ALCOHOLISM IN WONDERLAND

A Memoir

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CHAPTER I

I MEET HAROLD HUGHES

I first met Harold Hughes in late summer, 1962 when he invited me to lunch in Des Moines. He was then Iowa's Secretary of Commerce, and the Democratic candidate for governor. I was a University of Iowa faculty member and a candidate for full professorship.

We shared a common interest: beverage alcohol. Hughes had long been obsessively fond of its personal, intoxicating effects, though he had learned to control his obsession. I was fond of researching alcohol's use and its abuse, occasionally being a participant observer. Hughes, aware of my pioneering research on drinking in Iowa, wanted to discuss how we might help alcoholics if he was elected Governor. We agreed that hospital doors should be opened to those few advanced, physically ill cases. We disagreed, however, on the cause and the remedy for deviant drinking behavior. He believed a disease, alcoholism, to be the cause and residential treatment centers the remedy. This was despite the fact that he attributed his own "recovery," not to medical science, but to his faith in God and the help of Alcoholics Anonymous.

I believed that so long as the definition, diagnosis, treatment, and prevention of alcoholism all remained medical science mysteries, it was pointless, even unfair to physicians, to expect them to administer an unproven treatment for an undefined disease in a patient population that largely denied the disease and rejected the treatment. Moreover, building residential treatment centers for them would not be the first premature Iowa effort to fit chronic inebriates into the medical model. In 1903, Dr. C.F. Applegate, the superintendent of the State Hospital at Mt. Pleasant (one of Iowa's four "insane asylums") reported to the State Board of Control that he looked upon the inebriate not as a sinner but as "an unfortunate man suffering from a disease, not fully recognized by an unjust public." He reported that he had been treating them as though they had a disease. Although he claimed a 29% recovery rate, he described neither his treatment method, nor his success measure. Soon thereafter, in January 1906, Iowa built a special new hospital in Knoxville, where County Commissioners of Insanity could commit their male inebriates for treatment. The hospital's daily census, initially averaging 200 patients, soon began to decline. By 1919, the census had dwindled to only 11 patients and the facility was sold to the Federal Government for a Veterans Administration hospital. Apparently, too many discharged patients were getting drunk on their way home, leading the counties to conclude that they were not getting their money's worth.

I viewed alcohol abuse, not as a disease, but as deviant behavior largely influenced by social and cultural forces. I saw it not as a chronic brain or other physical disease, but as a behavioral problem over which the drinker has voluntary control. To me it was a behavior problem to be dealt with in and by the local community, not a physical "condition" that experts could fix within the confines of costly brick and mortar institutions. After all, alcoholics are recognized by their behavior, treatment is designed to change that behavior, and treatment effectiveness is judged by the behavior changes.

Hughes was an imposing, ruggedly handsome man with a deep authoritative voice. A Des Moines Register (Mar.6, 1988) reporter wrote of him, "…[his] physical presence and booming voice made him larger than life." He impressed me as a determined man, a goal-oriented man, and an action man. "Do something, even if it's wrong" appeared to be his motto. Risking redundancy, I will say that he was a complex, inconsistent and very able politician.

Hughes entered the Governor's office in January 1963. He won that election despite the fact that his opponent raised the issue of his well-earned reputation as a former alcohol abuser, and ridiculed his claimed recovery from the so-called disease, alcoholism. He was also elected despite his highly controversial campaign promise to legalize liquor-by-the-drink. At that time, Iowans could legally buy liquor stronger than 3.2% alcohol content only in a bottle, only from a state-owned liquor store, and only with a state issued “Individual Liquor Permit” costing one dollar and valid for one year.. Hughes argued that it was time to legalize an already widespread illegal practice. As Governor, he soon got legislation passed permitting Iowa taverns and restaurants to serve liquor by the drink for the first time in three decades.

In 1964, during his bid for re-election, his opponent took the opportunity of their final debate to report that he had recently learned that Hughes had been jailed in Florida for drunk driving. Hughes responded that indeed, he had been jailed in Florida for drunk driving, and also in five other states for the same offense, but he said that all that was more than ten years in the past. He said that he had since "recovered from the disease of alcoholism," and that he had had his last drink in 1954. Iowa voters re-elected him with an overwhelming margin (thus, assuring themselves that Minnesota's Jessie Ventura would not be the first man elected State Governor for his candor.)

After serving an unprecedented three terms as a Democratic Governor, Hughes went on to become a one-term U.S Senator before retiring from politics in late 1974. I went on to become a full professor of psychiatry and to earn a growing international recognition for my pioneering alcohol research. In addition, I worked with local Iowa communities developing self-help programs to deal with alcohol abusers.

Governor Hughes located his first residential alcoholism treatment center in the College of Medicine, at the University of Iowa. Some 30 years later, when the editor of a prestigious British journal, asked him how he managed to establish such a center in what was then a very uncommon setting, he replied, "Coercion." Addiction, (1997) 92 (2). I can attest to his use of that tactic. One of his first acts as Governor was to make a deal with the University. He would arrange to transfer control of the State's Tuberculosis Sanatorium at Oakdale to the University, if the College of Medicine would agree to establish an alcoholism treatment center there. The sanatorium was a large facility that, with the sharp decline of tuberculosis cases, had outlived its original purpose. The University administration coveted all that empty space only a couple of miles from the main campus. A year later the University possessed the Oakdale facility but had not established the promised alcoholism center. Just before Christmas, 1965, out of patience, Hughes arranged to come to Iowa City for a dinner meeting with top University and College of Medicine administrators.

I was invited too, but it soon became clear that Hughes was not there for my advice, or for anyone else's. He was there to open an alcoholism treatment center at Oakdale. He began the meeting with some unflattering remarks about the medical profession, which he said that he had resented ever since he had watched his father die because his family could not afford medical attention. He then talked about how soon (not whether) the University would open the Oakdale Alcoholism Treatment Center.

I rose to my feet and ventured to suggest a University-based program to train Community Alcohol Extension Agents to help alcoholics, their families and the larger community to cope with alcohol abuse, much as agricultural colleges had, for many decades, been training Agricultural Extension Agents to help farmers. I argued that since every community already had all of the services and resources of known value to alcoholics what was needed was someone trained to advise and assist alcoholics to use them. I also viewed such agents as full-time paid advisors who would supplement Alcoholics Anonymous (AA) 12Step workers who help each other along in the natural recovery process. Hughes responded, "Hell, I'm trying to get rid of those Agricultural Agents." I retreated into silence.

Early the next morning, Dean Robert Hardin of the College of Medicine telephoned me and several other faculty members asking us to form a committee to establish an alcoholism treatment center at Oakdale--immediately, if not sooner. Despite the Christmas holidays, within six weeks we had staffed the unit and had recruited Dr. Leo Sedlacek to serve as acting Director. Dr. Sedlacek was a Cedar Rapids private-practice psychiatrist. All who knew him loved him. He was low in stature and high in energy, with a contagious enthusiasm. Although not one himself, he had specialized in helping alcoholics, and had for years been lobbying the State Legislature to do something to help them. He admitted the first patients to the new Oakdale unit on February 1, 1966, less than two months after our dinner with the Governor.

CHAPTER 2

DIFFERENT CAREER PATHS

Harold Hughes grew up in a poor farming family living near Ida Grove Iowa. Beyond that, and his reputation as an alcoholic truck driver, I know little about his early life that might help explain his later commitment to the alcoholism disease concept and the building of alcoholism treatment centers nationwide. Did one obsession beget another? Ten psychologists might offer at least a dozen different, all perhaps partially valid, explanations.

As for me, two significant life events contributed to my career-long devotion to researching beverage alcohol use and developing programs to help alcoholics. One was my decision to research alcoholics for my Ph.D. dissertation. The other was Dr. Sedlacek's persistent badgering of the Iowa General Assembly to do something to help the state's alcoholics.

In the Fall of 1950, I launched my college faculty career at Northwest Missouri State College in Maryville, Missouri. I went there with a fresh Master's degree in Sociology from the University of Iowa. Two of my students, both WWII Air Force veterans failed to appear for a final examination. One of them reappeared in an AA drying out hospital in St Joseph, Missouri. The other one should have been there. They sobered up and I let them take the final late. Both passed it, and to show their gratitude, they invited me to accompany them to an AA meeting.

There I found a very friendly group of people openly discussing their common problem. Their intelligence seemed a notch above average, and I was especially struck by their ironic sense of humor. The first member I was introduced to extended a shaky hand and said, "Here, grab this. It shakes itself." Chatting with the group members after their formal meeting, I asked one of them how much he usually drank at a sitting. He said, "I started sittin' 25 years ago and was still sittin' when I joined AA last year." Another member, a municipal judge, told about coming home late one night, and explaining to his wife that his friend had been so drunk that he had to take him home. Later in the day the judge sought to reinforce his story to his skeptical wife. So he telephoned her from his office and told her, "That guy showed up in my court this morning and I just gave him 10 days for being drunk and disorderly."

