women, I mentioned alcoholism as one of the several problems that might be a worry to some members of the group. I mentioned nothing about my own recovery. In the course of conferences, four women mentioned that it was a problem for them or members of their immediate family. So it is helpful for the priest to know about it in a firsthand way.

It would be a big help for every superior to attend some of these meetings, especially Al-Anon. And certainly the friendliest thing a friend of a recovering alcoholic could do is to attend some meetings. If you take the time, you will be able to be supportive of the still-drinking and the recovering alcoholic, and you will learn from the strength and insights of the others in the program. It can be a big help for your apostolate.

Where are these meetings? Look up Alcoholics Anonymous in the phone book and give them a ring. They have a listing of all the meetings in your city and will be glad to tell you where they are. The meetings cost nothing. They pass a hat to pay for the coffee. *No one* will ask why you came. It is very anonymous. You do not have to say anything.

What goes on at an AA meeting? At an open meeting, where all visitors are welcome, someone gives a talk on how it was when he or she was drinking, what happened to change them around, and what it is like now that

they have become sober. It is a witnessing to what "a power greater than themselves" has done for them. In contrast, a closed meeting is only for alcoholics. There, for example, someone gives a short talk on some section of the "Big Book" of AA or on one of the Twelve Steps. Then others chime in with what they might like to add, to share their problems and progress with one another. The alcoholic is supported by the determination of each of the members, with God's help, to stay sober.

Stop in sometime at your city's local office of AA. They will not presume you are a dirty drunk. In fact, the drunk usually stays miles away from that place. You will see what literature and services they have to offer. It may come in handy when you are counseling someone to know what treatment is available in your area, to know what to do.

10. Rehabilitation

What goes on in a rehabilitation facility? The individual has initially to go through the withdrawal from alcohol. In relatively few cases does this involve *delirium tremens* (terrible shaking and convulsions, fantastic imaginings and hallucinations). Various medications can be given for a few days to ease the normal withdrawal. Then they try to build the person up physically again. Along with this come various talks on what alcoholism is, what the symptoms are, what the recovery can be. These are given by trained medical personnel. The person in rehabilitation attends many AA meetings conducted right there by recovering alcoholics. They are counseled to help them face what has happened to them and to see where their future may lie. They get some exercise and begin to socialize, minus alcohol, with the other people there. They begin to feel, think, and act like normal persons again.

What about the Jesuit who has been to Guest House or some other rehabilitation facility and goes back to drinking? Well, what about the Jesuit who has his second heart attack? You give both the treatment they need to make them well. When either heart failure or sobriety failure happens, it is normal for friends to say, "Just when he was doing so well!" It is disappointing, but you can only try again. The percentages for recovery on the return visits are very high and encouraging.

11. Drink and Drugs

Note that the problems of addiction to hard drugs and to pills are parallel to those of alcoholism. So is the effect on the community and apostolate. So is the road to recovery. There are many people, presumably many Jesuits too, who are cross-addicted to drugs and alcohol, or to pills and alcohol. Your doctor may well not know how to treat this. Less than ten percent of our medical schools take up these topics. But there are hospitals and rehabilitation centers (call AA for a lead, if necessary) which will gladly help and are fully prepared to do so.

If you drink at all heavily, beware of the doctor who prescribes any mood-altering drugs or sleeping pills. You probably have not told him the amount you drink. Nor may he be familiar with what the combination can do to you. But you can become doubly addicted and, sometimes, with some combinations, stone dead. (See Appendix III below for some details.)

12. A Community Meeting on Alcohol

Many communities have had someone in to speak on alcoholism. The information is helpful for their apostolate and for the community itself. But there is often not very much interaction after these talks are over. There is a certain squeamishness about addressing the question of community attitudes on the subject. For instance, is alcohol the only thing that can bring the community together to socialize? Can the members of the community really enjoy talking to one another without glass in hand? Is alcohol an anesthetizer, to be used when you are watching television, playing cards, reading the newspaper? Is that what the open bar caters to? What are the problems of alcohol use and poverty? Do we feel that we owe alcohol to ourselves? Why is that? Where is the pain coming from that is so strong? To be responsive to the needs of their recovering brothers, are members of the communities willing to face their need for Al-Anon? Or is that threatening? Can we as communities address these questions, raise our own consciousness about the possibility, let alone the reality, of the problem?

13. Signs of Addiction

Know some of the signs to look for of addiction: someone withdrawing from community life; obvious evidence of overindulgence; complaints from the community of someone's wild mood-swings; irresponsible behavior; continuing anger and insulting attitudes; references to physical symptoms described later in this issue; repeated accidents of one sort or another; the Jesuit losing interest in his work; frequent complaining; missing meals regularly; staying to drink in the recreation room when others go to dinner; the smell of alcohol about him early in the day; loss of energy to work or simple refusal to work responsibly; the Jesuit in the community who is identified with the bar; free-time companionship exclusively with heavy drinkers; leaving bottles around or making references to drinking, such as, "I might as well be drunk as the way I am." These latter actions and remarks are perhaps his way of crying out for help. It is clear that many of the symptoms noted can be of other ailments. But superiors and members of Jesuit communities should be aware that they *may* indicate a problem with alcohol abuse. If you think about a particular Jesuit and some of these symptoms, there may be a convergence of evidence that will tell the story.

Do not be lulled into thinking that a Jesuit cannot be an alcoholic *just because*: He does not slur his speech; he never misses a day in class or at the office; he says an early-morning Mass at some nearby convent or parish; he is an effective and respected administrator, teacher, or parish priest. These and other signs of normalcy do not necessarily counter-indicate the presence of the disease. The question is not whether he is still working, but whether he is doing his best work, realizing his full potential. This is a critical question to which no one drinking alcoholicly can honestly answer "yes."