"You should have given him 20 days," replied the wife, "because he dirtied your pants too." I got the impression that he might have been embellishing the truth somewhat. I later noticed that their life's stories, or "drunkelogues" as they called them, often "improved" with retelling.

I also noticed that most of them had a cup of coffee or a coke in one hand and a cigarette or a candy bar in the other one. Freudian psychobabble would have them fixated at the oral level, whatever that might mean. As I drove home from that meeting, I thought:" Alcoholics would make an interesting, challenging, maybe even fun doctoral dissertation topic." A couple of years later, when I returned to the University of Iowa for my final year of graduate work, I spent

several weeks interviewing the inebriates committed to Iowa's four state Mental Health Institutes for my dissertation. That work would later prove to be a major factor shaping my career course.

Dr. Sedlacek's influence on my career path derived from his tenacious lobbying of Iowa lawmakers until finally, in 1955, they appropriated $30,000 to the University of Iowa, and mandated a survey of Iowa's alcohol abuse problem with a report to be made within the next two years. Responsibility for the task fell to the Dean of the College of Medicine, who resented it. He said that he did not want to mess with "drunks."

At that time, the terms "alcoholic" and "alcoholism" to replace “chronic inebriate” and “dipsomania” were just coming into vogue. Not until 1961 did the Iowa Legislature define the term "alcoholic." They defined it to mean "…any person who chronically and habitually uses alcoholic beverages to the extent that he or she has lost the power of self control with respect to the use of such beverages, or while chronically and habitually under the influence of alcoholic beverages endangers public morals, safety or welfare."

After a yearlong, futile search for someone "really qualified" (i.e. a psychiatrist), to do the study, a search committee member, Professor Harold Saunders, Sociology Department Chairman, told the committee about my recently completed dissertation on Iowa's alcoholics. Facing the report deadline, the committee in desperation offered me the job. I accepted. Leaving my post at Northwest Missouri State College, I assumed my new duties in March 1956. I went on to become a University of Iowa faculty member by default, certainly not by career planning. That I might ever be offered a job at a Big Ten university, much less ultimately become a full professor of psychiatry specializing in alcohol use research, had never crossed this Iowa farm boy’s mind. When I asked to be relieved of my Maryville State College contract in mid-year, the College President said, "Ok, but only on condition that you find a replacement," which I soon did – “and that you never return,” which I didn't.

In my new position I reported to the search committee chairman, Dr. Paul Huston, who also headed the Department of Psychiatry. After I had completed the state survey and submitted my final report, Dr. Huston offered me an appointment as Assistant Professor in his Psychiatry Department although he was under no contractual obligation to do so. At that time, including a social scientist on medical school faculties was a growing national trend. I accepted his offer and eventually became a full professor of psychiatry without ever having to suffer the indignity of being a psychiatrist. When I am asked how I managed to get along with all those psychiatrists for more than 30 years, I reply that I thought of myself as a rose among thorns. It helped too, that my number of research grant awards and the length of my publication list soon exceeded most of theirs. Dr. Huston and I developed considerable mutual respect and got along quite well.

For the first few weeks after joining the department I sat idle in my office, wondering what to do. Finding idleness intolerable, I went to Dr. Huston and asked him just what he expected from a sociologist in his psychiatry department--a tulip in an onion patch so to speak. After some thought, he said, " Hal, let's just play it by ear." I returned to my office, thought about it for a few days and then wrote a half-page statement creating the University of Iowa Division of Alcohol Studies, making myself director of this new one-man division. When I showed the

proposal to him, along with an appropriate stationary letterhead I had designed, he hesitated, but then said, "Well, OK Hal."

I went to work, and managed to largely support myself with Federal research and other grant funds. I also developed a community alcohol consultant-training program that assisted local communities in developing self-help programs for alcoholics. In addition, I taught a seminar on the social aspects of alcoholism to the psychiatry residents, and through the sociology department I offered an evening course on alcoholism for upper level and graduate students.

At one point in our relationship, Huston asked me what I would think of his inviting his friend E.M. Jellinek, from the Yale School of Alcohol Studies, to visit the department as a guest lecturer. I said, "That's a great idea. As you know, he is nationally known as the 'Dean of Alcohol Studies', and I'm sure he is well aware of my research. Since I'm up for promotion to full professor, why don't you ask his opinion of my work?" I received the promotion.

CHAPTER 3

1966--A BUSY YEAR

The year 1966 was a very active one for both my Governor and me. In January, the month before the Oakdale Treatment Center opening, I assisted the Cedar Rapids Citizens Committee on Alcoholism in establishing Iowa's first Community Alcohol Counselor Office. Dr. Sedlacek and I had been working for more than two years to establish an office to help alcoholics. Finally, he signed a $600 bank loan for the first three-month's office rent. A retired, recovered alcoholic volunteered to run the office without pay until he could obtain local funding for the office, which he soon did.

Meanwhile, Hughes was seeking Federal grant funds to establish eight alcoholism treatment centers in Iowa. To that end, he appointed me to a ten-member "Alcoholism Action Committee" charged with preparing a grant application to the Federal Office of Economic Opportunity (OEO), a part of President Johnson's War on Poverty. I drafted a five-page statement defining Iowa's alcohol abuse problem as my research had revealed it. I described the state's drinking population, estimated the alcoholic target population numbers, and described that population's demographics, as no other state was yet prepared to do. However, my research had shown that only a small proportion of the state's alcoholics could be classified as indigent. The number of indigent alcoholics revealed by my research amounted to less than one tenth of one per cent of the state's total population. Even if Hughes' proposed treatment centers were to attract, treat and cure all 2500 of them that would hardly represent a major victory for the War on Poverty.

When the committee chairman, asked me if I couldn't somehow come up with a larger number of poverty-stricken alcoholics, I replied that I really wasn't into that kind of research, common though that might be among politicians and government agencies. When I said that I could only call 'em as I see 'em, he offered to describe for me the Governor's bloody arm-twisting to get the University to open the Oakdale Treatment Center. Curious as I was, I impulsively said, "No, I'm not interested. It would be a waste of time and would not change my study findings." (I now wish that I had accepted his offer. It did not occur to me then that someday I would be writing these memoirs.)

Instead of my puny target population figures, the final draft of Hughes' OEO grant application contained figures emphasizing the high proportion of indigent alcoholics among the state's arrested and institutionalized alcoholics. While those large percentage figures for institutionalized alcoholics did not contradict my alcoholic prevalence estimate for the state, they did give the appearance of a larger number of needy alcoholics in Iowa. The figures also buttressed the argument that alcoholism contributes to poverty.

Meanwhile, I had obtained a modest-sized ($20,597) Federal grant under Title I of the Higher Education Act of 1965 to develop what I called, a "Community Alcoholism Consultant-Aide Demonstration Training Project." The original idea was to train "consultants" to advise the community service professionals on identifying and helping alcoholics. The "aide" would assist

the consultant, as well as work directly with alcoholics. When it became apparent that this was not a useful distinction, I dropped it. I ended up training what came to be called "Community Alcohol Counselors" to facilitate and coordinate the interaction between the community service professionals and alcoholics. I hired Gordon Nelson, a recovered alcoholic, to help me develop the training program. He had been assistant director of Hughes' Iowa State Alcoholism Commission. The commissioners were mostly recovered alcoholics, as was the Commission director, Charles Churan.

As a kindred spirit, Gordy was closer to Hughes than I was. Hughes and I had little face-to-face interaction. Our relationship was not close, but it was always friendly and cooperative. Although I remained critical of the alcoholism disease concept that he seemed so committed to, and was even more critical of the costly treatment center movement that the concept generated, he never criticized my community program. Quite the contrary, Hughes evidently saw it as complementing his treatment center approach, and he helped launch it. April 4-6, 1966 Gordy and I hosted a two-day work-study conference for Iowa service professionals--physicians, judges, clergymen, attorneys, welfare workers, police, health workers, and AA members. Some 200 of them from across the state gathered to discuss the various problems presented by their clients, problems that were often related to the client's drinking. Even when the professional noticed the drinking problem he or she usually ignored it for want of knowing how to deal with it.

The University and Governor Hughes' State Commission on Alcoholism sponsored the conference jointly. Gordy got the Governor to send out conference invitations and also to be the keynote speaker. The Governor's invitation read in part, "…it is hoped that these 'firing line professionals' will acquire increased understanding of alcoholism, as well as the part each professional can play in meeting the alcoholics' needs…." His keynote address titled "Alcoholism is Everybody's Business," stressed the need for the community alcohol counselors that I was training to work with community service professionals. This, of course, gave a large boost to my community counselor program efforts.