14. Literature and Self-Understanding

Know some of the literature on alcoholism. At the end of this article is a short annotated bibliography. The literature on the disease is enormous. If you are interested, it is not hard to find. The ones I note are basic books which I found helpful.

Face the fact that the more alcohol becomes identified with normal living in the Society, the more alcoholics we, like society in general, will have. A study done at Rutgers pointed out that if you double the per capita consumption of a nation, you can expect the number of heavy drinkers to increase by four times. The more you support drinking, the more you support dependence on alcoholism. That is, as we say, a sobering thought.

Note that there is a National Clergy Council on Alcoholism whose purpose it is to disseminate information about the disease in order to help the recovery of clergy and religious in the United States. Membership is $20 a year, and it brings you a flood of helpful literature. The address is: National Clergy Council on Alcoholism and Related Drug Problems, 3112 Seventh Street, N.E., Washington, D.C. 20017. Phone: 202-832-3811.

Finally, I am sure you see that Simon Peter, S.J., is a pen name. My friends know of my AA affiliation. I tell others I think I might personally help. Otherwise I don't particularly spread it abroad. I am not a professional alcoholism counselor. If you know someone who needs help--or you need it yourself--call your local branch of AA. They are in the phone book. If you're ready to scream for help, ask your superior if you can go to Guest House or some other recommended center. Or call up AA. They will send someone out to see you. There are probably recovering alcoholics in your own or a neighboring community. Ask them. Remember, it is anonymous.

APPENDIX I. SOME PASSAGES FROM A VERY HELPFUL BOOK,

America's Worst Drug Problem: Alcohol

by

Richard L. Reilly, D.O.

There is an easily acquired book which I have found to be very helpful for anyone in possible danger of slipping into alcoholism, and also for his or her friends. It seems wise simply to quote, in the form of an appendix, some passages from it. Hence the following presentation is reprinted with permission from *America's Worst Drug Problem: Alcohol*, by Richard L. Reilly, D.O.*--238 pages, $3.50.

Doctor Richard L. Reilly, the author, was instrumental in founding West Center, Tucson General Hospital's rehabilitation facility for alcoholics and drug patients. He is full-time medical director there.

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Chapter 3

Just what is alcohol? How does it affect you?

The chemical formula of alcohol is C_2H_5OH. It is a clear, colorless, volatile liquid with practically no odor and a "burning" taste. When ingested, it is broken down into a substance called acetaldehyde, then on to acetic acid, and finally carbon dioxide and water. Ninety percent of this reaction takes place in a remarkable organ called the liver. Sounds very simple, doesn't it?

Biochemists have been trying for years to figure out just how and where

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all this reaction takes place. Enzymes--with simple names like nicotinamide, adenine, dinucleotide, and alcohol dehydrogenase--play major roles in the reaction; but the metabolic pathways and the exact mechanism of action have not yet been reached with certitude, not by any stretch of the imagination.

Pharmacologists classify alcohol as an anesthetic--it is closely related to ether, chemically. That's a bit of a shock, isn't it? Try convincing the local bartender that he is making a living pushing an anesthetic! It's a fact, nonetheless. Alcohol follows the classic pattern of an anesthetic. It first provides a euphoric state, then a hypnosis, and finally a deep narcosis.

Many moons ago, alcohol was the *drug-of-choice* for anesthesia. Until chloroform came along in 1847, it was all that was available. You must have seen at least one of those sterling Hollywood films, where the physician patiently waited until his subject was thoroughly plastered and then proceeded very adroitly to remove two arrows, four bullets, a tomahawk and, for an encore, the left arm and right leg.

Actually, alcohol is a very poor anesthetic. The period of anesthesia is extremely short, and the respiratory failure that looms ominously around the corner is not very desirable. To put it another way, if all the anesthetists had to work with was alcohol, malpractice insurance would be out of sight.

Let's explore the anesthetic value of the drug. The nerve fibers in our bodies are joined together by complicated tissue called ganglion cells. When the alcohol level reaches a certain level in the ganglion, it depresses transmission mildly and provides a state of sleep called *hypnosis*. Further rise in the alcohol concentration produces a deep sleep called *narcosis*, approaching unconsciousness. Next comes *anesthesia*, a complete block.

What attracts people to alcohol is the original state of euphoria that alcohol produces. I suppose if everyone could stop in that state, it wouldn't be too bad; but, even then, the constant insult of the drug would have its drawbacks. The euphoria is produced by depressing the inhibitory center of the brain. Alcohol is a *central nervous system depressant*, pure and simple.

Ever arrive at a cocktail party early? Notice what happens. The women are clustered together discussing the latest styles, and the men are usually expounding on politics or lying about their golf games. Several drinks later, the housewife is telling the doctor how to practice medicine, the local grocer is telling the mayor what a poor excuse of a man he is, the accountant is telling his lawyer friend that he has a license to steal, and the shoemaker is straightening out the clergyman on what is wrong with the Church. Yes, indeed, the inhibitory centers of the brain are being depressed.

Alcohol does not have to be digested; it is absorbed very quickly in its original state. Alcohol is not stored in the body as are other foods. It is oxidized quickly. An average-sized (150-pound) man can oxidize about three-fourths of one ounce of alcohol per hour. The typical drink, three-fourths of an ounce of alcohol, is provided by a "shot" of whiskey, a glass of wine (5 ounces), or one pint of 5-percent beer. Remember that any amount over this accumulates in the blood. O.K.!

Changes in mood start to occur at blood alcohol levels of 0.05 percent. The drinker feels free and easy. Thought and judgment are loosened. How much does this take? About two drinks in one hour.