Some three months later Hughes told a Daily Iowan reporter, "Mulford's Program is an excellent example of what I meant in April when I told a work-study conference on alcoholism in Iowa City---let's stop talking and start doing something about alcoholism…. I strongly urge the cities of Iowa to cooperate in the Program…"

By year's end Hughes had obtained a total of $1.2 million in Federal Office of Economic Opportunity and Vocational Rehabilitation grant funds for a demonstration project that would establish eight treatment centers and three halfway houses, plus funds to train alcoholism counselors. I had completed the first Community Alcohol Counselor training program. Conferees from ten of the communities represented at our April conference had returned home, formed Citizen's Councils on Alcoholism and opened Information and Referral offices---all with local city and county funds and with local control. Four of the communities had hired the first four graduates of my alcohol counselor-training program. I ended the year with a stomach ulcer from trying to serve two masters at once--my governor who was bent on building costly alcoholism treatment centers and my scientific principles that told me that alcoholism was a myth. After weeks of suffering sharp stomach pains, I went to the doctor's office where I passed out on his

examining table from loss of blood. I was immediately hospitalized with a duodenal ulcer. Lying in that hospital bed I vowed that I would stop getting ulcers, and start giving them. They have not bothered me since.

CHAPTER 4

SENATOR HUGHES GOES TO WASHINGTON

In 1968, after becoming the first Democratic Governor in Iowa's history to serve three terms, newly elected U.S. Senator Hughes went to Washington. Although a mere Junior Senator, within two years he had almost single handedly authored, and pushed through Congress, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public Law 91-616) often called the "Hughes Act." Legend has it that on New Years Eve, in the closing minutes of the year 1970, a Hughes friend and fellow recovering alcoholic, who was also a Nixon financial supporter, persuaded an intoxicated President Nixon to sign the Hughes Act. That bill created the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and launched the nation's Alcoholism Residential Treatment Centers Movement. Later Hughes authored and shepherded through the legislative mill an act creating the National Institute on Drug Abuse (NIDA). While his success owed much to his considerable political skills, he was also cultivating the alcoholism disease concept in very fertile soil:

- A few years earlier, in 1956, the American Medical Association, in a move more political than scientific, had declared alcoholism to be a disease.
- The alcoholism disease concept, having lain dormant since Dr. Benjamin Rush had promoted it more than a century earlier, was now being revived in an atmosphere of growing public health consciousness, faith in the ability of medical science to conquer all disease, and a growing reliance on "experts" to solve personal problems. (The number of psychological counselors was burgeoning.)
- Philosophically, portraying the deviant drinker as a broken machine, needing repair fit neatly the Cartesian, mechanical clock paradigm that has dominated Western thought for some three centuries
- The alcoholism disease-treatment-cure promise appealed to a public and to its legislators longing for a simple explanation and a promising remedy for a persistent, complex and vexing problem. What could be simpler than the "no-alcoholism, no-alcohol-problem" promise, unless it was the earlier Prohibitionists' ill-fated promise, "no-alcohol, no-alcohol-problem?"
- Americans welcomed the professional experts' offer to relieve them of responsibility for coping with alcohol abusers, the growing army of therapeutic experts welcomed the new business, and the alcoholics were glad to be excused for their behavior. In addition, there was society's growing inclination to excuse all sorts of deviant behavior as due to an uncontrollable addiction.
- The alcoholism disease concept was particularly appealling to alcoholic politicians who would rather be seen as suffering an illness than as morally weak.

Ignored amid all of this euphoria was the sobering fact that the Residential Treatment Center Movement had no solid scientific foundation. It rested on shifting political sands and fickle public opinion. As recently as 1997, the NIAAA director, Enoch Gordis, reminded us of that when he wrote,

> "Our whole [alcoholism] treatment system, with its innumerable therapies, armies of therapists, large and expensive programs, endless conferences, innovations and public relations activities is founded on hunch, not evidence and not on science." (Journal of Alcohol Studies (Vol. 48, pp.579-585)

Given the movement's shaky foundation and its failure of purpose, along with the high value that Americans place on efficiency, one wonders what sustains public support for it. Why has the Movement not yet gone the way of Iowa's century-earlier failed efforts to fit drunkards into the medical model? My Alcohol Studies Assistant, Jerry Fitzgerald, postulated a partial explanation: many families are grateful for a place to get rid of an alcoholic member at someone else's expense, if only for a few weeks.

In search of a more viable alternative to the residential treatment centers movement, I turned to the historical and anthropological literature on the human/alcohol relationship. I learned that Americans, in their search for the cause of deviant drinking (as though there is a single cause), had narrowly focused attention on first one and then the other of two supposed, all too obvious causes--the drink and the drinker. The colonists had faulted the drinker. They defined the drink as "God's good gift" particularly to health. Men, women, and children drank copious amounts daily, equaling some three times today's average consumption. However, informal social controls more effectively prevented deviant drinking than is the case today. The colonists did hold the few "chronic drunkards" among them accountable for their excessive appetites and sometimes displayed them in the stocks. However, they also conceded that the Devil might be involved, and considered drunkards to be good candidates for redemption.

However, in the early 1800s, Americans began to perceive a growing alcohol problem. They also began to shift responsibility for the problem from the drinker to the drink. "God's good gift" gradually became "the Devil's own brew." The remedy for the problem was all too obvious and all too simple: abolish alcohol. After nearly a century of emotional public debate, with arguments waged largely on moral grounds, the Prohibitionists finally saw their remedy implemented in the form of the Prohibition Amendment to the Federal Constitution in 1920. Some people were so convinced that alcohol was the root of all crime, if not of all evil, that passage of the Amendment prompted the town fathers of at least two Iowa towns, Vinton and Buckgrove, to sell their jails. Only 13 years later, the American public declared as error what President Hoover had called "the noble experiment" and voted to repeal Prohibition. Today's neo-prohibitionists have redefined the drink as more of a health, than a moral, risk. Ironically, recent studies showing certain health advantages from a drink or two a day, move us back toward the colonist's definition of the drink as "God's good gift."

At the time that I began researching the subject in the mid-1950s, the alcoholism disease concept, until then only an idea in the head of the observer, was being reified and located in the body of the observed. Alcoholism was, and is, a social invention, not a scientific discovery. With the "Hughes Act" Americans were reacting to this invention. Now the cause of deviant drinking was back in the drinker once again, but in the form of a supposed disease. The only thing that alcoholism has in common with other diseases is the sympathy that it evokes. While the disease concept may be of some benefit for some alcoholics under some unknown conditions, it also has unintended and counterproductive consequences for others. For some it provides another excuse

to continue drinking, and relieves them of responsibility for correcting their behavior. The alcoholism disease myth shifts responsibility to therapeutic experts, even though there is precious little scientifically confirmed knowledge for them to be expert about. Moreover, reducing the stigma on deviant drinking eases the normal social pressures on deviant drinkers to control their drinking. Hence, many alcoholics became more victim than beneficiary of the alcoholism disease mythology.

CHAPTER 5

WE HAVE MET THE ALCOHOL PROBLEM AND IT IS US

When Senator Hughes went to Washington, Americans were asking, "What is wrong with alcoholics and how can we fix them?" Senator Hughes answered by giving alcoholics alcoholism and promising Americans that medical science would treat the disease. Meanwhile, I was asking a much different question, or set of questions, and arriving at much different answers.

I had come to view the human machine as more than a machine; more than a Cartesian, mechanical clock. I believed that human behavior is the result of conscious decisions influenced by a multitude of individually weak social, cultural, biological, and environmental factors interacting in complex ways that science does not understand. Their behavior is best understood if humans are viewed as living in a symbolic universe of their own creation. The social inventions, "alcoholism," and “addiction” being prime examples.

The historical and anthropological literature on the human/alcohol relationship led me to ask, "How is it that the human species has survived thousands of years of interaction with beverage alcohol. Our prehistoric ancestors knew of the natural law of fermentation, and the intoxicating pleasures of "kickapoo joy juice." How is it that all societies that have long known alcohol (and few have not), have integrated its use into their culture in ways that discourage most of their members from drinking all they can get their hands on, and that rehabilitate most of those few who do? How is it that members of Alcoholics Anonymous can help each other correct their deviant drinking and maintain sobriety, as Hughes said was true in his case?

Furthermore, given today’s growing popularity of the “ addictions” concept and the belief that “addicts” need expert treatment, how do we account for the fact: (1) tens of millions of us American nicotine addicts have quit smoking without any special treatment; (2) 96% of the Vietnam Veterans who were treated for heroin addiction upon their return home soon gave up the drug, and so did 96% of those who were <u>not</u> treated; (3) most alcoholics eventually gain control of their drinking. Most, including Harold Hughes, do so without formal treatment. Granted, some do drink themselves to death first.

The answer to all of the above questions is the same as the answer to the question, “Why do so few Americans, as compared with certain other cultures, eat cat or dog flesh.” Americans, in their historical preoccupation with the drink and the drinker, first one then the other, as the cause of deviant drinking, have largely ignored the influence of *drinking norms* and their informal enforcement on individual drinking behavior. A society's norms are survival techniques representing the collective common sense wisdom of the ages. Drinking norms express a group’s consensus on who should drink what, when, where, with whom, and under what conditions, as well as how much is too much, what drinking behavior is acceptable under what conditions, and what is not, and on and on. This includes agreement regarding what alcohol is expected to do <u>to</u>, and <u>for</u>, the drinker, and what he or she should and should not do <u>to</u>, and <u>with</u> it. The drinking norms are often very detailed and specific. For example, the norms specify that wine be served in a wineglass, not a coffee cup or beer mug.

One can mentally experience the power of the informal normative controls on individual behavior by simply contemplating the act of spitting into the middle of the Thanksgiving dinner table. Of course, you won't actually do that. Why not? There is no law against it, and no need for one. You won't do it because during your entire life your mother, your father, and everyone that you have known have all agreed on the norm: WE JUST DO NOT DO THAT. If our drinking norms condemned alcohol abuse as equally reprehensible, we would have far fewer alcoholics.

Just as water is the last thing one might expect a fish to discover, so a society's members are so immersed in the never-ending process of developing and maintaining their behavioral norms that they are hardly conscious of the process. There may be some risk in calling public attention to the process, considering what happened to the centipede who, when asked how he managed all those legs, stopped to think about it and never walked again.

As a person simultaneously advances in the natural alcoholic and rehabilitation processes, he or she is continuously pressured by others to conform to the norms. The punishments for nonconformity can take a variety of forms including shame, guilt, disgrace, humiliation, ridicule, ostracism, institutionalization and so on. For the few drinkers who defy these ordinary social controls, additional forces come into play. Family, friends, employer and other associates urge, cajole, coerce, and otherwise pressure the deviant drinker in many ways to bring his/her drinking behavior more in line with the norms. Depending upon the case, such pressure tactics might include threatened or actual police arrest, job loss or spouse departure. Incentives also come from the negative health effects of aging on the body's ability to handle alcohol. For some cases, a physician's diagnosis of liver disease triggers a great hunger for sobriety and the determination to sustain it.

Although each case involves a unique set of social, environmental and biological variables, the following case history illustrates the natural control process at work. Early one morning, in 1978 a man, whom I will call "Clancy" was arrested, handcuffed and jailed by the Iowa City police for drunk driving after having crashed his car into a tree. His wife, desperate for help, called me at home that evening. Clancy had, for the first time, admitted a drinking problem, and had agreed to talk to someone about it. His wife was concerned that the next day he would feel better and would change his mind. I gave her the telephone number of an AA member who visited her husband within the hour.

Note the numerous players in this drama, and the normative community forces pressuring Clancy to correct his deviant drinking behavior. The drama's main character got drunk and wrecked his car. The police played a role. They arrested and jailed him. The wife played her part. She recognized and acted on his readiness for help. The local press, which is where she got my name, played a role when it ran a story about my work on the alcohol problem. I played a role--the role of the Community Alcoholism Counselor---by referring her to an AA member. The AA member and Clancy discussed the possibility that Clancy enter a 30-day private inpatient treatment center in Cedar Rapids. Clancy then went so far as to visit the center where the director gave him a tour and talked with him for a couple of hours. Clancy chose not to become an inpatient, but he did remain sober.

Because he had no formal treatment, Clancy's sustained sobriety would generally be classed as a "spontaneous remission." Giving credit to his two-hour experience with the treatment center and its director would be quite consistent with the classic British treatment evaluation study that found the same low treatment success rate for a one-year hospital-based treatment as for only two hours of advice by the same clinic staff. (Edwards, et al, JSA, 1977).

Evidently, Clancy had become "sick and tired of being sick and tired" as they say in AA. The many pressures to correct his drinking had reached a critical mass that might be triggered by a great variety of experiences including any of the countless treatments available. He had progressed in the natural recovery process to the point where he wanted sobriety and was determined to maintain it. Like Harold Hughes, he achieved sobriety without formal treatment. Clancy might have had a much different treatment center experience had his wife received a different answer to the call that she had made earlier that evening to the Mid-Eastern Council on Chemical Abuse ("MECCA").

Some years earlier, as a member of the Johnson County Committee on Alcoholism I had helped establish MECCA as one of Iowa's first Community Alcohol Counselor offices. However, when Clancy's wife called the center that evening, it had become a state-controlled, state-licensed, fully accredited alcoholism treatment center. Had a real person answered her call and offered help, Clancy's treatment story likely would have been quite different. Instead, the taped voice that did answer her call instructed her to call back during normal 8 to 5 business hours. Had she done that instead of calling me (or called the Community Alcohol Counselor, had there still been one) she would have been invited to come to the center during business hours, fill out numerous forms documenting compliance with government-imposed standard operating procedures, and enroll herself in an eight-week "coping group." After she had completed that, her husband, Clancy would have been invited in and required to complete more forms before he could commence so-called treatment. This assumes that he had not drunk himself to death in the meantime. An alcoholic with the patience to fit himself into someone else's treatment time-schedule probably doesn't need the treatment.

MECCA was Iowa' first center to apply for and receive Federal accreditation, even before the state took control of the community centers. As a member of the MECCA Board of Directors, I voted against requesting accreditation, even though I sensed that accreditation was an inevitable state bureaucratic move. I thought that the considerable money that the accreditation procedure would cost could better be spent helping alcoholics. After the two men from the Joint Commission on the Accreditation of Hospitals spent two days inspecting the MECCA program they called a public meeting, to announce their approval of our center for accreditation. There I asked them, "What evidence is there that accredited centers see any more alcoholics or deal with them any more effectively than do unaccredited centers?" They assured me that such research was underway, and promised to put me on the mailing list for the study results. Some 30 years later, I still vainly dash to the mailbox every day (except Sundays and holidays) only to return empty handed and ever more disappointed. I'm beginning to wonder whether I might be a flim-flam victim.

Some years later, in 1991, I had another telling experience trying to get help for an alcoholic friend from the fully accredited MECCA and its certified professional staff. The

experience further illustrates the change in the center's operation after the state take-over, and what that change meant for alcoholics seeking help. My friend was one of the worst alcoholics I ever met. He had lost everything. His wife had divorced him. He had lost his license to practice psychiatry and he was living in a Mission Home in Des Moines. One Saturday he called his former wife from the Iowa City Bus Station, and asked her to come get him. She said she would, but then she got to thinking that he sounded drunk, and she did not want to deal with him. She called me asking advice. I suggested that she call MECCA. A recorded message told her that the center was not open weekends. She called the Police and asked them to check on her former husband. The Police found that he was indeed intoxicated. They gave him what some around here call "I-80 therapy." The police bought him a one-way bus ticket back down Interstate 80 to Des Moines. Despite numerous treatment center experiences, he eventually drank himself to death. That Monday morning I called the MECCA Director to inquire why it was that when we first opened the Iowa City center and Gill Voss, a Community Alcohol Counselor was operating it on an annual budget of about $30,000, an alcoholic could call Gill any time and get help. "Now" I said, "with an operating budget of more than a half million dollars…" With some obvious pride in his voice the center Director interrupted me, to say, "Would you believe the budget is now closer to one million dollars?" I hung up the phone.

With that wisecrack, the MECCA Director unwittingly characterized, not only MECCA's progress, but also the progress of the entire Alcoholism Treatment Center Movement as nothing more than budget growth. It still remains for science to demonstrate any progress improving treatment success rates beyond Dr. Applegate's century-old 29% figure. There has been no more progress on the prevention front.

Although my repeated requests for a copy of a recent MEECA Annual Report have so far gone unanswered, I did manage to obtain a copy of the "Independent Auditor's Report" elsewhere. That report shows that MECCA's budget for fiscal year 2000 was $3,382,053. Only one half of it was spent on treatment. Nearly one-fourth of the budget went for administration, and the remaining one-fourth of it was spent on "other programs" including prevention.