As the level climbs to 0.10, voluntary motor function becomes more clumsy. At 0.20, the depressant action of alcohol on the brain is obvious. The individual tends to stagger, and, more often than not, he assumes a horizontal position. He becomes easily angered and has poor control of his emotions. At 0.30 he becomes stuporous. At 0.40 he is usually in a coma, and at 0.50 to 0.60 the breathing center in his brain is so depressed, death ensues. All this is not peculiar to alcohol. Similar conduct is experienced with most of the depressants, that is, the barbiturates, ether, etc.; they are all *hypnotic, sedative* drugs.

One principle must be brought into play before these facts are committed to memory. That is the principle of *adaptation*. It isn't a big deal, but it is very important. With enough practice, the body is able to *adapt* itself to the presence of the drug. This is primarily due to a combination of learned metabolic and central nervous system adjustment. Which is why Uncle Milo can drop that fifth and act normal. Adaptation

is different for each of us.

Alcohol and performance: Alcohol severely affects muscle coordination. This is not a big surprise, I'm sure. All you have to do is go to the nearest bar and observe. All sorts of data have been gathered to prove this--most of it in regard to driving.

Impressive studies have been made demonstrating what intoxication does to the reflexes, judgment, etc., but, again, who needs to prove it? Look at the carnage on our highways! Over half the fatalities on our highways are alcohol-related.

Sensation and perception are altered by alcohol. High doses of the drug cause a decrease in differentiation of light intensities and adjustment to certain colors--particularly red. As one might suspect, this comes in real handy at stoplights. Hearing appears to be affected, also. The ability to distinguish various sounds is diminished.

Alcohol and sleep: Much exciting work is being done on the physiology of sleep. A phenomenon called REM, or "dream sleep," takes place when we sleep. We need this to rest properly, and alcohol interferes with the normal pattern. The greater amount of alcohol, the greater block in this type of sleep. People wake up fatigued, and they toss and turn during their sleep--all very abnormal.

What happens when you don't sleep well? Sure, you wake up tired and more anxious than ever. What do most people do to correct the fatigue factor? They hit the coffee pot. The caffeine provides enough boost to get the motor running and, of course, it raises the anxiety level even more--a nice vicious cycle. . . .

Chapter 4

<u>What happens when you drink?</u>

What happens when you drink alcohol? How does the body handle it? Why do you get drunk? How is the alcohol detoxified? These are a few of the many questions presented by thinking people.

O.K., so you slurp down a few at a party--what happens? Unless the

aim is poor, they end up in that marvelous receptacle, the stomach. Alcohol is quickly absorbed by the lining of the stomach, called the *gastric mucosa.* Fortunately, nature puts the skids on this gastric absorption rate in a hurry, and a good 90 percent alcohol absorption takes place when it hits the small intestine.

Generally speaking, the speed in which someone gets "crocked" depends upon the blood alcohol level he or she develops, and this in turn depends upon how quickly the alcohol is dumped into the small intestine. Therefore, anything that slows down the emptying time of the stomach, slows down the absorption process.

O.K., now what slows down the emptying time of the stomach? The main factor is food. If you eat when you are drinking, the process is delayed up to several hours. Alcoholics learn this simple fact early in the game. They have never heard of a gastric emptying time or alcohol blood levels, but they know that if they drink on an empty stomach, they are bombed very quickly. What else slows the absorption time? The higher the concentration of alcohol ingested, the slower it is emptied. Cold temperatures slow it down. High sugar concentrations slow the process down. The big factor, however, is food-carbohydrate, protein, and fat.

Now, let us assume that our beloved C_2H_5OH has escaped from the stomach and is proceeding merrily down into the small intestine. Alcohol doesn't last very long in the small intestine. It is absorbed quickly and into the blood it goes. Essentially it stays there and is diffused through our tissues until our good buddy, the liver, gets hold of it. We do get rid of some alcohol through the lungs and the kidney, but the liver handles the job to the tune of over 90 percent. This remarkable organ provides some 500 odd functions. It is truly a unique piece of equipment.

Now, friends, we come upon one fact that we should dwell upon. *The rate at which the liver metabolizes alcohol is almost constant, regardless of the blood alcohol content.* What is the significance? Well, it means that you are not going to sober up until the liver gets rid of the alcohol; and the liver will take its own sweet time, regardless of what you do. Oh, there are some intravenous mixtures, such as fructose, which speed things up; or you could always hook up to a kidney machine. But generally you

can stand on your head, drink nine quarts of tomato juice or burn incense to Buddha; no matter, the rate of detoxification proceeds at the same pace.

We pointed out that on any given day the rate at which an individual detoxifies alcohol remains the same, and there is little we can do about it. As time marches on, however, and the liver gets more and more practice, its efficiency picks up. The rate at which it can dispatch booze may double. Let me tell you, an alcoholic's liver gets one hell of a lot of practice. This is important for two reasons:

1. It is one explanation why it takes more booze to gain the *effect* an individual desires.
2. Since many other drugs use these same metabolic pathways, it is a reasonable explanation why *these drugs* disappear from the system so quickly.

The central nervous system learns, too. As it is subjected to constant depression by alcohol, it learns to operate at blood levels higher than the average. These two factors explain why some people can drink enormous quantities and still appear to be sober. Of course, their bodies may be shells from the direct damage of alcohol, but they can still operate to a point. Remember that the liver can handle just so much; after that, alcohol just builds up in the system.

One phenomenon should be mentioned. As the chronic alcoholic progresses, he seems to hit a point where the pendulum swings the other way in regard to quantity versus intoxication. Indeed, if there is liver damage, then this organ cannot detoxify the alcohol as it used to, and blood levels rise quickly. Why this phenomenon occurs in subjects without liver damage, I cannot explain; but most alcoholics eventually experience a *reversal of tolerance*.