Without the center's Annual Report I don't know the number of clients that it served during the year. However, if we assume that MECCA's annual per-client cost approximates the $317 unit-cost that I describe below for the nearby Washington County Bob Gray Outreach Center, then we can calculate that with its $3,382,053 budget MECCA could have served more than 10,000 alcoholics last year. Since that is several times the estimated number of alcoholics in the area, the center could have provided a year of counseling for every alcoholic in the area and had considerable money left over to research its treatment success rate. Surely, it is not too early to ask of the MECCA multi-million dollar operation the question uppermost in Hughes' mind, WHAT'S IN IT FOR THE ALCOHOLIC, or WHO IS GETTING WHAT OUT OF IT? As I describe below, early on, in 1974, Harold Hughes in a speech to the North American Congress on Alcohol and Drug Problems listed many groups of people, including those he called "bureaucratic empire builders" who he saw benefiting more than alcoholics from the Alcoholism Movement.

CHAPTER 6

THE COMMUNITY ALCOHOLISM COUNSELOR

The known variations in alcohol abuse rates across societies, across different segments of the same society, and across time, suggest that a society somehow controls its members drinking behavior. Such variations also convinced me that if I went about it in a systematic, scientific way, I could help Iowa local communities strengthen those natural drinking behavior controls. To that end, I developed a University-based program that integrated: (1) services to alcoholics; (2) service-provider training; and (3) program monitoring and research.

As described above, in 1966-67 Hughes contributed to the development of my community counselors training program. He sent people for me to train as counselors to staff the eight treatment centers he was establishing in Iowa. This infusion of funds enabled me to extend the three-month demonstration training program to six months. He sent mostly recovered alcoholics with backgrounds similar to those of the persons that I was recruiting for training.

Later, when I became director of the Oakdale Center, July 1, 1972, additional federal grant funds enabled me to further expand the training into a ten-month program. It was now an intensive, 60-hour per week schedule. It was about half classroom work and half field placements in centers across the nation. A new class of about a dozen students began in September and May of each year.

Our unique training program attracted applicants nationwide. Their backgrounds were as varied as the clients they would work with. One student had been a Bunny in a Playboy Club. One was an alcoholic son of an Alaska Eskimo Chief. There were ex-farmers, ex-nurses, and former Catholic nuns. Applicants varied widely in their academic backgrounds as well. One student was just short of a Ph.D. in physics while another 15-year denizen of Kansas City's Skid Row was barely literate. That he had lived in his car for several weeks in mid-winter waiting for a new class to open, we took as evidence of the dedication every trainee should have. He began the program, then dropped out for a year, learned to read and write, and then returned. We considered him to be especially qualified to work with skid row alcoholics. We favored applicants whose experience in working with alcoholics showed that they could relate to, and empathize with such individuals. Hence, some three-fourths of them were themselves recovering alcoholics, mostly AA members. However, we considered AA to be only one of the many and varied community services that might be solicited to help alcoholics, depending upon the nature of the case.

Some of the few more naive students who had not worked with alcoholics expressed disappointment that our training offered no pat formula for treating, or relating to, or empathizing with alcoholics. Recalling Louis Armstrong's remark about jazz swing music, I responded, "If you have to ask what empathy is, you ain't never going to know."

Our educational objectives contrasted with conventional counselor education programs. Whereas professional psychotherapists are taught to play mind games designed to help alcoholics

think their way into new ways of acting, we taught our counselors to focus first on changing the alcoholics' behavior, thereby helping them *to act their way into new ways of thinking*. All too often, with mind games the alcoholic outwits the conventional therapist, wins the game, and gets on with his drinking. An AA member once told me that earlier, he had had three years of psychotherapy. I asked him, "Didn't the psychiatrist help you with your drinking? He grinned and said, "Hell, I never told him that I drank."

Our counselors could not be all things to all people. However, they were many things to some people and some things to many people. Depending on the case, they functioned as out-reachers, facilitators, motivators, coordinators, advisors, empathic friends, and confidants to their alcoholic clients, to name only some of the roles that they performed.

The Community Counselor reaches out to contact alcoholics, especially in locations where the alcoholic is hurting and is receptive to help. These include police stations, courts, hospitals, physicians' offices, welfare offices, attorneys' offices and company personnel offices where alcoholics appear, not for help with their drinking problem, but rather for help with a problem that is often related to their drinking. My research had revealed that during the course of a year, about half of Iowa's alcoholics appeared in one or more such offices. More often than not, the service professional is unaware of the client's drinking problem and, in fact, would rather not know about it, because he/she does not know what to do about it.

If the professional's client's presenting problem is related to drinking, that may provide an incentive that the Alcohol Counselor can build on. The Counselors learn to be alert for the alcoholic's "motivational moments" when the individual suddenly experiences an overwhelming desire to quit drinking. The nature of such moments can vary greatly. One alcoholic told me that the moment came for him when he overheard his 12-year-old daughter tell her friend, "Don't pay any attention to my Dad, he's drunk again." For another member it was emerging from a blackout to learn that he had struck his wife and broken her jaw. Often, receiving a liver cirrhosis diagnosis is such a moment, but not always. An Oakdale Treatment Center patient said to me, "I sure hope they can get my liver fixed up so I can get back to drinking."

Once contact is made, the counselor helps the alcoholic sort out his problems, which by this time may be overwhelming. Together counselor and client prioritize the problems and attack them one at a time. This might include finding a job, locating housing, restoring relations with a spouse, or getting finances in order, to name only a few.

The public perception, however false, is that residential treatment centers somehow medically repair the alcoholic. The community counselor makes no such pretense, stressing self-reliance instead. That the alcoholic does not become too dependent on the counselor, the counselor does nothing for the alcoholic that the alcoholic can be persuaded to do for him/herself. The counselor involves as many other community persons as possible, including, family members, employer, physician, clergyman, police, court, AA members, all depending upon the circumstances of the case. The counselor coordinates and facilitates the efforts of the persons and agencies involved. Theoretically, maximizing community involvement also reinforces the community's responsible drinking norms. Taking a tough-love approach, and depending upon the nature of the case, the counselor would not hesitate to recommend to the

court some jail time for a client, hoping to motivate him to change his drinking habits. Above all, the counselor must build credibility with the police, the court, and the public.

In 1970, with the three-component community Counselor Program in full operation, we began issuing quarterly and annual monitoring reports back to the community centers. Until the State took control of the centers January 1975 we regularly brought center directors together to discuss our monitoring results. This helped them to learn from their own, and from each other's experiences. For example, at one meeting, we discussed the monitoring system evidence that one of the centers was serving an exceptionally large number of alcoholic employees. The center director described his outreach efforts and how he worked with company personnel directors to convince them that it would be to their advantage to identify and refer alcoholic workers for help.

I have tried and failed to list and codify the community counselor's helping efforts. I finally concluded that in the absence of a proven one-size-fits-all "therapeutic modality," it is foolish, even counterproductive, to standardize treatment in the way that state and federal bureaucrats have imposed standard operating procedures on the centers. Every client is different, every counselor is different, and every client/counselor relationship is unique.

CHAPTER 7

TELLING IT LIKE IT IS:
THERE IS MORE THAN ONE WAY TO SKIN A CAT

The Bob Gray Outreach Center (originally the Washington County Outreach Center) has been serving Washington County, Iowa since 1974. Using The Iowa Alcoholic Intake Schedule, and Continuing Case Record that I designed, I monitored the center's operation for some 20 years. It's operation is typical of that of Iowa's local Community Alcohol Counselor programs before the state took control of them. The center has largely escaped state control. This was because when the State asserted control of the local centers January 1, 1975, the Washington County Attorney and a District Judge on the Problem Drinking Advisory Committee that I was also a member of convinced the Iowa State Attorney General that this "outreach" Center did not treat alcoholism or even pretend to. The Center provided information and referral for anyone seeking help, including alcoholics. However, it did not pretend to understand, much less treat diseases of any kind. Therefore, it was exempt from the law giving the Iowa Division On Alcoholism authority to take control of alcoholism treatment centers. Bob Gray, the center director was not even called an "alcoholism counselor." Rather, he was an "outreach worker." The Bob Gray Outreach Center has remained uniquely locally funded, locally controlled, and largely free of state-imposed standard operating procedures.

Bob soon became quite popular in the community and highly respected for his honesty and candor. He earned the respect and close cooperation of the courts, law enforcement people, and other county and city officials.

An Army Paratrooper in WWII, Bob had landed and fought on the Normandy beachhead. Following his Army discharge, he had worked as a roustabout in the Oklahoma and Kansas oil fields. He developed a bad habit of entertaining himself by getting drunk and shooting holes in the ceilings of local honky-tonks. One night a stray bullet accidentally struck another bar patron. After serving a prison sentence, he joined Alcoholics Anonymous, stayed sober and, a few years later, applied for admission to my Counselor Training Program.

When I was slow to respond to his application, he wrote to Senator Hughes and complained. The letter that I received from Hughes expedited my response to Bob. Bob's letter to Hughes demonstrated the kind of initiative we sought in our counselor trainees. We soon had him in for an interview.

Bob was a muscular, solidly built man who immediately impressed me as an honest, matter of fact, straight talker. He evidently understood and liked alcoholics and had experience working with them through AA.

When telling people about that admissions interview with me he would say, in his Oklahoma drawl, "The last question ol' Doc ask me was whether I had any common sense. I said, 'Yup, I got lots of it.' Doc says, 'OK, you're in'."

Bob was a hard-working student who contributed much to the training program. At one point in his training we admitted a patient to the Oakdale treatment center who was on the verge of delirium tremens. Bob took on the task of "baby sitting" or "talking down" the new patient, sitting with him and explaining, for example, that the sound he heard was a toilet being flushed, not a herd of buffalo about to run him down. Bob worked with the patient all afternoon and into the evening when the patient finally went to sleep. By that time Bob had missed dinner. While he was off looking for something to eat, the night nurse came on duty. Unaware that Bob had spent most of the day with the patient, when he returned she began to reprimand him for leaving his post. Bob responded, "Next time you can stomp them snakes yourself."

His approach to helping alcoholics was practical, pragmatic tough-love. Free of bureaucratically imposed standard operating procedures, Bob tailored his help to the client's needs. Depending on the situation, he might talk with one client for a couple of hours, while another client might merely stop by Bob's office for a quick cup of coffee on his way to work. Bob expected his clients to stop by his office about once a week. He might invite a client to join him for an evening of fishing or a night of coon hunting. He might dig into his own pocket to loan the client a few dollars to get a hole in his shoe repaired. He might help another one to restore relations with his wife or to find a job. He might even get a client up in the morning and drive him to a job until the client developed the habit of getting himself to work. While Bob demanded that clients do all they could for themselves, he also involved community service professionals as well as family, employer and others, depending upon the case.

While others might speak of various "treatment modalities" or "different treatments" Bob, telling it like it is, said, "There's more than one way to skin a cat." He could be tough when the situation demanded. For example, a young adult drug offender paroled to him by the court sauntered into Bob's office, slouched down in a chair across the desk from Bob, put his feet up on Bob's desk, lit a cigarette, flipped his ashes on the floor and said, "Well, here I am. What are you going to do about it?"

Bob stood up, reached across the desk, grabbed the young man's shirt front, jerked him to his feet, then set him back down hard in his chair. The kid gave Bob his undivided attention for the next half-hour. Bob helped him get a job, work through some other problems and stay drug free. Thereafter, whenever they met, he expressed his gratitude to Bob for turning his life around. He said no one had ever explained things to him like that before.

That incident might have returned Bob to prison for assault. However, the following incident was even more risky. One evening as Bob was chairing a community meeting on teenage drug use, the new Assistant County Attorney stood up and said, "So what's all this fuss about smoking pot? I smoked it all through college and through law school and look at me, I'm now a County Attorney."

At that point, Bob, who was up on the stage behind a table, stepped up on top of the table, down on the other side, jumped down off the stage and took out after the young county attorney who by this time was in full retreat. Several men caught up with Bob and restrained him. Bob

said, "If that SOB wants to smoke pot that's his business: if he wants to encourage our kids to use it that is my business. Turn me loose and I'll slap him silly."

Some weeks later Bob heard someone mounting the stairs to his second floor office. In walked the county attorney, now clean-shaven, and with a fresh hair cut. He was wearing a new, more conservative looking, dark colored suit with tie and button-down collar. He had even replaced his large horn-rimmed glasses with more conventional looking ones. He held out his hand and said, " Bob, I just stopped by to say how much I appreciate what you did for me. I'm a changed man."

The attorney's conversion likely was not nearly as sudden as it might appear. Very likely, Bob's actions only triggered a critical mass of social pressures against the attorney's pot use that had been building for some time. I did not witness that incident. I only learned about it from Bob's widow a couple of years later. I did, however, observe that County Attorney deliver a moving eulogy at Bob's funeral, publicly thanking Bob for what he had done for him.

One evening in 1983, Bob saw a TV documentary featuring Willie Nelson doing benefit performances to help American farmers who were suffering financially. As he walked into his office the next morning Bob said to his assistant, Jerri, “Get Willie Nelson on the phone.” A couple of hour, and many phone calls later, Jerri had located Nelson in a bar in Englewood Colorado. Bob got on the phone explained to Willie that many Washington County Iowa farmers were in financial straights and could use a helping hand. Willie agreed to contribute some funds, and arrangements were made with a local church organization to distribute them to needy farmers in the area.

Each fall semester I invited Bob to be guest lecturer for the 30 or so students in my University course on alcoholism. He would begin by candidly telling them that his only degree was a "KSP," which, he said stood for Kansas State Prison. Bob's captivating Oklahoma drawl, was made the more so by his colorful metaphors. A student asked Bob his favorite "therapeutic modality."

Bob drawled, "I don't know anything about therapeutic modalities. Hell, I couldn't counsel a horse turd out of a fruit bowl. But I do know how to talk to alcoholics." The class wanted me to invite him back.

An Iowa legislative committee, having heard of Bob's work invited him to come to Des Moines and tell the committee about it. Since I had been monitoring Bob's operation and making reports to the County Supervisors for some years, he wanted me to go along and present a report to the committee.

A few days before our scheduled meeting with the Committee, Bob dropped by my office. "Whatcha doin' Doc?" he asked. I said, "Well, I'm getting some notes together for our Des Moines trip." Bob said, "Whatcha worried about, Doc.? All ya' gotta do is tell it like it is."

That is what he did, and the legislature rewarded his center with an annual appropriation of $10,000. In 1976, The U.S. Department of Health, Education, and Welfare cited the

Washington Center as one of several bicentennial projects nationwide exemplifying a model community self-help effort.

Following Bob's death in 1990, Jerri Ginkens, the woman who had been Bob's long-time secretary/assistant took over the office. Although not quite as tough as Bob, she continued to operate the office much as he had, and did so to the continued satisfaction of the local government officials who fund the center.

I most recently checked the center's performance in 1997 and found that it was carrying an active caseload of 100 clients, with seven new cases per month. Its annual caseload amounted to about one fourth of the estimated number of alcoholics in Washington County. On an annual operating budget of only $72,428, counseling was available on demand to all clients at an annual per-client cost of $317 (not including the additional cost of hospitalizing some half dozen clients for detoxification). In other words, the Washington County office was providing the alcoholic an entire year of service for less than the daily charge of $400 at the nearby University of Iowa hospital-based Chemical Dependency residential treatment center. At that daily rate, one year of counseling would cost $146,000 per patient. Had all 195 of the Washington Outreach Center clients that year received the usual two-week treatment at the University Residential Treatment Center the cost would have exceeded the center’s actual budget by more than $1 million. The Washington Center unit cost was likewise only a fraction of what it was at MECCA, the nearby state-controlled center in Iowa City.

Evidently, cost-effectiveness was not considered when NIAAA refused to renew my community counselor-training grant in 1975. They said that it was not "professional" enough. Had I been more politically shrewd, I might have yielded to the University Administration's encouragement that I make the program more professional. However, I did not know how to do that without becoming part of the Alcoholism Treatment Center Movement. My commonsense goal was a State program that delivered the most help to the most alcoholics at the least cost.

CHAPTER 8

AND THEN CAME THE BUREAUCRATES

In 1974, I received a letter dated March 27, from Charles Churan, the Executive Director of the State Alcoholism Commission, an agency that Governor Hughes had established. The letter asked me to analyze Iowa's 1973 State Plan written by Mr. Harry Gittens, head of Governor Ray's new Iowa Division on Alcoholism. Ray was seeking legislation enabling the state to assert control over the local alcoholism centers.

To qualify for its share of the growing Federal appropriations under the "Hughes Act," each state had to submit an Annual State Plan. The plans had to follow certain guidelines set down by the Federal Government (NIAAA). Churan's letter stated that my critique of Gitten's State Plan would be invaluable when Churan's own Commission prepared its alternative State Plan, "…designed", he said, "to further the community service center philosophy that has worked so well…."