I suppose this is as good a place as any to mention the *dehydration* principle. Everyone, including the physician, assumes that when the alcoholic stops drinking, he is dehydrated. He needs fluids. As a general principle, this is entirely wrong. Occasionally, we see a chronic addictive, skid-row type who is in and out of jail and hasn't eaten for days and is found flat on his back in the gutter. He indeed may need fluids; but the other 99 percent are usually overly hydrated.

Ever get up in the morning after a prolonged drinking bout? Your mouth feels like the Russian army walked through it. Alcohol, being blown off by the lungs, has been expired through it for many hours. This dries the mouth out. The salivary glands have cut down their fluid production as a direct result of ethanol insult. Alcohol acts as an astringent. It shrinks up the blood supply. Smoking dries the mouth out too. Small wonder the mouth is all puckered up! The doctor looks in the oral cavity and says to himself, "This guy needs fluids!"

Another factor should be mentioned that is slightly more complicated. Most alcohol is consumed in a fluid vehicle. As all this fluid is being consumed, the body naturally strives to get rid of it. The pituitary gland secretes a hormone called ADH--*antidiuretic hormone*. As you may have guessed, when this hormone is released, fluid is retained. Alcohol does not allow this hormone to be released as long as the blood alcohol level is rising. In other words, as our friend is getting plastered, he keeps running to the bathroom. However when he stops drinking, nothing prevents the pituitary from releasing the hormone, and all of a sudden the fluid is being conserved. The *ADH* goes to work and puts the skids under the kidneys. In cutting down on the fluid loss, valuable minerals like potassium, sodium, chlorides and magnesium are conserved. There is no dehydration unless there is protracted vomiting, diarrhea, profound malnutrition, or infection.

A sad commentary is that many physicians are totally unaware of the complications of alcohol ingestion. It really isn't their fault, either. Less than 10 percent of the medical schools teach anything about alcoholism!

Chapter 5

Drug interactions with alcohol

Drug interaction is almost a field all by itself. Take a good look at all the pills and liquids at your local pharmacy. Some of those medications contain multiple drugs. When ingested, many of these drugs do not get along with each other. This is a problem that physicians worry

about constantly. *The most abused drug is alcohol.* Unfortunately, your physician is usually unaware of how you abuse it, and it never enters his mind when he pulls out his prescription pad.

Ninety-five million Americans drink booze. About 10 percent develop the disease of alcoholism. Those 10 percent are in deep trouble when other drugs are prescribed unless the physician involved takes this into account. The other 90 percent do not get off "scot-free" either. There are a lot of hard drinkers in their ranks too. I believe it is wise for anyone who does any serious drinking to take a hard look at the interaction of alcohol with the drugs he takes, whether he drinks routinely or sporadically.

Just out of curiosity, I researched specific drugs that have interaction with booze. I stopped counting at 126. These are all medications commonly prescribed by good physicians day in and day out. That in itself is a little frightening, isn't it?

I'm going to list some general classifications of drugs and try to explain as simply as possible how they get along with the old firewater. You can't be expected to remember all of this, but it should leave a general impression, and that's what I'm after. My purpose is not to frighten. *Awareness* is a goal worth pursuing, and awareness of what alcohol does in combination with other drugs may save a life.

Hypnotics

Hypnotics are sleeping pills. Combined with enough booze, they kill. They form a toxic interaction. I suppose the worst of the lot is the barbiturate family; "downers" form a list as long as my arm. The alcohol-sleeper depresses heart function and also causes respiratory failure. It sure helps to be able to breathe. Just imagine how quickly someone with a bad heart or defective lungs can get into trouble.

Diuretics

Almost constantly, new, more potent diuretics appear on the market. They pull fluid from the body. With alcohol, they may drop the blood pressure too much. You stand up too quickly, and you may land on your

head. It is called "orthostatic hypotension."

Analgesics

These are "pain killers." Alcohol potentiates analgesics. This holds true for codeine, morphine, Darvon, etc. It holds true for aspirin and acetaminophen too. Of course aspirin given in combination with alcohol increases the probability of stomach hemorrhage. Buffering the aspirin helps cut down this probability.

Antidepressants

This is a potentially lethal combination. Alcohol and antidepressants are contraindicated. United, they may result in enough central-nervous-system depression to cause death. Also, most of them are slow-acting. Driving coordination may be seriously impaired for the first few days of therapy. Add booze to the picture, and a driver who is fairly conscientious when sober could wipe out a carful of innocent kids.

Antidiabetics

Since alcohol causes the oral antidiabetic medications to be metabolized faster, the blood sugars stay high. With alcohol, the potency of these drugs may be weakened as much as 50 percent. Some of the oral medications may cause an "Antabuse type" reaction too when combined with booze. Insulin is even worse news. Alcohol itself has a *hypo*glycemic effect--it tends to lower blood sugar. Apparently it inhibits the normal process in the liver whereby the blood sugar is normalized. When insulin is used, it may produce such a low blood sugar that irreversible neurological damage, coma, and death can result.

Tranquilizers

I'd say that tranquilizer abuse with alcohol is the most common problem. Tranquilizers potentiate the central-nervous-system depressant effect of booze. This may result in severe blood pressure drops and deep sedation. Also the effect they produce is much like alcohol, and

substitution is likely. Instead of reaching for a bottle, people find themselves looking for a pill.

Central-nervous-system Stimulants

These are mostly amphetamines, caffeine, etc. Kids know them as "uppers." They antagonize the central-nervous-system depressant effects produced by the sauce, but they do not improve the decreased motor function induced by alcohol. In simpler language, even though the CNS is perked up, coordination is still impaired.