Churan was a dapper, always well-mannered, properly spoken and nattily dressed English immigrant. Some years earlier he had drunk himself out of a job as a reporter for an internationally famous newspaper. Gittens was a former school administrator. Despite my mother's admonition, "If you cannot say anything good about some one, then say nothing at all," I must say that I found little good and much bad to say, not about Mr. Gittens but about his Plan. It had virtually nothing to do with helping alcoholics but much to do with establishing bureaucratic control of the local community centers. He made no effort to define the alcohol problem, much less offer a coherent set of ideas for addressing it. The first half of the volume was mere filler--a collection of statistics on such disparate, irrelevant topics as home ownership, population characteristics, and so on. Many of its assertions contradicted each other. Many contradicted established knowledge.

Gitten’s Plan clearly intended to impose a top-down bureaucratic structure on Iowa's existing bottom-up self help community alcohol programs. It called for the Director (Mr. Gittens) of the new State Alcoholism Authority to make all decisions relating to local center programs in accordance with Federal guidelines and directives and state restrictions. Regional Coordinators, under the supervision of the Director, would assist the treatment centers in meeting required standards. Personnel recruitment criteria would be developed, as would standards for services, personnel, and facilities.

My critique pointed out that while a centrally directed administrative structure would be quite appropriate for addressing a problem for which there was a known solution, such as delivering polio vaccine to a population, no such solution was available for “alcoholism”, which still defied a medical definition. Science, much less policy makers, social engineers and program managers, still did not understand alcoholism sufficiently to justify imposing standard operating procedures on the centers.

To his credit, Mr. Gittens did not pretend to have an effective alcoholism treatment to offer. On the contrary, his Plan stated, "Scientists have not found a specific treatment for alcoholism. There seems to be no evidence that any treatment is better than another treatment and most treatments are administered on the faith that they do more good than harm." That accurate description of "the state of the art" explains why Churan's Commission and I had been helping Iowa's local communities to define the alcohol problem each in its own way and to seek its own solution, as all societies have always done. Despite my critique of Gittens' State Plan, however, Governor Ray (who succeeded Governor Hughes) obtained the legislation enabling the state to impose firm control on the centers as of January 1975.

The state takeover might have occurred a year earlier had my assistant Floyd Gardner not successfully lobbied the 1974 Iowa legislators. Floyd was a recovered alcoholic who had had some state and local political experience. The Governor's assistant, Dutch Vermeer, credited Floyd's lobbying with forestalling the necessary legislation. Robert Hardin, Dean of the College of Medicine called me in to and reminded me that such lobbying by university faculty violated University regulations, and admonished me, "Don't mess with Dutch Vermeer any more." The new state bureaucracy soon imposed program accreditation, counselor certification, and state licensure criteria on the local centers—all in the name of “professionalization.”. Although these untested, standard operating procedures included such details as requiring written treatment plans and 50-minute counseling hours, no effort was made to show their benefit to alcoholics. Thus, Iowa's treatment centers joined the national multibillion-dollar-a-year Alcoholism Treatment Center Movement. It was a clear triumph of politics, propaganda, and public relations over science, logic, and common sense, a victory of form over substance.

After 35 years and the expenditure of untold billions of dollars, it remains for science to demonstrate that the costly standard operating procedures imposed on the centers by well-meaning policy makers in the name of professionalizing alcoholism treatment, is of any special rehabilitation or prevention value.

The state administrators continued to use my client monitoring system for a while, not for research to learn from experience as originally intended, but to police the centers' compliance with the new standard operating procedures. During the first two years of State control, the growing federal funds allowed Governor Ray's new State Alcoholism Authority to nearly double the number of alcoholism treatment centers in the state, from 43 at the beginning of 1975 to 73 in 1977. The Alcoholism Authority's administrative budget and staff both increased approximately ten-fold. Much time, effort, and funds were expended preparing Annual State Plans and conducting endless conferences, workshops and training programs ostensibly to improve administrative and counseling skills, still with no obvious benefit to alcoholics. Center paper work increased five-fold. Additionally, the centers' staff spent much time and effort preparing for program accreditation, counselor certification, and state licensure. The time now given to these activities was time that had previously been spent contacting and trying to help alcoholics. This priority shift prompted some conscientious Community Counselors to resign.

The time had come to again ask, "WHAT’S IN IT FOR THE ALCOHOLIC?" The State did continue to allow me access to data on new client types and numbers for a couple of years. Those data, together with public budget figures, permitted me to make before-after trend

comparisons. In an article published in the Journal of Studies on Alcohol (May, 1979), I documented the fact that, although the number of centers had nearly doubled during the first two years of State control, they were serving only about half as many new clients. Expenditures per new client seen had more than tripled, from $501 to $1638. After the article appeared, the state administrators modified their monitoring system so as to preclude any further trend analysis or independent program evaluation.

In December 1974, a few months after my ineffectual critique of the Gittens' State Plan, and on the eve of the State asserting control of the centers, both Hughes and I spoke at the North American Congress on Alcohol and Drug Problems in San Francisco. As reported in the Alcoholism Report (Dec.27, 1974) Hughes, in an address to the opening session characterized the rapidly growing Alcoholism Treatment Center Movement with the pejorative term, "alcohol and drug industrial complex." He said,

> "We have, in effect, a new civilian army that has now become institutionalized." He went on to lament, "…the ever-enlarging structure of scientists, 'think tank' personnel, administrators, governmental funding agencies, lobbyists, associates, consultants, evaluators, technical assistants, and so on. Are we truly interested in helping human beings in need, or is our involvement a device for massaging our egos by regimenting people in the guise of helping them?" he asked.
>
> "Do we feel ourselves beginning to surrender to the false glory of bureaucratic empire building? Are we in the alcohol and drug treatment scene because we like the gamesmanship--the exhilaration of writing grant applications, running training programs, doling out money, traveling around giving advice, savoring the title of expert?"

Meanwhile, down the hall in a much smaller meeting room, I was extolling the merits of my Community Alcohol Counselor approach unaware that Hughes was being so critical of the Treatment Center Movement that he saw growing out of control. Had I anticipated that he would express such doubts about the development of his brainchild I would have brought Hughes a supply of the lapel pins that I had ordered made up for an earlier state conference. In bold white-on-black print, the two-inch diameter pin asked, ”<u>WHAT’S IN IT FOR THE ALCOHOLIC?”</u> His criticism of the mushrooming bureaucracy, led me to wonder, “Had Hughes studied my critique of Gittens' State Plan, or do great minds really run in the same deep channels?”

CHAPTER 9

HUGHES IN WONDERLAND

On February 5, 1988, after I had watched the Treatment Center Movement grow unchecked in the ways that Hughes had said some fourteen years earlier that he feared it might, I felt compelled to echo the doubts that he had expressed in that December 1974, San Francisco speech. I did so metaphorically at a national conference on treatment outcomes at the University of California, San Diego. There I presented a paper titled, “Enhancing the Natural Control of Drinking Behavior: Catching Up With Common Sense,” (later published in the journal, Contemporary Drug Problems, Fall, 1988).

In it I imagined that Hughes had taken his Treatment Center Movement down the illusory disease-treatment-cure lane into Alice's Wonderland. One day he met the Red Queen striding down the path. She had a smile on her face and a bulging moneybag in her hand. She was on her way to the bank. Although she was obviously in a great hurry, she could not resist taking the time to tell him all about the Alcoholism Treatment Center she had recently started with government grant funds.

She excitedly described how busy she was dreaming up innovative therapeutic modalities, upgrading admission policies, composing television and other advertising copy promising an 80%-- even a 90%, salvation rate, not only for alcoholics, but also for their co-dependent spouses, children, grandchildren and even their codependent cousins. In fact, her center would welcome anyone that she might entice to warm her procrustean one-size-fits-all treatment beds.

She did complain about the great amount of time and effort she must spend completing endless forms documenting her center's compliance with the ever-changing government program accreditation, counselor certification, and licensure standards--as though they had anything to do with helping anyone do anything. However, she did find time, she said, to write grant applications, conduct a training program, attend conferences, and supplement her income doing consulting work.

When Hughes asked her, "What's in it for the alcoholic?" the red Queen just smiled, glanced at her bejeweled Rolex, and said, "Oh dear, Oh dear. I'm late, I'm late." Then she hurried on down the path--smiling all the way to the bank.

The Director of the Betty Ford Treatment Center who followed me on the stage was not amused. He thought that I meant the Red Queen to be a metaphor for the former First Lady. That connection had not occurred to me, but I shamelessly accepted credit for it.

CHAPTER 10

SO WHAT?
WHAT'S IN IT FOR THE ALCOHOLIC?

"If a man will begin with certainties, he shall end in doubts."-- Francis Bacon.