Muscle Relaxants

Most doctors prescribe these when there is a muscle-ligament sprain involved--bad back, sore arm, stiff neck, etc. Add booze to muscle relaxants (at least the centrally acting ones--and that encompasses most of them), and you get an additive effect. Enough alcohol and pills may cause central-nervous-system depression, respiratory arrest, and death.

Antihistamines

Antihistamines are present in most "cold" preparations. They can have a potent sedative action. Alcohol as you know is one hell of a sedative. The combination can be substantial, particularly when the user is at the wheel propelling two tons of steel down the road.

Nitrates and Nitrites

These drugs have been around for many years. Many coronary patients take them. They cause the blood vessels to dilate. Together with alcohol, severe blood-pressure drops can occur with cardiomuscular collapse. That "ain't" healthy.

Anticoagulants

These are blood-thinning agents. They are commonly used following strokes and coronary problems. Patients with liver disease have an

unpredictable response to them. Since hard drinkers frequently have damaged livers, alcohol may complicate things considerably.

Antibiotics

For some reason or other, most people think that you can't drink and take antibiotics. Actually, alcohol potentiates the action of tetracyclines. Alcohol sometimes causes an "Antabuse type" reaction with Chloromycetin. These two specific antibiotics are the only ones that I know that have a specific interaction.

As you may have guessed, this information is merely a drop in the bucket compared to the complete story. There's enough here, however, to make a person think twice before doing any serious drinking if he or she is on medication. Alcohol by itself is *toxic* enough; but when you add other chemicals, you're headed for double trouble.

Chapter 6

What does alcohol do to your body?

Most people who drink too much are worried about what alcohol does to their body. I think it is very important, but I don't think that this knowledge stops many from pursuing their wanton ways. I've seen too many people--threatened with certain death if they kept up the pace--cut down for a period, but not for long. Nonetheless, I feel it necessary to point out some irrevocable facts and leave the rest to the individual.

Alcohol affects deleteriously just about all of the organs of the body. The only organ that escapes, to my knowledge, is the kidney; and why the kidney, I'm not sure.

Let's start with the brain. The brain is a most delicate piece of tissue. Ethanol, or ethyl alcohol, causes cell destruction. Enormous evidence substantiates this fact. There is no need to argue this point. Merely visit the closest mental hospital. As high as 40 percent of the males hospitalized are there because of booze. They are vegetables. Some are in their forties and fifties.

It has been estimated that some 10 to 15 thousand brain cells are destroyed with each drinking bout. We have anywhere from 14 to 16 billion cells between the ears, but, let's face it, few of us can afford to lose any of them. Many theories have been put forth to explain this destruction. One postulates that it is due to oxygen deprivation from a "sludging" effect of the red cells that carry the oxygen. Whatever the cause, the "wet brain" that results directly from booze is a fact of life that cannot be ignored.

Wernicke's Syndrome is interesting. It is heralded by abrupt mental confusion, rapid eye movements apparently caused by ocular paralysis, and loss of coordination known as "ataxia." Polyneuropathy is also a factor in this problem. People complain of pain and loss of feeling in their extremities. It may advance to marked weakness and fatigue.

Korsakoff's Psychosis is a fascinating thing to watch. It usually follows some form of mild or severe manifestation of Wernicke's Syndrome. Memory slips and loss of normal information retention often lead to lying in order to cover up the deficiency. The victim, being easily confused, has trouble performing simple tasks. He goes out for a loaf of bread, and halfway down the block he can't remember what he was supposed to get. I think I'd lie too.

There are other neurological problems connected to alcoholism. Fascinating names like Jolliffe's Encephalopathy (Vitamin B3 deficiency) and Marchiafava's Disease are great for stimulating conversation at the next party, but it would not be practical to describe them here. By the way, Marchiafava's Disease is usually diagnosed at autopsy--that isn't too comforting, is it?

As has been previously noted, alcohol is a central-nervous-system depressant. When the system has been continously depressed, say over a two-week period, where about 40 percent of the caloric intake has been alcohol, strange things happen as alcohol is withdrawn. "All hell breaks loose," to use a phrase. Messages sent from the periphery take strange pathways and are interpreted by the brain in strange ways. This is one current explanation of d.t.'s. Hallucinations develop--snakes crawl off the walls, bugs are all over the bed, etc.

Convulsions may result after alcohol withdrawal, and they may be very

dangerous. Many theories are put forth in explanation. One of the most recent theories is that the alcoholic enters a state of "alkalosis," the blood becomes more base than acid. This, in turn, interferes with oxygen saturation in the brain and, together with low magnesium levels in the blood and disturbances in sleep patterns, convulsions result.

Even with updated theories, d.t.'s are poorly understood. Most physicians who see a person with the "shakes" diagnose delirium tremens. Actually, it is much more complicated than this. The first set of symptoms usually noticed is attributed to the autonomic nervous system--which system we cannot control. The hands shake, the heart beats fast, the body perspires; there is a rise in temperature, the blood pressure rises, the pupils dilate, and the patient just can't sit still or remain inactive. Hallucinations may then become evident. *Disorientation,* which means that the patient doesn't know where he is, who he is, what day it is, etc., may follow. It is at this point that we diagnose d.t.'s. Progression to convulsions may or may not be subsequent. If it does happen, it can be dangerous.

You'll notice that there is usually some progression to all of these symptoms. To have *delirium tremens* is not funny. Studies have shown that full-blown d.t.'s result in as high as *10 percent fatalities* in general hospitals. How's that for a grim statistic!

Esophagitis and Esophageal Varices

When we eat something, the food descends through a long tube called the esophagus which empties into the stomach after passing through the diaphragm. The lower third of the esophagus is the ordinary site of the dreaded varicose veins which are usually secondary to liver pathology. Pressure builds in these veins causing enlargement and often bleeding. The medical and frequently surgical management of this unfortunate problem is difficult. It suffices to say that the mortality rate is great in those patients and the incidence of *esophageal varices* in alcoholics is significant.