If Harold Hughes began building alcoholism treatment centers with certainty, he ended in confessed doubts. As the Movement grew, so did his doubts that a disease is the cause and medicine the remedy for deviant drinking behavior. Some 26 years and untold billions of taxpayers' dollars after his legislative victory had launched the treatment center movement, and shortly before his death in 1996, Hughes told a British journal editor,

> "And we're still seeking the truth to this very day.… We don't know the answers yet. Maybe we never will. Maybe the answer is, we won't find it, and we are going to have to live with what we've got, the best we can." Addiction (1997 92(2)).

He went on to commend my efforts to help communities do the best they could with what they've got. He said of my Community Alcohol Counselor Training Program that he had helped develop back in 1966-67,

> "We had the first counselor training program I know of in America that amounted to anything. And we sent addiction counselors in the next five or six years all over America to start programs and to work in programs. If they had come through the addiction-training center at the University of Iowa, they were well received and well accepted wherever they went. I still run into some of them who are my age around the country, who went through that center for training."

If, as Emerson alleged, "A foolish consistency is the hobgoblin of little minds," then Harold Hughes was no small mind. Although his expressed doubts about the alcoholism disease concept grew apace with the growth of the Residential Treatment Centers Movement, he never renounced the movement. Although he often denounced the Movement's burgeoning bureaucracy for losing sight of alcoholics, he never suggested ending it. He often spoke favorably of my inexpensive Community Counselor approach and never criticized it. Still, he never suggested that it replace the costly residential treatment centers.

Back to the basic question that both Hughes and I repeatedly asked, <u>"WHAT'S IN IT FOR THE ALCOHOLIC?"</u> Opening hospital doors to alcoholics has undoubtedly saved lives as Hughes hoped it would. Some alcoholics might otherwise have lain in the gutter drowning in their own vomit. Some alcoholics are alive and drinking today who otherwise might be dead and sober. Some may even be alive and sober who otherwise would be dead and sober.

However, the alcoholism disease concept and the Alcoholism Treatment Center Movement that it spawned have done little to rehabilitate the bulk of the nation's estimated millions of alcoholics. What, if anything a certified professional clinician contributes to changing an alcoholic's drinking behavior remains to be demonstrated. Neither has the incidence of the supposed disease been noticeably reduced. Reported treatment success rates continue to hover around Dr. Applegate's century-old 29%. However, we are not sure what that means. From my experience as the director of the Oakdale 21-bed residential treatment center, I know that many of those 29% who remained sober following treatment freely gave us "grateful testimonials." However, we don't know how many of them would have recovered anyway in the natural course of events.

In 1999, NIAAA published its tenth triennial Report To Congress. The following summary paragraph, introducing the volume's chapter on treatment distills the essence of the Alcoholism Treatment Movement's progress to date.

> "Research progress in resent years has led to a number of important findings, including the following: (1) matching broad categories of client characteristics to different types of treatment does not substantially improve overall treatment outcomes; (2) professional treatments based on 12 Step approaches can be as effective as other psychological approaches and may actually achieve more sustained abstinence; (3) supportive ancillary services can be effective in remediating common problems that co-occur with alcoholism; and (4)higher intensity outpatient treatment may help patients gain control over drinking more quickly." (p.428) (Emphasize added.) The Tenth Report To Congress is available on the Web at http://www.niaaa.nih.gov.

That passage seems to say that the definition, diagnosis, treatment, prognosis, and prevention of alcoholism all remain no less mysterious to medical science today than they were when Harold Hughes and I first discussed the issue nearly 40 years and billions and billions of tax-payer dollars ago. Scientifically, alcoholism remains a behavioral, not a medical phenomenon. This lack of progress in the prevention and correction of deviant drinking reflects an observation by Daniel Boorstin, Librarian of Congress Emeritus, in another context. He said, "The main obstacle to progress is not ignorance, but the illusion of knowledge." It seems fair to conclude that alcoholism remains a myth, its diagnosis an illusion and its treatment a delusion.

So, what about the efficacy of my Community Alcoholism Counselor program? It hardly had time to become conspicuous, much less be adequately tested, before the state took firm control of the community centers, and aborted the program. The experiment had been fully operational for only about four years. To that point, the 43 community centers had established themselves as models of cost efficiency. All had served many alcoholics at relatively little unit cost as the Washington County Bob Gray Outreach Center still does today.

But, again, what was the alcoholic getting out of it? What were the Community Alcohol Counselors contributing to the natural recovery process? It pains me to admit that while their treatment success rates were no less than, neither did we find them to be significantly greater than, any other treatment. Follow-up interviews with former clients of three different community

centers found that, on several outcome measures, the success rates for the three centers did not differ from each other. Neither did they differ from the six-weeks residential treatment in the nearby Oakdale treatment center. All clustered around the all too familiar 29% figure.

If, as it appears, some alcoholics sometimes get some benefit under some unknown conditions from most, if not all, helping efforts, and given confirmed similarly low outcome rates regardless of treatment type, then cost-effectiveness becomes the chief consideration. Of course the free-for-the-asking AA 12Step program ranks first followed closely by the Community Alcohol Counselor who seeks to supplement the AA approach. Compared to more formal, institutionalized bureaucratic efforts, the Community Alcohol Counselor approach reaches far more cases at far less cost. No less important, as we have seen, a community counselor's help can be readily available to an alcoholic for an entire year for less than the cost of only one day of counselor service in a residential treatment center.

The Community Alcohol Counselor approach has another advantage over professional therapists: the widespread citizen involvement in every community counselor's case has the potential for strengthening responsible drinking norms. The very costly Residential Treatment Center option hardly deserves any consideration as a special help to alcoholics, except those with a physical illness needing medical attention.

A major lesson to be learned from the Alcoholism Movement is that we don't yet know enough about managing drinking behavior to justify such formalized, institutional or governmental efforts to control it by standard operating procedures. We should have learned that lesson from the failed Prohibition Movement. I have great faith in our society's capacity for self-correction. Eventually, the Alcoholism Movement will go the way of the Prohibition Movement, and for the same reason. It doesn't work. Barring the long hoped-for scientific breakthrough, we can only wonder what Americans in their common sense wisdom will try next.

I sometimes wonder, had Hughes known then what medical science knows now (or has failed to learn as he had hoped it might), where would the nation's efforts to cope with alcohol abusers be today? He might have invested his time, effort, and his considerable political skills in simply opening hospitals to the few advanced cases needing medical attention, and then promoted my Community Alcohol Counselor approach. He might have promoted action programs that depend less on medical science and more on the two things he said helped him gain and maintain sobriety, AA and his faith in God.

I hesitate to say it, since he is not here to defend himself, but I think that in some respects, Hughes and I thought much alike. We agreed that alcoholics helping each other to use existing community resources was more effective than professional psychotherapists sitting in their offices playing mind games with the alcoholic. We certainly agreed that the costly, irrelevant standard operating procedures imposed on the centers by Federal and State bureaucrats were more self-serving than alcoholic-serving. I believe that if he could do it all over again America would have more inexpensive Washington County type outreach offices, and fewer costly residential treatment centers.

His expressed doubts and criticism of the residential Treatment Center Movement that the “Hughes Act” launched back on 1970 did not keep him from ending up back in Iowa owning several personally profitable such centers. According to the Des Moines Register (Mar. 6, 1988), after leaving the U.S. Senate, and spending a few years doing religious work, much of it with Native Americans, Hughes returned home to Iowa in 1981. He returned in an old pickup truck, nearly broke financially. However, he soon owned several so called "Harold Hughes Treatment Centers" around the state. According to the Register, his profit from those centers combined with hefty lecture fees soon made him a wealthy man. Seven years after returning home he was driving a Cadillac during his stays at his Des Moines home and a Mercedes while in his Phoenix home where he also kept a stable of thoroughbred race horses that he had bought for his new wife.

I was never sure exactly what Hughes thought of me. I think he was always somewhat suspicious of me as an egghead. The following incident involving Governor Hughes and my Dad may hold some clue. In mid winter of 1966 my Dad, then an elderly retired farmer living near Kingsley, IA awoke in the middle of a cold February night to see a strange light flickering on his bedroom walls. He looked out the window and saw the next-door neighbor's house aflame. He rushed over and found the elderly, nearly blind homeowner couple, standing outside the burning house. The neighbor said that his 85-year old aunt was still in the house. Dad dashed in through the smoke and the fire, found the Aunt, and led her out to safety just before the house collapsed in flames. When the press reports of Dad's courageous action reached Governor Hughes, he decided to honor Dad with the State Life Saving Award. Governor Hughes personally presented the award to Dad in a public ceremony in Spirit Lake, Iowa on August 1, 1966.

A few weeks later Hughes and I met at a conference, where he said to me, "Mulford, when I met your Dad, I knew you couldn't be all bad."

I said, "Thank you, Sir."

Harold Hughes departed this earth October 24, 1996, and went off to that great happy hour in the sky.

THE END

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