What is much more significant is the reflux of the acid from the stomach up into this lower third, causing marked irritation. This marked

irritation in turn causes chest pain that simulates the pain experienced from heart attacks. It is no joke.

The Stomach

Ever get a good old "heartburn"? This is a minor form of transient *gastritis*, and most people who indulge too much know it well. Alcohol breaks down the mechanism called the "protective barrier" and permits alcohol to seep into the stomach tissue. It also robs most people of their natural appetite. Insult this staunch ally enough and you have a full-blown *gastritis*. Ever notice how big drinkers are always munching on antacids? They're trying to put the fire out--by neutralizing the excess acid production. Their stomachs begin to look like raw hamburger. Also, this *may* lead to ulcer problems. One more possibility. At the end of the stomach we find the pylorus, which acts as a sphincter. Alcohol may activate this. When it contracts, there's no place for the contents of the stomach to go but up--hence vomiting.

Small and Large Intestines

Recent studies have demonstrated that alcohol *directly damages* the lining of the small intestine, somewhat like the cell damage that alcohol does to the liver. Cell damage to the intestinal mucosa is not exactly hilarious. It can cause diarrhea, and this is a frequent problem encountered with hard drinkers. With chronic insult to the intestine, malabsorption of water, fat, and water soluble vitamins takes place. Valuable minerals such as potassium and magnesium are lost. On withdrawal, loss of magnesium may lead to convulsions; and *potassium* loss may lead to profound weakness and often cardiac arrhythmia, which means the heart beats irregularly. If someone has an unstable rhythm, it could mean a visit to the friendly undertaker.

The Pancreas

The pancreas is a large body of tissue found immediately below the

stomach along the back of the abdomen. It secretes chemicals (enzymes) that help digest our food. It also secretes insulin into the blood-stream. Mention the word "alcoholic" to a physician, and the first two pathologies that pop into his mind are liver disease and pancreatitis.

At least 40 percent of *acute* cases of pancreatitis are associated with alcohol ingestion. It is usually a horrendous medical problem with a high mortality rate.

The cases of *chronic* pancreatitis are bad enough. People show up in the emergency room, usually after "tying on a good one" the night before. They have gut pain; that's what brings them in. They also lose weight quite suddenly, their skin turns yellow, they run high blood sugars. They usually have a lot of fat in their stools, because they do not have the enzymes to digest it in the small intestine. The pancreas itself becomes filled with calcium. The nightmare begins when the chronic cases become *acute*. Fifty percent die with acute hemorrhagic pancreatitis.

How does alcohol cause this? The cause of this malady is not known. The leading theory is that an abnormal protein is secreted by the pancreas which forms a gel, which in turn captures calcium and plugs up the small ducts leading from the gland itself. It is enough to know that alcohol has been classified as a primary factor in the disease process of the pancreas for many years. All too many boozers have paid an untimely visit to the friendly undertaker from this problem.

The Liver

Almost everyone figures that if you are a big drinker, you are automatically going to end up with liver disease. This is simply not true. About one in five will indeed develop a problem as a direct result of alcohol insult.

The most innocuous problem is what we call a "fatty" liver. Fortunately, it is generally rectified in two to six weeks of a good diet and no booze. One of the liver's functions is to get rid of the fat. If the liver cell is preoccupied with booze, that fat builds up in the cell, and the patient develops an enlarged liver. It may or may not develop

into other more serious trouble, but it has not been proven to date that the fatty liver is a preliminary stage of the more serious difficulties.

Alcohol Hepatitis is something else. Those who suffer from this are sick, sick people. These patients complain of nausea, weakness, vomiting, jaundice, weight loss, abdominal pain, fever, and diarrhea. On examination, they are found to have enlarged livers, fluid in the abdomen, vascular "spiders" on the face, chest, and on the abdomen, as well as enlarged spleens. They are what we call "plus four" sick. People die with this malady.

Cirrhosis is what we hear most about. It occurs in about 10 percent of alcoholics which makes it a fact that one can hardly ignore. Many doctors feel that some form of alcohol hepatitis is a precursor of cirrhosis, but to my knowledge this is still speculative. In cirrhosis, the individual liver cells and their connective tissue are gradually replaced with scar tissue and nodules. As you might surmise, the numerous functions of the liver are impaired more and more, and a slow, painful death ensues. As a cause of death, cirrhosis is exceeded only by heart disease, cerebrovascular disease, and cancer.

Question: How can you tell whether you are in the 10 percent group that will develop cirrhosis? Answer: You can't, buddy. All you can say is that if someone in your immediate family died of cirrhosis, you are pushing your luck. Anything over a daily six-pack of beer or its equivalent (one-half pint of whiskey, etc.) pushes the percentages up.

Here is something else you might find interesting. People who suffer from alcoholism tend to get infections easily. Cirrhosis of the liver has been implicated. This is particularly true of what we call "gram-negative bacilli" infections. What would amount to a moderate infection in a normal person may mean a *lethal* infection in a cirrhotic patient.

One other little thing. I know some heavy drinkers who periodically waltz down to their local physician to have him run some liver function tests. The tests prove to be normal, so they give a sigh of relief and continue to kill themselves with booze. Liver function tests are poor, to say the least. A hefty percent of the liver can be "shot all to hell," and you can still come up with reasonable function studies.

The Heart

Did you know that alcohol causes heart damage? Heavy drinking and heart disease have been discussed for over 100 years. Vitamin B_1 (Thiamine) deficiency causes heart muscle damage, this we know for sure; but more recent studies demonstrate a direct muscle damage to the heart. Long-term drinkers may develop what is known as cardiac-myopathy--diseased heart muscle. Clinically, the patient develops sudden congestive heart failure. The neck veins are engorged, the legs swell, the patient has difficulty breathing.

Intoxicating amounts of alcohol cause the heart rate to increase, and they alter the efficiency of the heart. The heart is a big, efficient muscle, and alcohol injures the individual heart cell. It no longer contracts the way it used to. When this happens, the volume of blood that used to be pushed out by the heart just isn't there. In other words, you end up with a heart that doesn't work too well. This holds true for the blood flow in the coronary arteries too. As the alcohol blood levels rise, there is a decrease in the blood delivered to the heart itself. That's just great, isn't it? Here we are ingesting a drug that not only makes the heart function poorly but it also cuts down the blood supply so necessary for its operation.

Muscle

It has been well known for at least 150 years that alcoholism has an associated "muscle disease." Some patients develop sudden muscle cramps which last for minutes, which is a minor form of the disease.

More severe forms of the disease cause severe pain and swelling, mostly in the extremities. Although poor blood supply and nutritional deficiency have been blamed for this severe problem, recent studies again point the finger at alcohol, because of its direct effect on the individual muscle cell.

Osteoporosis

Recent studies have turned up some rather interesting findings linking

alcoholism to osteoporosis. Osteoporosis is a big word signifying a *decrease* in the amount of bone present in the body. The bones become soft and brittle as they become demineralized. Crush fractures of the vertebrae and fractures of the long bones are relatively common. It is an aging process more prevalent in women. This is the primary reason why they lose height and develop curvatures so often described in the words "little old ladies."

Heavy drinkers apparently experience these bone changes at a much earlier age. One researcher found that alcoholics in their early forties had osteoporosis comparable to ages 71 and 80. His finds were confirmed in another country using a different method of measurement. Again this points to the toxicity of that good old fun stuff--alcohol.

Orthopedic wards are loaded with heavy drinkers. Formerly, I attributed this fact solely to trauma. Inebriation does not make one too steady. I wonder now how many of these fractures resulted from a combination of osteoporosis and trauma?

APPENDIX II, PASSAGES FROM *Alcoholics Anonymous*--the "Big Book"

Chapter 5

How It Works*

Rarely have we seen a person fail who has thoroughly followed our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. There are those, too, who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest.

Our stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it--then you are ready to take certain steps.

At some of these we balked. We thought we could find an easier, softer way. But we could not. With all the earnestness at our command, we beg of you to be fearless and thorough from the very start. Some of us have tried to hold on to our old ideas and the result was nil until we let go absolutely.

Remember that we deal with alcohol--cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power--that One is God. May you find Him now!

Half measures availed us nothing. We stood at the turning point. We asked His protection and care with complete abandon.

Here are the steps we took, which are suggested as a program of recovery:

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1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

Many of us exclaimed, "What an order! I can't go through with it." Do not be discouraged. No one among us has been able to maintain anything like perfect adherence to these principles. We are not saints. The point is, that we are willing to grow along spiritual lines. The principles we have set down are guides to progress. We claim spiritual progress rather than spiritual perfection.

Our description of the alcoholic, the chapter to the agnostic, and our personal adventures before and after make clear three pertinent ideas:

(a) That we were alcoholic and could not manage our own lives.

(b) That probably no human power could have relieved our alcoholism.

(c) That God could and would if He were sought.

APPENDIX III: ALCOHOL AND MEDICATIONS

Medication--how long is it active in the body?

The average time for any medication to become "used" in the body is four to six hours. Some medications that are called "spansules" or "time released" will take from eight to twelve hours.

Therefore alcohol, a drink, should not be taken within at least eight hours after taking the medications listed below. This is especially important at night when medication for sleep has not worked and "a little drink" might help. In mixing some of these medicines with alcohol, you run the risk of never waking up.

A general rule: one ounce of liquor (80 proof) equals
3 - 4 ounces of wine (12 - 18 percent) equals
one bottle of beer (3.2 - 3.6 percent).

Alcohol--how long is it in your body?

The normal metabolism time for one serving of the types of liquors mentioned above is 60 minutes--one hour for each serving consumed. So none of the medications listed below are to be taken within a time determined by the measure of alcohol taken.

SOME MEDICATIONS are on the next page.

SOME MEDICATIONS WHICH REACT DANGEROUSLY WITH ALCOHOL

Alurate Elixir
Amytal
Aquachloral Supprettes
Atarax
Buff-A Comp Tablets
Buticaps
Butisol Sodium Elixir
Carbrital Kapseals
Dalmane
Deprol
Dialog
Doriden
Equinal
Etrafon
Eskalith
Gustase-Plus
Haldol
Hydnomix
Hyptron
Kesso-Bamate
Kutrase
Levsin/Phenobarbital
Levsinex/Phenobarbital
Librax
Libritabs
Librium
Lithane
Lithotabs
Manrium
Matropinal Elixir
Matropinal Forte
Mebaral
Mellaril
Mepergan
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Meprotabs
Milpath
Milprem
Miltown
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Moban
Navine
Nembutal
Noctec
Noludar
Parest
Pathibamate
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Phenergan
Placidyl
Plexonal
PMB-200
PMB-400
Prolixin
Quaalude
Quide
Raudaxin
Rau-S ed
Repoise
Serax
Serentil
Serpasil
Sinequan
Ski-Bamate
Sopor
Stelazine
Taracian
Thorazine
Tindal
Trancopal
Tranxene
Triavil
Triclos
Trilafon
Tuinal
Tybarton
Unisome
Valium
Valmid
Vesprin
Vistaril

A note on Valium, Librium, and Serax: these medications differ from the other drugs listed in that they remain alive in the body for 12 hours. Therefore do not ingest any alcohol for at least twelve hours after taking a dose of these medicines.

Note, too, that antihistamines which may be prescribed for colds and allergies can react with alcohol in the same way as the medications listed above.

A note on barbiturates: these drugs, many of which are noted above, serve as sleeping pills and sedatives. Most drug-drink fatalities result from ingesting barbiturates and alcohol.

A final note: new medications are always coming. The list above is only partial. When you receive a new medication from your physician, ask how it interacts with alcohol. Since physicians often do not know, the safe rule is: Do not medicate and drink.

APPENDIX IV. NEW ORLEANS PROVINCE POLICY ON ALCOHOL ABUSE

Preamble. The New Orleans Province, in accordance with the highest professional authorities, hereby officially recognizes alcoholism as a human disease condition which demands our enlightened concern. This judgment has been stated unambiguously by the World Health Organization in 1951, the American Medical Association in 1956, and many other health organizations.

This disease, which can and does occur among us, generally manifests itself in a threefold impairment of body, mind and spirit which, unless arrested, can lead to irreparable damage and even death. The victims of alcoholism need and deserve proper understanding and professional help. The primary objective and concern of all of us should be to relieve the pain and suffering and restore the health and dignity of the victims, and to help them return to more productive and rewarding involvement in the important work of the Province.

Extensive experience indicates that persons afflicted with this disease are usually blind to the developing symptoms in themselves and are rarely capable of effective self-help. Hence, we consider it our obligation in justice and charity to establish procedures to facilitate proper treatment and productive recovery for such victims among our fellow Jesuits.

Health Panel. A permanent panel of professional advisers on health, competent in the field of alcoholism, has been set up to whom any Jesuit with a drinking problem may voluntarily go or be referred by the local Superior. The Superior should implement the panel's recommendations concerning the problem and treatment of the Jesuit involved. If a Jesuit refuses to accept his disability as an illness, and steadfastly denies his dependency in the face of competent recommendations to the contrary, the Superior should insist that he follow the recommendation of the Health Panel, even assigning the Jesuit to a professional treatment center if this has been recommended by the panel. If he refuses to comply then he will have to accept the consequences the same way that any Jesuit would if he refused a legitimate assignment.

Identification of the Problem. A person may have a drinking problem when his consumption of alcoholic beverages repeatedly interferes with the proper performance of his assigned duties, reduces his dependability, impairs his interpersonal relations, affects his health, and/or reflects discredit upon his religious role in the Mystical Body of Christ. The problem is not only measured by the volume or frequency of one's drinking, but also by its effect on behavior and functioning.

Intervention. An alcoholic is very seldom able to diagnose himself and volunteer for treatment. In the vast majority of cases, constructive coercion has been necessary to effect proper treatment and recovery. All too often friends, fellow Jesuits, and Superiors have failed to intervene until it was too late to reverse the cumulative damage. But surely, fraternal love demands that we be able to recognize alcoholism in its early stages and be prepared to initiate effective and timely intervention. And St. Ignatius' insistence on the proper regard for our health urges the same.

Superiors will guarantee that any of our men who need, apply for, and accept treatment for alcohol abuse will, in accordance with the recommendations of the Health Panel, be given the very same consideration as any other Jesuit in the matter of placement, further studies, and the choice of apostolates.

A SHORT BIBLIOGRAPHY

Alcoholics Anonymous. Third edition, 1976. Published by Alcoholics Anonymous General Service Office, 468 Park Avenue South, New York, N.Y. 10016.

This is the basic book on the topic, often referred to simply as "The Big Book." It gives the history of AA, the therapy, and case histories. It could well be a basic reference book for any Jesuit community library. It is available at any AA office, and usually at any Open Meeting.

The Blue Book, Volume XXX, 1978. *Proceedings of the Thirtieth National Clergy Council on Alcoholism.* To obtain it, write to: National Clergy Council on Alcoholism, 3112 Seventh Street N.E., Washington, D.C. 20017.

This book has excellent chapters on confrontation, written by religious, on pages 17-24, 109-141, 147-200. It also offers an excellent bibliography, on pages 321-327. Finally, there is also a listing of treatment centers, on pages 328-330.

Vernon E. Johnson. *I'll Quit Tomorrow.* New York, N.Y. 10022: Harper and Row, 10 East 53rd Street, 1973.

This is a practical guide to treatment of alcoholism. It is the single clearest and most helpful book which I, Simon Peter, have found. Every superior should have a copy to consult. Chapter 5 is helpful on confrontation. The book also gives an excellent reading list on page 117. It is listed at $8.95.

Richard L. Reilly, D.O. *America's Worst Drug Problem: Alcohol.* Liguori, Missouri 63057: Liguori Publications, 1974. $1.75.

Richard L. Reilly, D.O. *I'm Not an Alcoholic Because . . . .* Liguori, Missouri 63057: Liguori Publications, 1978. $3.50.

These two publications give a great amount of helpful information in a small paperback format. As you can see from the section reprinted above in my article, pages 36-53, Dr. Reilly's style is lively and easy to read. If you think that you--or some friend--might be an alcoholic, these books are good ones to start with. If you want to get them in an anonymous way, send the amounts indicated, plus 50 cents a book for handling and postage, to Liguori Publications, One Liguori Drive, Liguori, Missouri 63057. These two books are also useful for book racks in parishes and retreat houses.

Liguori Publications has several other publications helpful in the circumstances tied in with some cases of alcoholism: *Alcohol and the Family*, by Father Frank, C.SS.R. ($1.50) and *One Day at a Time*, by Monsignor Joseph E. Farrell ($1.50).

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